ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:

Sunnybrook Health Sciences Centre

Toronto, ON

On-site Survey Dates:

November 14, 2010 - November 19, 2010

December 17, 2010

ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Sunnybrook Health Sciences Centre.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Sunnybrook Health Sciences Centre only. Accreditation Canada does not release the Report to any other parties.

In the interests of transparency, Accreditation Canada encourages the dissemination of the information in this Report to staff, board members, clients, the community, and other stakeholders.

Table of Contents

About the Accreditation Report..... ii
Accreditation Summary..... 1
Surveyor's Commentary..... 2
Organization's Commentary..... 6
Leading Practices..... 7
Overview by Quality Dimension..... 11
Overview by Standard Section..... 12
Overview by Required Organizational Practices (ROPs)..... 13
Detailed Accreditation Results..... 14
Performance Measure Results..... 56
Instrument Results..... 56
Indicator Results..... 64
Next Steps..... 73
Appendix A – Accreditation Decision Guidelines..... 74

About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

Legend

A number of symbols are used throughout the report. Please refer to the legend below for a description of these symbols.

Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.

Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.

Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.

Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Sunnybrook Health Sciences Centre

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

On-site survey dates	November 14 to 19, 2010
Report Issue Date:	December 17, 2010

Accreditation Decision	Accreditation

Locations

The following locations were visited during this survey visit:

1 Holland Orthopaedic and Arthritic Centre
2 Sunnybrook Health Sciences Centre

Service areas

The following service areas were visited during this survey visit:

1 Ambulatory Care
2 Cancer Care
3 Diagnostic Imaging
4 Emergency Department
5 Hospice/Palliative Care
6 Intensive Care Unit/Critical Care
7 Long Term Care
8 Maternal/Perinatal
9 Medicine
10 Mental Health
11 Operating Room
12 Sterilization and Reprocessing of Medical Equipment
13 Surgical Care
14 Telehealth

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Overall Strengths:

The organization, Sunnybrook Health Sciences Centre (SHSC) is located on two sites namely, the Sunnybrook Hospital and the Holland Orthopaedic and Arthritic Centre. There are more than one thousand staff at SHSC and in excess of one million patient encounters every year. As well, more than two thousand students of various disciplines are educated at SHSC and the research budget is $100 million. SHSC is constantly balancing among its mandates, research and education with the clinical roles, tertiary and complex care, with the needs of the community, and emergency and scheduled care.

The SHSC board composition has 22 members and its work flow is based on six committees. Committees report at least quarterly to the board as a whole. Every board member participates in at least one committee. The strategic plan was developed in 2008 and the process included an in depth revision of the mission, vision and values (MVV). The strategic plan is viewed as a dynamic document and is revised on an annual basis. The next cycle of the strategic plan is underway, due for release in 2011. Board members have a nine year time limit. Currently, board members are appointed for a three year renewable term, but annual reappointment is being considered. Board orientation is a multi-tiered learning experience for the members and is reinforced with continuing education at each of the meetings. The board has developed a skills matrix for renewal. Major board concerns include the problems of occupancy, the disclosure policy and effectiveness of critical incident reviews. A strong talent management plan is in place and it includes identification of potential executives across the organization, as well as executive education initiatives.

The 2008 strategic plan identified seven programs namely; Brain Sciences: Holland Musculoskeletal; Odette Cancer Centre; Schulich Heart Centre; Trauma, Emergency and Critical Care; Women and Babies; and Veterans and Community Care. The four strategic priorities are: cancer, with a focus on breast, prostate and colorectal; heart and stroke, with a focus on image guided innovations and stroke recovery; women and babies, focusing on complex pregnancies and critically ill newborns; and, trauma, with a focus on serious injury and major burns. At this time, a major redesign of the Schulich heart program is underway. In September 2010, the women and babies program was repatriated.

