ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Services de santé de Chapleau Health Services

Chapleau, ON

On-site survey dates: November 22, 2021 - November 25, 2021

Report issued: January 18, 2022

About the Accreditation Report

Services de santé de Chapleau Health Services (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 November 2021. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

A Message from Accreditation Canada

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

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

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Services de santé de Chapleau Health Services's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: November 22, 2021 to November 25, 2021**

- **Location**

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

  1. Chapleau General Hospital

- **Standards**

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

  System-Wide Standards

  1. Governance
  2. Infection Prevention and Control Standards
  3. Leadership

  Service Excellence Standards

  4. Biomedical Laboratory Services - Service Excellence Standards
  5. Diagnostic Imaging Services - Service Excellence Standards
  6. Emergency Department - Service Excellence Standards
  7. Inpatient Services - Service Excellence Standards
  8. Long-Term Care Services - Service Excellence Standards
  9. Medication Management (For Surveys in 2021) - Service Excellence Standards
  10. Point-of-Care Testing - Service Excellence Standards
  11. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  12. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	39	0	0	39
Accessibility (Give me timely and equitable services)	49	0	0	49
Safety (Keep me safe)	431	1	33	465
Worklife (Take care of those who take care of me)	92	0	1	93
Client-centred Services (Partner with me and my family in our care)	175	7	0	182
Continuity (Coordinate my care across the continuum)	29	0	0	29
Appropriateness (Do the right thing to achieve the best results)	715	2	26	743
Efficiency (Make the best use of resources)	46	0	1	47
Total	**1576**	**10**	**61**	**1647**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	35 (97.2%)	1 (2.8%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	48 (98.0%)	1 (2.0%)	1	93 (97.9%)	2 (2.1%)	1	141 (97.9%)	3 (2.1%)	2
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0
Medication Management (For Surveys in 2021)	82 (100.0%)	0 (0.0%)	18	45 (100.0%)	0 (0.0%)	5	127 (100.0%)	0 (0.0%)	23
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	104 (99.0%)	1 (1.0%)	0	176 (99.4%)	1 (0.6%)	0
Diagnostic Imaging Services	59 (100.0%)	0 (0.0%)	9	66 (98.5%)	1 (1.5%)	2	125 (99.2%)	1 (0.8%)	11
Emergency Department	70 (98.6%)	1 (1.4%)	1	100 (98.0%)	2 (2.0%)	5	170 (98.3%)	3 (1.7%)	6
Inpatient Services	59 (100.0%)	0 (0.0%)	1	85 (100.0%)	0 (0.0%)	0	144 (100.0%)	0 (0.0%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Long-Term Care Services	56 (100.0%)	0 (0.0%)	0	97 (99.0%)	1 (1.0%)	1	153 (99.4%)	1 (0.6%)	1
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
Reprocessing of Reusable Medical Devices	74 (100.0%)	0 (0.0%)	14	38 (100.0%)	0 (0.0%)	2	112 (100.0%)	0 (0.0%)	16
Transfusion Services **	75 (100.0%)	0 (0.0%)	1	69 (100.0%)	0 (0.0%)	0	144 (100.0%)	0 (0.0%)	1
Total	**723 (99.7%)**	2 (0.3%)	45	811 (99.0%)	8 (1.0%)	16	1534 (99.4%)	10 (0.6%)	61

* Does not includes ROP (Required Organizational Practices)
** Some criteria within the standard sets were pre-rated based on your organization's accreditation through the Quality Management Program – Laboratory Services (QMP-LS) program managed by Accreditation Canada Diagnostics

Overview by Required Organizational Practices

A Required Organizational Practice (ROP) is an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, categorized as major and minor. All tests for compliance must be met for the ROP as a whole to be rated as met.

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
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
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Les services de santé Chapleau health services (SSCHS) is a rural organization that is situated in the Sudbury district of Northern Ontario. Since the last accreditation survey in 2017, the organization initiated a multitude of achievements including a nurse call bell system upgrade, a refreshed strategic plan, COVID19 management, the activation program, MDRD upgrade, privacy, and confidentiality improvements.
The on-site survey demonstrated that the facility is valued by the patients and families, the physicians, the management team, and staff and by the community members. The entire staff members, physicians, leadership team and community partners who were met during the survey are proud of the SSCHS and enjoy coming to work.
The facility is clean and well maintained. There are gardens, and flower beds and patios for patients, families, and staff. Patients' rooms are bright and overlook beautiful landscapes of forest. There are hand hygiene stations throughout the facility and the organization is commended for its response to the COVID19 pandemic.
A focus on Health and Safety for patients, clients and employees is an organizational value and patients and families are invited to participate in planning and service designs. In long term care residents are cared for staff who treat them like family.
SSCHS is led by a dynamic, kind, and dedicated leadership team and Board. Communication with the leadership team is transparent and appreciated. The community partners that were met during the survey were proud of 'their hospital' but also expressed a wish of being more involved in clinical and in administrative services.
The exchanges that took place with the leadership team emphasized the challenges that the organization is facing which include: the upcoming implementation of meditech expanse, and the ongoing challenges of retaining and recruiting qualified staff and leaders.
From a patient quality and risk management perspectives, appropriate policies are outlined, and the organization recognizes the need to acquire an integrated quality and risk management system for tracking data and identifying trends and to ultimately embed quality and safety at the front line.

Detailed On-site Survey Results

This section provides the detailed results of the on-site survey. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary. Results are presented in two ways: first by priority process and then by standards sets.

Accreditation Canada defines priority processes as critical areas and systems that have a significant impact on the quality and safety of care and services. Priority processes provide a different perspective from that offered by the standards, organizing the results into themes that cut across departments, services, and teams.

For instance, the patient flow priority process includes criteria from a number of sets of standards that address various aspects of patient flow, from preventing infections to providing timely diagnostic or surgical services. This provides a comprehensive picture of how patients move through the organization and how services are delivered to them, regardless of the department they are in or the specific services they receive.

During the on-site survey, surveyors rate compliance with the criteria, provide a rationale for their rating, and comment on each priority process.

Priority process comments are shown in this report. The rationale for unmet criteria can be found in the organization's online Quality Performance Roadmap.

See Appendix B for a list of priority processes.

INTERPRETING THE TABLES IN THIS SECTION: The tables show all unmet criteria from each set of standards, identify high priority criteria (which include ROPs), and list surveyor comments related to each priority process.

High priority criteria and ROP tests for compliance are identified by the following symbols:

!	High priority criterion
ROP	Required Organizational Practice
MAJOR	Major ROP Test for Compliance
MINOR	Minor ROP Test for Compliance

Priority Process Results for System-wide Standards

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

Some priority processes in this section also apply to the service excellence standards. Results of unmet criteria that also relate to services should be shared with the relevant team.

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

The services de santé de Chapleau health services are assisted by a totally engaged Board of Directors who are passionate about their role in serving the communities across the Sudbury district. The board is comprised of seven members who participate on a variety of committees which include the Quality committee, the Executive committee, the Joint committee, Community relations, and the Recruitment and Retention committee. The board has a good mix of talent, expertise, and competencies. There are processes in place to evaluate the effectiveness and functioning of the Board meetings and the performance of board members. By-laws are reviewed periodically. Feedback is provided to the Board chair on his performance at every meeting and quarterly.

There are processes in place to monitor the performance of the CEO and the Chief of Staff. There appears to be a good working relationship between the board and the leadership team. Succession plans are in place for members of the senior executive team.

In 2019 the Board began a strategic planning exercise that resulted in the development of a four-year strategic plan (2020-2024) emphasizing the hospital's mission, vision, and values statement - inclusiveness, integrity, compassion, and focus on health and safety. The Strategic Plan comprises of three broad directions which are to continuously improve care and services, to collaborate to build a healthy community, and ensure sustainable operations. Patient and staff health are prominent throughout the plan.

The board understands its role as a governing body and is aware that oversight for patient safety, risk management, and quality improvement. It receives regular reports on the hospital's performance, quality improvement, adverse events, compliments and complaints, privacy breaches, and on patients and family satisfaction. Trends are tracked and variances are noted and questioned.

The board receives patients' stories at every board meeting, and it is encouraged to include a patient as a permanent member of the board.

A Board policy exists on conflict of interest and there is a formal process to identify and declare conflicts of interest during Board meetings: a standing agenda item on conflict of interest is declared at every board meeting. In terms of clinical ethics, although a policy on that concept exists in the Surge software, the board is encouraged to acquire additional knowledge in clinical ethics to better understand and support clinical ethics across the organization.

Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.5	Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families.	
6.5	Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

Les services de santé de Chapleau Health services (SSCHS) launched its strategic plan in 2019. The exercise was led by an outside consultant who assisted the organization in reviewing its vision, mission, and value statement. Input into the strategic plan included participation from the hospital's Board of Directors (BOD), who like many rural areas also represented the voice of the community. The hospital intends to, in the future, further engage clients, families, community partners, physicians, leaders, and staff in similar exercises.

The strategic plan outlines three broad directions that include continuously improving care and services to collaborate to build a healthy community and to ensure sustainable operations. Goals and objectives that derive from the strategic plan will be developed, reviewed, and updated annually. The strategic planning process is monitored using an action log with key objectives and timelines and it is available to the entire staff via the hospital's intranet.

SSCHS is one of two organizations that is working with the Ontario Health Teams. The hospital provides services and care to residents who live in the Sudbury district, and the organization is striving to create a model of care that is patient and family-focused. The hospital's values of inclusiveness, integrity, compassion, and focus on health and safety reinforce the importance of client and family centeredness. In addition, the hospital is designated as a French language institution and being the primary care provider for the Maawesying indigenous community speaks to the value of inclusiveness that the is embraces.

The patient satisfaction survey is an adaptation of the NIC Picker patient experience questionnaire and results from the survey are reviewed by the quality working group. Opportunities for improvement are implemented such as the installation of privacy glass in the emergency department, a ticket system at registration, ensuring that patients have items in reach in their room, and upgrading televisions so that they are user friendly.

In terms of policies and procedures, it was noted that some policies are outdated or were reviewed only a

few weeks prior to the survey. The organization is aware of the importance of putting in place a 'policy on the policy and procedure development' that will outline a systematic approach to policy and procedure creation and revision.