The SHSC has been successful in a number of areas. From an organizational perspective, SHSC is recognized as one of the top 100 employers in Canada. It is noted for its sustainable environmental programs and its family friendly atmosphere. The organization revised its mission and vision in 2008 as a first module in the LIVE Sunnybrook program. The RESPECT program and the Customer Experience program (to be launched in January, 2011) are the remaining modules of the LIVE Sunnybrook campaign, both of which also aim to reach out to employees and engage staff in customer service oriented activities.

Strategic planning is ongoing and a major update is planned for 2011. Leadership at all levels of the organization is strong. The staff at all locations and at all levels are proud of the organization. The hub and spoke model for ethics is an important model for other organizations, and a great resource for the staff. Transparency is exemplified by the "MYCHART" program where patients are encouraged to commence development of personal electronic medical records. Nursing and professional practice are well integrated and are focused on research and best practices. The SHSC has developed a model that encourages continuous quality improvement (CQI) at all levels of the organization. Quality activity is seen at the bedside nursing level as well as at the organizational level. At the clinical level, all services reviewed were characterized by the use of an interdisciplinary team. This was particularly evident in some of the medical programs. The organization has developed a model that is built on the foundation of patient centred care. Academically, programs are research based.

The two sites of SHSC attract an increasingly culturally diverse population. As a result, the organization should consider offering services in ways that are more culturally or linguistically diverse. This would effectively remove some barriers to care and empower some groups of patients by increasing the use of key community languages, both in terms of translation and written materials.

Care maps and best practice guidelines are used extensively at the Holland Orthopaedic and Arthritic Centre, but only sporadically at the Sunnybrook site. More widespread use of care maps could be an additional strategy in the bed management program. A recent modification of care map management at the Holland Orthopaedic and Arthritic Centre resulted in a reduction of average length of stay (LOS) from 4.8 days to 4.1 days for hip and knee replacements. Similar impacts on LOS may be possible in other areas of SHSC. An additional measure that could be undertaken that is an evidence based improvement in patient safety would be the use of pre printed order sheets. Although the gold standard is automated physician order entry, and is a stated goal, this is likely several years away from fruition. In the interim, the programs are encouraged to develop and use pre printed order sets. Another area for improvement relates to the physical plant. Most clinical areas are inordinately cluttered. The major concern is medication carts, which are often placed in high traffic areas. This poses a significant risk for the organization because nursing staff are too easily distracted when administering medications.

The Sunnybrook Health Sciences Centre has had a number of recent successes. The organization has successfully branded itself as an acute care hospital because of the trauma program, the burn program and the critical care programs. As a result, it is the hospital of choice for many people in the Greater Toronto Area (GTA). Another recent success is the integration of the women and babies program in September 2010. The logistics of the move were complex, and were managed very effectively ,and as of November 2010, the program is operating efficiently and effectively. Unlike many health care organizations, Sunnybrook has a very high retention rate, great staff satisfaction and committed volunteers. This is due in part to the RESPECT program, which is talked about by staff, but it is also related to a culture that cares about the employees. The SHSC is also highly valued as a partner. Clinical partnerships are evident in the cancer program and partnership with the North York General Hospital, and a partnership in thoracic surgery with the Toronto East General Hospital. This organization has been a leader in the development of the regional STEMI program, the regional stroke program and the EVAR program. The SHSC also works in collaboration with Thunder Bay in an imaging research program. It has established strong, collaborative partnerships with many organizations in the community, often providing leadership where needed. These partnerships enhance the profile of SHSC in the community and contribute to the well being of patients in the community.

In terms of success, the organization is a leader in quality, patient safety and risk management. In the area of risk, the culture of reporting adverse events is strongly embedded at all levels of the organization. The culture is non punitive and staff are not hesitant to report errors, near misses or adverse events. Critical incident reviews are undertaken as needed and all staff are aware of the activity. Adverse events, errors and near misses and critical incident reviews are viewed as a learning opportunity. The quality programs are deeply entrenched in the organization, ranging from organization wide quality initiatives to local initiatives undertaken by front line staff. This activity has created a culture of quality in the organization. The culture of safety is also an integral part of SHSC. A number of patient safety initiatives are in priority order. The organization works in collaboration with the Hospital for Sick Children and the University of Toronto to form the Centre for Patient Safety. The culture of patient safety is reinforced with frequent Patient Safety Walkarounds with senior leadership. Staff are aware of these initiatives and look forward to them.

Overall Areas for Improvement:

As with most health care organizations, SHSC faces a number of challenges. The most urgent is overcrowding. Eighteen months ago, the SHSC opened a new emergency department (ER) and occupancy jumped from a very manageable 95 percent to 105 percent, with spikes as high as 114 percent. Emergency visits increased by 20 patient/day from 100 to 130 and this was accompanied by an increase in acuity, as reflected in an admission rate that increased from 21 to 23 percent. More than 20 patients per day are admitted to ER, with no bed available on the units. Major areas of bottleneck are with critical care and increased unit activity, and in an effort to relieve the problem, a number of measures have been undertaken. These include the use of a computer based bed management system, with bed meetings two times per day. This facilitates earlier discharge and identifies patients that are close to discharge. Inpatient surgical patients undergo surgery early in the day, thus freeing up beds for admitted patients. Some short term rehabilitation patients are transferred to the Holland site. Patients may also be admitted to the hallways on the nursing units under some circumstances. On one occasion, the regional gridlock conditions were met. However, most regional hospitals are experiencing the same or even worse occupancy problems than at Sunnybrook. Innovative measures that are available include increasing the size of the short stay surgical unit and widening the scope of patients eligible for the program, more extensive use of care maps and pre printed order sets, a discharge area for patients ready to be discharged but for various reasons, are unable to leave until later in the day, and focusing on patients that fit the strategic priorities. The other main area of challenge is the aging physical plant. The dialysis unit is in need of an extensive upgrade. Space is crowded and the area is dark and uninviting. Nursing units are small and cluttered because of a lack of storage space.

Communication:

Communication across the organization is effective and transparent. The intranet contains all the policies and procedures and is available to most employees. Board, senior management, and medical advisory committee (MAC) minutes are posted. The web site contains extensive information for the public, including information about medical management, pamphlets, workbooks and guides. Printed copies of newsletters, activities and information for patients and staff are distributed in accessible public areas. Posters and information screens are strategically located. The volunteers are located near the front entrance and are a friendly first encounter for many people, particularly those with disabilities.

The organization has put forth an extensive effort toward communicating with the public and to erase the barriers to understanding. The SHSC leads many community outreach programs on health issues. Staff are frequently attending self help groups and educating the public on health related matters. There are many very successful education sessions, with expert speakers at the hospital. Sessions on key topics such as diabetes management and Alzheimer disease frequently attract as many as 350 members of the public. These are held six to eight times per year. The clientele of the organization are canvassed for future topics of interest. The SHSC is justifiably proud of its research accomplishments. Current, peer reviewed scientific papers are posted in clinical and department areas, and posters for scientific presentation are mounted throughout the two sites of the organization.

Community and Organization Relationships:

Sunnybrook Health Sciences Centre has effective relationships with the community. The health outreach initiatives are well received. The scientific participation nationally and in some cases internationally, is a source of pride and recognition for the organization. In the Community Partners' focus group meeting held as part of the on site accreditation visit, there were twelve participants either on teleconference, or in person. They described their relationship with Sunnybrook as exemplary. The partners ranged from a distant hospital in Thunder Bay to rehabilitaton/convalescent centres namely, St John's Rehabilitation Hospital, and Baycrest Centre for Geriatric Care, to academic linkages at the university to emergency medical services (EMS). All partners described open and easy communication with SHSC and cited a number of innovative and fruitful partnerships. They recounted the diligent work of SHSC individuals in collaborative projects around areas of clinical care, teaching and research. This extended to the chief executive officer (CEO), members of the senior leadership team, physicians and other staff. The organization was called, among other things, “an exceptional partner” and an “open, willing and flexible partner”. Specific examples were many and included among others, a strong leadership role in quality improvement in cancer services with Cancer Care Ontario, joint partnership in the Patient Safety Centre, leadership in telehealth, joint research projects, and close work with rehabilitation/convalescent centres to streamline care.