Since the last accreditation survey in 2017, there have been exciting organizational achievements and accomplishments such as a complete revision of medication reconciliation, quality huddles at the front line, the revision of the hospital strategic plan, new patient safety technology (call bell system, panic push button), new health safety orientation, revising the nursing model of care, partnering with Ontario Health Teams, COVID-19 initiatives. The organization is encouraged to monitor the progress of these achievements. In addition, although Kotter's change management model is used implicitly as a guide for change, the organization is encouraged to apply the model to enhance decision-making processes.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is to be commended for having a balanced budget for the past five years after experiencing important deficits for several years. There has been a concerted effort and attention to identify and implement cost-saving strategies that resulted in positive cost-saving outcomes for the hospital.

The annual budget preparation begins at the unit level with the previous year's allocation and variances as a starting point. There are well-established processes in place to analyze budget variances for each period and a rigorous process includes analysis of workload and utilization data and includes assessment of risk and opportunity. It is felt that managers are effectively using their financial reports to appropriately manage their budget portfolios.

The board is engaged in the operational budget planning process and receives detailed financial information regarding each department as well as a comprehensive report on activity levels and performance metrics including sick time, overtime, orientation hours, emergency room visits, and other relevant information related to service volume. These data are benchmarked against similar facilities and the organization ranks in the middle when compared to others. The finance department is excited to implement in the new year the Kronos software system to improve staff scheduling and workforce performance.

Cost-saving strategies over the years include all LED retrofit lighting, the purchase of shredding bins, and modifying the reception area to save on human resources expenses.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Human Resource (HR) department provides support to approximately 125 staff, of which approximately 85% are unionized. There are three bargaining units and there are approximately 20 volunteers and two permanent physicians.

There is a well-developed wellness program to support the quality of work-life balance and to promote healthy work environments for staff, leaders, physicians, and volunteers. Examples are the employee spotlight, Christmas events, Christmas turkey for all staff, hot chocolate, candy baskets, an escape room for team-building purposes, a health equity policy, flex time, turning point weekly emails on mindfulness, and encouragement to access the Employment Family Assistance Program (EFAP) is provided. In addition, social workers are tasked with assessing and identifying staff who are overly anxious and stressed. Since the onset of the COVID-19 pandemic, the visibility of wellness programs across the organization has increased.
The hospital's workplace violence prevention policy is regularly updated and revised. Training to better understand the policy and to carry it out appropriately includes a crisis prevention intervention module for all staff, leaders, and physicians.

Like in many remote hospitals, recruitment and retention are ongoing concerns and the organization is monitoring human resources data very closely. The application of Kronos software will be helpful in better understanding trends in human resource management. Talent management is seen as a hospital strength and 'star' employees who have the talent to assume leadership positions are flagged.

Since the onset of COVID-19 staff participation at meetings and on focus groups is offered virtually. This new work reality has been instrumental in supporting staff who live far from the hospital. The organization is encouraged to assess the impact of this 'new virtual reality' on cost effectiveness and on staff satisfaction.

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)

Les services de santé de Chapleau health services (SSCHS) has a well-developed quality plan that is aligned with the hospital's value statement which is to 'focus on health and safety.' We will care about the health and safety of patients, clients, and employees. Quality improvement is fully supported by the senior management team and by the Board of Directors. Quality is regularly discussed at the Board of Directors meeting and the organisation is encouraged to ensure that quality is a standing agenda item at all Board of Directors meetings. Department heads are in the process of developing goals and objectives that are linked to quality improvement and risk management initiatives.

The quality work group is multidisciplinary with leadership and front-line staff representation. The committee members provide oversight for quality and safety and monitor indicators and their compliance with set targets. The organization is encouraged to provide leaders with quality improvement reports that are easy to access and to understand and explore ways to facilitate incident tracking and reporting.

Medication reconciliation is well established across the organization as well as violence prevention, falls and wound assessments, patient double identification and transfer of accountability. Leadership huddles occur regularly, and the organisation may wish to transform 'huddles' to 'huddle boards' and to use them to display data and to communicate the work that is being conducted around quality and safety. This initiative could also become an opportunity to involve patients in discussions on quality and safety. Patient satisfaction questionnaires are regularly reviewed and updated. The organisation is encouraged to continuously consider patient and family input in planning and service design and a to appreciate that the patient's voice is essential in any change to the organisation.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

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

Surveyor comments on the priority process(es)

The services de santé de Chapleau health services Clinical Ethics Committee (CEC) was refreshed in 2016 and is led by a dynamic occupational therapist. The committee is multidisciplinary and representation from the front line and from the management team populates the committee.

The hospital decided to embrace the I.D.E.A; identify the fact-determined ethical principles in conflict-explore options-act and evaluate, ethical decision-making framework to assist the organisation in identifying and addressing ethical issues.

Although a contractual clinical ethicist from Ottawa acts as the hospital consultant for the staff, participation from the ethicist over the past six months occurred only twice. Committee members are keen and excited about ethics; however, they would benefit from the services of the clinical ethicists to guide them along their clinical ethics journey.

During the exchanges with the CEC, examples of ethical dilemmas that were brought up for discussions included wait listings in mental health, conflicts of interest when treating members from the same family, substitute decision makers, transferring patients and issues with ORNGE, to name a few.