In summary, Sunnybrook Health Sciences Centre effectively balances the triad of patient care, research and education. Continuous quality improvement and patient safety are engrained in the culture of the organization. Interdisciplinary management of complex patients assures effective patient care. This organization is highly respected as a partner in the community. It recognizes key challenges, acknowledges them and puts in place measures to attenuate them. Critical incidents are recognized and reviewed and disclosure of adverse events is very well done. The SHSC is a very high functioning academic health sciences centre.

Organization's Commentary

The organization has no comment at this time.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

Leading practices are commendable or exemplary organizational practices that demonstrate high quality leadership and service delivery. Accreditation Canada considers these practices worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue.

Leading Practices
- are creative and innovative
- demonstrate efficiency in practice
- are linked to Accreditation Canada standards
- are adaptable by other organizations

Sunnybrook Health Sciences Centre is commended for the following:

Chemotherapy Appointment Reservation Manager (CHARM) & Communication Tool

The Chemotherapy Appointment Reservation Manager and communication tool is aimed at improving inter-departmental communication, improving management of chemotherapy treatment appointments and decreasing appointment wait times.

Chemotherapy is extremely complex. Treatment must consider patient age, wellness, and can consist of either 1 or more regimens, administered for a duration of 45 minutes to 8 hours, over one or multiple days, for a period as short as 1 day or as long as 2 years. In conjunction to the above requirements, all chemotherapy treatments must be coordinated with the chemotherapy unit resources, physician clinics appointments, radiation treatment, blood work, interventional radiology and the patient. To provide the best and safest treatment environment for patients and staff, it is imperative that all patient and treatment activities are coordinated. CHARM ensures that the chemotherapy treatment rules and requirements are applied consistently.

CHARM supports communication between pharmacists, nursing and clinicians regarding status of the chemotherapy orders, e.g. ‘approved’, ‘processing’, ‘ready’, etc. This is extremely important to effect the prompt processing of medications, commence more timely treatment, reduce patient treatment wait times and decrease medication wastage.

In summary, CHARM is an innovative web-based open source application that is highly sustainable and flexible with tremendous growth potential. An innovative approach to design and development of the system was employed. It was designed and built in-house as there were no existing products that met oncology treatment specific needs. CHARM addresses the unique needs of a chemotherapy treatment unit as well as being user friendly and efficient.

This Leading Practices relates to Cancer Care Standards 1.4, 3.5, 3.7, 12.5, 13.1 and 13.2 (Cancer Care and Oncology Services)

Hip & Knee Arthritis Program - Intake & Assessment Centre

A team-based care model has been introduced for patients with arthritis that includes: centralized referral intake using an electronic referral tracking system; timely assessment by specialized health professionals; emphasis on patient choice and empowerment; selective referral for specialist care based on defined criteria; improved follow-up care after discharge; and community partnerships to support healthy, active living. To maximize health human resources, a role for Advanced Practice Physiotherapists (APPs) was introduced. This role extends the physiotherapist's skill set in order to shift clinical workload from orthopaedic surgeons and add value to the patient experience through enhanced education. Sunnybrook's Holland Orthopaedic and Arthritic Centre began the introduction of this new model of care to improve access and quality of care for patients with hip and knee arthritis in response to the Ontario Wait Time Strategy. The model has served as the framework for the Toronto Central LHIN's Hip and Knee Arthritis Program. A current focus is on enhancing our community partnerships and stronger links with family health teams.
The leadership of an interdisciplinary team was key to the project's success. The team was empowered to be creative, while at the same time using sound quality improvement methodology, including multiple plan-do-study-act cycles of change. Patient and other stakeholder input was sought at all stages. Their values and input have been critical to the team throughout the evolution of the model.