When the topic of ‘trending’ and ethics came up the team members were unable to identify trends in clinical ethics. It was also noted that Terms of Reference in clinical ethics were developed, however, going a step further and developing a policy and procedure on the topic is recommended.

As the hospital's Clinical Ethics Committee pursues its efforts to build capacity and awareness around clinical ethics support from the Clinical Ethics Consultant, it is highly recommended.

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)

At the services de santé de Chapleau health services communication strategies include Facebook, the hospital website, Instagram, Twitter, the JJAM-FM radio station, LinkedIn, huddles, MediTech medical information system, Microsoft Teams, departmental meetings with staff and with the management teams, emailing, patient satisfaction surveys and face to face walkabouts. During the COVID-19 pandemic, several communication strategies were developed in response to the pandemic and the organization is commended for its ability to take the lead and to communicate efficiently during the crisis. To share pertinent information across the Chapleau region, the organization worked collaboratively with the community to develop, translate, and distribute communication material. A crisis communication approach is activated when bad publicity puts at risk the hospital's reputation.

A robust communication plan is in place and mechanisms to protect the privacy and confidentiality of patient information are respected; breeches in confidentiality are investigated in a timely fashion.

Staff members have access to information on the intranet and they appreciate reading the regular emails from the CEO.

During the on-site survey, when asked about their Rights and Responsibilities(R&R) patients were not able to describe them. The organisation is encouraged to remind patients and families of their R&R's.

Patient satisfaction survey results are communicated to the organization's management team and opportunities for improvement are developed such as involving residents in meal plans and putting in place strategies to promote patient privacy.

Although the organization utilizes a variety of strategies to obtain patient feedback (patient questionnaire, multi disciplinary rounds, patient and family advisory council, resident advisory councils), the hospital is encouraged to continue to include patients and family voices on hospital affairs and to provide patients with documentation that is easy to understand.

A future communication goal includes 'fixing up' policies and procedures redundancies and streamlining them.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Chapleau Hospital is well maintained and does not show its actual age (built in 1976) save for some areas that could use fresh paint. The organization has invested in several upgrades (new roof, new flooring in LTC and some other areas, new lighting (switched to LED lights) that have resulted in decreased energy costs to the organization. They have also installed a new call system. Since the last survey they have acquired a new back-up generator (back-up to the back-up). Several of the principal mechanical systems have also been upgraded in the past 5-10 years. All these systems are regularly checked and maintained. Systems are alarmed and monitored.

The organization has made several upgrades to ensure privacy and confidentiality. They instituted a numbering system in the reception/registration area so services (ER, DI, Lab) don't have to call out names in the waiting room. They have added walls to separate areas in order to increase privacy; they added glass walls and glass doors during COVID-19 to respect separation of acute care from long term care. The organization has a small fleet of vehicles (five) that undergo regular maintenance. One area for improvement is the wayfinding in the hospital. Using a people centered approach (fresh eyes from a user's perspective) wayfinding could be reviewed to ensure that departments are clearly signed and found. Hallways and units should also be visited to declutter the number of (outdated) paper communications posted on the walls and nursing stations.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Emergency preparedness (EP) is a noted strength of the organization. The SSCHS has developed an impressive Emergency Management Plan that is comprehensive and inclusive. The entire organization is committed to ensuring that patients, residents, family members and staff are safe and that employees are well prepared to manage emergency situations. Ongoing education and information on EP are available; all new hires and physicians receive training on codes during their orientation and are required to complete EP training modules upon orientation and one year thereafter. The organization is supported by the OPP including a memorandum of agreement, the local bus line, the fire chief and the fire department, paramedics, primary health care, the township, the department of public health, and the secondary school to assist in managing all types of emergencies. The hospital follows a standardized colour coded system for all codes and mock codes are carried out yearly. All codes are consistently debriefed and opportunities for improvement are developed, such as the installation of Remar stickers on all hospital doors, the process of lock changes following a debriefing of code white, becoming a certified 'crisis prevention institution,' to name a few. The process of identifying new codes and to prioritize them is based mostly on past experiences. For example, following a water shortage, the organization reached out to HIROC and developed with them mitigation strategies including access to a 24-hour water supply back up and eventually landed on the creation of a 'code agua'. In addition, a windstorm prevention and forest fire prevention contingency plans are being established. Given the vulnerability of the organisation in being located in a remote area and in order to maintain staff's response skills to emergencies, the hospital is encouraged to conduct mock codes on a more regular basis.

The organization works closely with Health Science North (HSN) who controls the hospital's information technology infrastructure. In 2018 the organization experienced a cyberattack that emanated from HSN, and the computer system was down for five days. The lessons learned following the attack included the importance of creating redundancies in IT as well as having designated computers in hot spots.

Excellent outbreak management structures and processes are developed and implemented. Teams rapidly respond to emergencies; the organization was recently challenged with a real code white that was managed in minutes.

Communication strategies are in place to inform and keep families updated during emergency situations. Arrangements are in place with the local high school to accommodate patients should there be a need to decant the facility. Regarding COVID-19 the organization works in full partnership with IPAC and is a designated center for COVID-19 assessment and vaccination. When asked about the hospital's management of COVID-19 and lessons learned responses included the importance of ensure that staffs' vacation were respected and that an eight-week supply of PPE (personal protective equipment) is

available.

Priority Process: People-Centred Care

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

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
2.3 The governing body includes clients as members, where possible.	

Surveyor comments on the priority process(es)

The organization takes great pride in being patient-centred and has a culture of care and commitment to clients.

Throughout the survey, clients and family members that were met indicated that they felt respected by the staff and involved in the development of their plan of care. Patient and family input is obtained through various mechanisms such as a complaint process, a patient satisfaction survey, and informal interactions.

In terms of patient safety, quality and experience, clients and family members expressed their appreciation with having access to clinicians, dietary services, and to the activation room. They also stated that feedback from patient satisfaction questionnaires was provided to them in a timely fashion. Family members stated that their loved ones were in a safe and clean environment. They expressed, however, that for some patients with mobility challenges, bathrooms in acute care did not accommodate their wheelchairs. The accessibility work group may wish to explore this issue more deeply. There was also the issue of bilingualism and that for some patients who were primarily French speaking, receiving care from an English care provider was challenging. The organization is encouraged to put every effort in place to enable French speaking residents and patients to receive care in French.

Finally, the organization is encouraged to ensure that patients, residents, and family members are aware of their Bill of Rights and of their Rights and Responsibilities.

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)
This organization has no overcrowding and patient flow issues. They do have contingency plans (in the emergency room and medicine services) in the very rare and unlikely circumstances when all beds are occupied. Their biggest challenge is managing ALC cases, and they have good plans in place for those.

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)

SSCHS has a small but modernized MDRD. They recently benefited from a grant from the Ontario Medical Association to purchase a mechanical cleaner and a new autoclave during COVID-19. This also gave them the opportunity to physically reconfigure the physical space of the MDRD that now has one decontamination room and one sterilization and packaging room separated by a wall but also by the mechanical cleaner. This allows staff to manually decontaminate instruments and place them in the mechanical cleaner that is accessible on the clean side. It is staffed by registered nurses certified in reprocessing. They mostly reprocess minor surgery trays from the Emergency department. The spaces (dirty and clean) are well organized and clean. Access is strictly limited to reprocessing staff. Reprocessing procedures and policies are all up to date.

SSCHS has a lot of relatively new medical devices and equipment (DI X-ray and ultrasound, the Ortho Vitros in Lab, MDRD cleaner and autoclave, as a few examples). The process is collaborative and consultative to define needs and criteria. They do use regional standing offers to procure certain equipment.

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 direction to teams providing services.

Competency

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

Episode of Care

- Partnering with clients and families to provide client-centred services throughout the health care encounter.

Decision Support

- Maintaining efficient, secure information systems to support effective service delivery.

Impact on Outcomes

- Using evidence and quality improvement measures to evaluate and improve safety and quality of services.

Medication Management

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

Organ and Tissue Donation

- Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Diagnostic Services: Laboratory	
7.10 Access to spiritual space and care is provided to meet clients' needs.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

This service has implemented a universal fall precautions strategy.

Priority Process: Diagnostic Services: Laboratory

The Laboratory service at the Chapleau hospital is small but well equipped. They provide services to the hospital in patient services, ER and LTC as well as for the community. It is staffed by 3 medical laboratory technicians, and they have a new recruit that they are in the process of training in anticipation of an imminent retirement. The medical director is a pathologist from the Thunder Bay Hospital who meets with the team regularly. The laboratory is in a secure area and closed to general access. The phlebotomy area is spacious, clean, and free of clutter. SOPs, policies, and procedures are kept up to date. Equipment undergoes preventative maintenance and all records are up to date. The organization is proud to have acquired a new state of the art biochemistry analyzer, Ortho Clinical Diagnostics (OCD) VITROS® Chemistry System. They received a certificate from the company for being the first organization to inaugurate the use of this new system. With no wait time and fast turn around of results satisfaction amongst the population and the medical doctors is very high, nevertheless the laboratory service uses every possible opportunity to improve their services. Staff benefit from excellent support from the organization to participate in continuing professional education activities to meet their regulatory body requirements. Staff undergo regular performance appraisals and express pride and satisfaction in the work and the services they provide.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
4.12 Access to spiritual space and care is provided to meet clients' needs.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

The diagnostic imaging (DI) service offers plain film x-rays and ultrasound services. This small department is staffed with two experienced radiology technicians that share a work schedule of seven days on and seven days off which allows for great work life balance. They offer 24/7 services. The volume of procedures is around 2400 a year (or an average of eight procedures a day). They serve the hospital as well as the community doctors. The Medical Director is a radiologist working out of the Timmins and District Hospital and who is readily accessible to the two technicians as needed. The DI team surveys doctors annually for their needs and surveys clients regularly for feedback and satisfaction. There is no wait time for services at this hospital. Films ordered through the emergency department are prioritized for reading and regular exams are read within 14 hours. The technicians have great support from the organization for access to continuing professional education to meet their regulatory body requirements. Technicians also benefit from organization wide training like First Aid, CPR, civility training, etc.

Policies and procedures are kept up to date. The equipment for plain film and ultrasound are relatively new and are subject to regular preventative maintenance.