Patients are highly satisfied with the comprehensive assessments, enhanced education and improved coordination and delivery of services. Additional performance indicators and outcome measures have been implemented to enable evaluation of each of the core elements. The introduction of our electronic Referral Tracking System has enabled real time tracking of referrals and reporting of wait time data. The successful implementation of this program has garnered tremendous national interest and has led to the establishment of community partnerships to support healthy active living for our patients. A tool kit has been developed to support this knowledge transfer. The change process that was used and the key elements of the model can easily be transferred and adapted to other patient populations. (Surgical Care Services)

Recreation and Creative Art Therapy Programs - Quality Indicators

•Utilization of the QI's has demonstrated to Recreation Therapists, the value the residents place on their experience in RT, which helps us advocate for and educate about RT practice.
•Resident feedback has provided evidence of importance of their relationships with RT and the link with the quality of their lives.
•This approach provides support for the shifting of RT practice away from quantitative activity-focused programming ("Mr. Jones participated in the baking program three times this month for 30 minutes") towards qualitative experience-focused programming. ("I like helping when I go to the baking program… Most of us aren't that mobile, we are in wheelchairs so we can't help a lot…, so I contribute in my own way, using my own personal knowledge")
•Use of the QI's in each component of our practice provides a transferable, systematic, method to identify, provide and evaluate meaningful Recreation Therapy opportunities.

Please note: This practice is linked to the Long Term Care Standards, sections 11.0, 15.4, 17.0. (Long Term Care Services)

Partners in Veterans Care: Families as Partners with the Interprofessional Team

The Partners in Veterans Care program has allowed staff and families to develop more insight into the perspective of the other, thereby improving their ability to communicate constructively and effectively. It has helped to improve our understanding of what "partnership" means to both care providers and families, as well as surfacing the successful communications strategies we already have in place, and revealing the challenges that we still need to address.

Please note: This links with Long Term Care Standards, 3.3, 4.6, 10.10, 10.11, 11.0, 17.0. (Long Term Care Services)

Dr. Thomas & Harriet Black Acute TIA Unit

The Dr. Thomas and Harriet Black Acute TIA Unit at Sunnybrook's Regional Stroke Centre is an innovative outpatient service dedicated to patients with high-risk TIA and minor strokes. This unit is a highly specialized "one-stop shop" enabling the most rapid and comprehensive diagnosis and treatment for this patient population that is at very high risk for recurrent stroke, disability, hospitalizations and death. This unit represents one of the few rapid-response programs of its kind in the world. We take a proactive approach to care that can reduce the risk of stroke by as much as 80 per cent. Aggressive diagnostic and treatment protocols literally condense three months worth of tests and physician visits into a single day. We have found a solution to bypass the standard wait-times and provide high-risk TIA patients with "same-day diagnosis". Patients receive a fast-track to consultation with a stroke neurologist and advanced practice stroke nurse, state-of-the-art MRI scans, Neuro-Doppler ultrasound and cardiac tests, and initiation of a personalized treatment plan to prevent stroke. Our team focuses special attention on early identification and intervention for carotid artery disease, atrial fibrillation, hypertension, and other vascular risk factor reduction strategies to protect the brain, the heart, and the mind. By preventing stroke, we prevent dementia and long-term disability.