The department is clean and well kept. Since the last survey the DI team has implemented a falls prevention strategy and all clients are screened at the registration desk for risk of falls and those at risk are flagged to the technicians on the requisition.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.6 Seclusion rooms and/or private and secure areas are available for clients.	!
Priority Process: Competency	
12.12 Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
16.2 The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
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 centre de santé Chapleau health services (SSCHS) emergency department is open 27/7, 7 days a week all year round. There are two procedure rooms, one trauma room, one eye room and three stretchers. The department is strongly supported by its community partners, including Emergency Medical Services (EMS), the OPP and Turning Point, which offers a mental health first aid class to the emergency department staff.

Information is collected from patient satisfaction surveys, length of stay and patients who leave without seeing a physician. An accessibility work group is formed with patients' representation and the group provides the organisation with suggestions on how to support patients who are in the emergency department with mobility issues. The emergency department nurse was unaware of these endeavours and expressed a desire to receive additional information on the patient's experience in the emergency department.

Priority Process: Competency

Learning opportunities are abundant and tailored to the staffs' role in the emergency department, which can include pediatric, trauma and acute care training. In addition, staff receive ongoing support from Turning Point who assist the clinicians in the management of patients with mental health issues. Applied Suicide Intervention Skills Training (ASIST) is also offered to the emergency department nurses to assist them in providing care to patients who are at risk of suicide.

The organization is currently supporting a nurse who is pursuing her nursing degree to become a nurse practitioner and the intention is to ensure that she will be returning to the emergency department once her course is completed.

Priority Process: Episode of Care

The ED does not encounter flow, overcrowding and long wait time issues. When the unit was visited there was one patient who was waiting to be treated. All the ROP's that are related to the ED were successfully met. Where the organization would require improvement is at the nursing station where brochures, posters and information on the glass area surrounding the nursing station prevent patients who are on the stretchers from being properly monitored and observed. The area is also cluttered and would benefit from some reorganisation.

The department is well equipped with both pediatric and adult equipment. Virtual care links with the ICU intensivist at the Health Sciences Center in Sudbury are established.

Finally excellent collegiality exists among the emergency department staff, the ED physicians, the emergency medical services and the OPP.

Priority Process: Decision Support

Suicide prevention, falls prevention, VTE and restraint free policies are inspired and guided by best practices.

There is a mix of paper charting (nursing notes) and electronic charting (medication orders) which can pose a safety risk as hybrid documentation can lead to duplication of information and errors.

Priority Process: Impact on Outcomes

Emergency nurses agree that quality improvement at the front line is not a familiar concept and that training on the concept of quality and safety would be an added value to them. Although white boards do not exist in the ED, the staff expressed their interest in pursuing verbal huddles on quality and safety issues.

Priority Process: Organ and Tissue Donation

This hospital is not an organ and tissue donation site.

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

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

Infection prevention and control (IPAC) at SSCHS is led by a very dynamic, engaged, knowledgeable and experienced IPAC CIC certified registered nurse who also oversees the hospital's Occupational Health and Safety program. The IPAC program is well defined, and its objectives and responsibilities are clearly laid out. All policies are updated. There is a main multidisciplinary IPAC committee that meets regularly and that was obviously very engaged and active during the COVID-19 pandemic. There is also a reprocessing subcommittee as well as an antimicrobial stewardship committee that is active and reports to the IPAC committee. SSCHS had no positive COVID-19 cases admitted and the infection rates at the hospital are very low. Any nosocomial infection is closely monitored. Outbreaks are investigated and reported to local/regional public health agencies. Regular audits are conducted and feedback is provided to the participating units as well as rolled out to the Quality and Safety Director. The IPAC Nurse also carries out risk assessments, especially where construction/ renovation projects are concerned to respect CSA regulations. SSCHS has its own kitchen that provides meals to patients and residents of long term care. All staff are trained in food handling. Environmental services staff are also trained in cleaning and disinfection procedures. IPAC and Environmental services just went through a thorough process to research and select the best cleaning product for housekeeping staff. It was a very collaborative and consultative process. There are regular audits using glow germ. It is recommended that housekeeping staff keep their cleaning protocols on their carts rather that in the cleaning closet. Also, staff should be more familiar with spill protocols and a code brown response. The IPAC program uses information from their various audits and patient satisfaction surveys to identify goals for their quality improvement program.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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

This is a small service comprised of 13 beds with several currently dedicated to ALC and one to palliative care. They admit mostly adults and infrequently some pediatric patients. There were no acute care admissions at the time of the survey. The leadership team reviews services and use several sources of information, including patient satisfaction surveys, to identify issues and opportunities for improvement of services. They have one negative pressure room, and two other rooms are piped to convert to negative pressure rooms (this was put in place because of COVID-19). The leadership team are members of the Multidisciplinary committee where a number of agenda items are reviewed. There is only one registered nurse on shift for this medicine department.

Priority Process: Competency

The staff of medicine services have many training modules on model of care and a variety of clinical topics available through their internal SURGELearn system. This is where staff can find training on infusion pumps, etc... In addition, nursing staff get requalified on ACLS annually. They also enjoy great support from the organization for continuing professional education. Interviewed staff report receiving regular performance appraisals. The team implemented in recent years the SBAR communication technique to standardize information sharing between team members about patients.

Priority Process: Episode of Care

The team uses a standard intake process with input from clients and families and patients wishes are well respected. Clients are provided with a variety of information, but it is unclear if all admitted patients are specifically informed of their rights and responsibilities, though they are posted in several areas of the hospital. All patients are screened for falls, pressure ulcers and risk of VTE. Medication reconciliation is done on all admissions and is very well done. There is one individual who is responsible for discharge planning and this process is started as soon as the patient is admitted. This individual ensures that the plan is well understood, and the discharge plan is transmitted to the patient's family health team. A follow up was done after discharge to ensure that everything went according to plan.

Priority Process: Decision Support

The medical team uses a hybrid model of charting with nurses completing their assessment and charting in the MEDITECH electronic chart while all other team members chart in writing in the paper chart. The organization knows this hybrid model presents a risk and are part of a regional initiative to expand the capabilities of Meditech (Meditech expanse). Nonetheless, they have a standardized set of health information that they collect and chart.

Priority Process: Impact on Outcomes

Patient safety incidents are reported and investigated. All incidents are rolled out and reviewed at the MDC committee and by the Quality Coordinator. All incidents are disclosed to patients and families. The team also conducts regular prospective analyses to improve safety. The discharge nurse also reviews all readmission data in view of finding the root cause of readmission and where possible make improvements to processes or put in place community-based strategies to prevent further readmissions.

Standards Set: Long-Term Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
9.14 Access to spiritual space and care is provided to meet residents' needs.	
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 LTC services are provided by a team of RNs, RPNs and PSWs. In addition, they are assisted by a Dietician, Behavioural Services Officer (BSO), two recreation specialists an OT and a Physiotherapist. The unit is secured, and the leadership and staff have made several efforts to personalize the living quarters for the residents, like applying decals to each resident's room doors that resemble front doors. Residents and families are consulted on many aspects of the services offered as well as the design of the living quarters.

Priority Process: Competency

All new staff are oriented to the service and retrained in the model of care. Staff are well supported by the organization for continuing professional education. This support has paid dividends for the service and the organization. Following a conference, the two recreation specialists attended an organization procured system called Activity Pro, a web-based Recreation Software for activity and recreation professionals in long-term care. This software allows the recreational professionals to create a personalized activity chart for residents and track the activities they enjoy in order to customize further activities. Family members can access their loved one's chart and see what activities they participate in. It also generates reports for the leadership team and the organization's leadership. This system has generated enthusiasm in the team, with the residents and their families.

The team holds regular multidisciplinary meetings tat which residents' family members are invited to go over goals and care plans. They have a very consultative approach on many aspects of the resident's living conditions and services.

Priority Process: Episode of Care

All intakes are done in collaboration with input from residents and their family members. Intakes follow a standard format. Residents are encouraged to take an active part in their care plan and to remain as autonomous as possible. The Activation Centre is greatly appreciated by residents, family members and staff. The pharmacist reviews each resident's medications in order to reduce as much as possible issues related to poly pharmacy. All residents' charts are reviewed by the multidisciplinary team on a regular basis to adjust care plans. There is a Resident Council and a Family Council for residents that provides great input to the team for improvements. The Recreation professionals develop a monthly calendar of physical, emotional, intellectual, spiritual, musical, and social activities. Participation in activities is monitored through the Activity Pro software and information is used to customize programs to meet the individual needs of the residents. The team respects and celebrates cultural diversity.

Priority Process: Decision Support

The team has adopted the PointClickCare chart for long term care. This system not only charts but allows scheduled monitoring and alerts and generates reports for team leads and care teams to use to monitor the progress of residents and adjust goals and care plans. All team members are mindful of protecting the privacy of the residents.

Priority Process: Impact on Outcomes

The team uses information from the residents council and family council to make improvements to services. They also monitor and analyze incident reports, especially falls incidents, to guide their quality improvement initiatives.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

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

This organization's pharmacy is staffed with one certified pharmacy technician (CRT) and one offsite pharmacist. The pharmacy is a secure site with limited access. It is clean and well organized with high alert, look alike, and hazardous items well labelled. They do not do sterile compounding or handle cytotoxic products. The CRT is active on the units in verifying/validating BPMH on admissions and assisting with med rec on discharge and raising with the local community pharmacy. She and the pharmacist will review requests for addition to the formulary, research the product and present findings to the multidisciplinary committee that will then make recommendations to the Medical Advisory Committee for approval. The drug formulary is reviewed regularly. The CRT also goes on the medicine services ward to check medication carts and ward stocks. Medications on the ward are kept in locked medication cabinets and oral drugs are dispensed in unit doses. Narcotics are well controlled and there is a rigorous process of drug destruction that is well documented. The CRT also performs regular checks of the medication room in the ER and crash carts and tag drugs that are about to expire. All doctors orders are audited by the CRT for use of "Do not Use" abbreviations. Statistics are compiled and presented at the Multidisciplinary Committee and also shared with the chief of medical staff who brings this item to the medical advisory committee. All medication error incidents are also reviewed by the Multidisciplinary Committee. The organization is in the process of moving to automatic dispensing carts which will be an additional improvement to medication safety.

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

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

The organization has met all criteria for this priority process.

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

Chapleau hospital currently only does glucose monitoring as a point of care testing. They have a total of three glucometers in the hospital. These glucometers are used inpatient service areas. Nurses are trained in their use and are responsible for their maintenance. The Laboratory Services are responsible for the calibration and regular quality control testing.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Transfusion Services	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Episode of Care
This criteria is met.
Priority Process: Transfusion Services
The organization keeps a minimal supply of blood and blood products. They do transfusions infrequently. When products are close to expiration the products are shipped to Thunder Bay hospital where they get used. A senior lab technician testified that they have not wasted any blood products in decades. They have met all OLA criteria and all the lab services personnel are current in their training and competency in transfusion services.

Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

Governance Functioning Tool (2016)

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

- Board composition and membership
- Scope of authority (roles and responsibilities)
- Meeting processes
- Evaluation of performance

Accreditation Canada provided the organization with detailed results from its Governance Functioning Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: May 6, 2021 to May 28, 2021**
- **Number of responses: 8**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	13	0	88	95
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	13	0	88	96
3. Subcommittees need better defined roles and responsibilities.	71	14	14	75
4. As a governing body, we do not become directly involved in management issues.	38	13	50	88
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	13	0	88	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	13	13	75	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	13	0	88	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	13	13	75	92
9. Our governance processes need to better ensure that everyone participates in decision making.	50	0	50	69
10. The composition of our governing body contributes to strong governance and leadership performance.	13	13	75	92
11. Individual members ask for and listen to one another's ideas and input.	13	13	75	95
12. Our ongoing education and professional development is encouraged.	13	0	88	84
13. Working relationships among individual members are positive.	13	13	75	96
14. We have a process to set bylaws and corporate policies.	13	0	88	94
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	13	0	88	97
16. We benchmark our performance against other similar organizations and/or national standards.	13	0	88	74
17. Contributions of individual members are reviewed regularly.	13	13	75	63
18. As a team, we regularly review how we function together and how our governance processes could be improved.	13	0	88	78
19. There is a process for improving individual effectiveness when non-performance is an issue.	25	25	50	59
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	25	0	75	78

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	50	0	50	45
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	13	0	88	77
23. As a governing body, we oversee the development of the organization's strategic plan.	13	0	88	95
24. As a governing body, we hear stories about clients who experienced harm during care.	13	0	88	76
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	13	0	88	89
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	13	13	75	88
27. We lack explicit criteria to recruit and select new members.	75	0	25	80
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	13	0	88	89
29. The composition of our governing body allows us to meet stakeholder and community needs.	13	0	88	90
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	13	0	88	92
31. We review our own structure, including size and subcommittee structure.	13	0	88	88
32. We have a process to elect or appoint our chair.	13	13	75	92

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2021 and agreed with the instrument items.

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	83

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
34. Quality of care	0	0	100	85

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2021 and agreed with the instrument items.

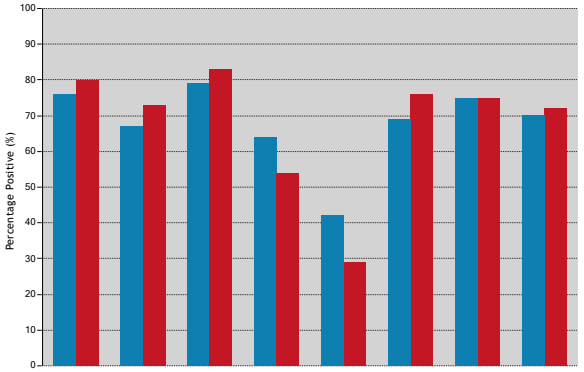
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: May 6, 2021 to June 3, 2021**
- **Minimum responses rate (based on the number of eligible employees): 63**
- **Number of responses: 63**

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
	76%	67%	79%	64%	42%	69%	75%	70%
	80%	73%	83%	54%	29%	76%	75%	72%

Legend

Services de santé de Chapleau Health Services

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2021 and agreed with the instrument items.

Worklife Pulse

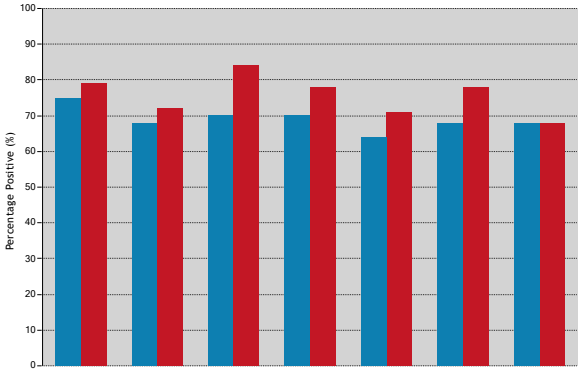
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: May 6, 2021 to May 28, 2021**
- **Minimum responses rate (based on the number of eligible employees): 68**
- **Number of responses: 70**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	75%	68%	70%	70%	64%	68%	68%
	79%	72%	84%	78%	71%	78%	68%

Legend

Services de santé de Chapleau Health Services

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2021 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

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

Priority processes associated with service excellence standards

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

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