The Acute TIA Unit Protocol includes:
-Same-day or next-day MRI scanning of the brain and the blood vessels of the head and neck
-Same-day or next-day Neuro-Doppler ultrasound of the carotid arteries
-Urgent specialty consultation by a Stroke Neurologist
-Consultation with a stroke Advanced Practice Nurse
-Comprehensive risk factor evaluation, education, and risk stratification
-Initiation of stroke prevention medications aimed at reducing the risk of subsequent strokes
-Rapid referral for carotid artery surgery to remove blockages as needed
-Follow-up care continued through the Regional Stroke Prevention Clinic

Our unit has set a new standard of care for urgent management of patients with TIA and minor stroke. The unit has enabled rapid access to specialist consultation and state-of-the-art, multimodality diagnostic investigations to optimize stroke prevention. We expect that clinical outcomes are improved compared to routine care elsewhere because our patients are being assessed faster and receive stroke prevention treatments right away (rather than waiting days, weeks or sometimes months). Over the past 2 years the Acute TIA Unit has helped about 200 of the highest risk patients to avoid stroke, including over 20 extremely high-risk patients who were saved from imminent stroke by quickly identifying dangerous carotid artery blockages in the neck and rushing them for urgent surgery (or stenting procedure) to treat the blockage.

Please note, this practice supports the following Ambulatory Standards: 1.4, 3.0 - 3.7, 6.1, 6.3, 7.2, 8.1, 8.5, 10.1 and 10.2 (Ambulatory Care Services)

Interprofessional Certificate in Advanced Neurosciences

The Interprofessional Certificate in Advanced Neurosciences was successful in engaging stakeholders and received endorsement from the North & East GTA - Ontario Stroke Region's Steering Committee and Ryerson University. The pilot offering of the first 4 certificate courses attracted 43 health professionals (as enrolled students), representing 14 professional groups and 16 organizations. Another 32 students expressed interest in enrolling in the Certificate, providing strong evidence that it is indeed positioned to meet the professional development needs of multiple disciplines. Development of the Certificate was also supported by knowledge exchange events focusing on principles of interprofessional practice and care. This included a one-day conference attended by over 140 participants representing diverse professional domains across the continuum of care.

This level and type of reach reflects a systemic quality that is often absent in educational interventions. Distance education programs traditionally focus on improving access across a wide geographical scope, irrespective of student affiliation. While the Certificate enrolment represented geographic diversity, this was accomplished by engaging multiple organizational partners within the allied health system, as opposed to recruiting individual, disconnected students. This allowed for the promotion of interprofessional practice within single organizations and across the system. The expectation of systemic change following from skill and knowledge acquisition is bolstered by interprofessional environments fostered through organizational participation and endorsement. This is a very promising model of system capacity building that has implications for many other health and social service domains. Sunnybrook's partnership with Ryerson and the North and East GTA Stroke Network should encourage the transfer of knowledge regarding this initiative – how it was built, and how it is implemented and maintained – to other systems. (Medicine Services)

Environmental Sustainability Program & Manager Position

As a result of the Environmental Sustainability Program, Sunnybrook has been recognized for many distinguished awards including being named as one of Canada's Greenest Employers for 2009. Of 30 winners, Sunnybrook was the only hospital to receive this distinction. The Greenest Employers competition is organized by the editors of Canada's Top 100 Employers and recognizes employers that are leaders in integrating environmental principles into their culture and having developed environmental programs that are recognized not only within the facility, but also at a local and national level. To continue the momentum, Sunnybrook was also recognized as one of Canada's Greenest Employers for 2010. It was another great accomplishment for Sunnybrook that the commitment to sustainability was recognized once again.
Sunnybrook was also recently awarded Employer of the Year for 2009 by Smart Commute; a company that promotes sustainable transportation. This was awarded because of Sunnybrook's efforts to launch a carpool zone - an online program that allows interested car poolers to look for commuters based on various preferences. It was also awarded for efforts to develop new strategies and tools to encourage non-single occupant vehicle commuting. These initiatives along with promotion of bicycle-friendly commuting also helped win the Bicycle Friendly Business Award for 2009 through the City of Toronto. (Effective Organization)

Overview by Quality Dimension

The following table provides an overview of the organization's results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	74	3	0	77
Accessibility (Providing timely and equitable services)	120	2	0	122
Safety (Keeping people safe)	500	4	19	523
Worklife (Supporting wellness in the work environment)	156	4	0	160
Client-centred Services (Putting clients and families first)	205	1	2	208
Continuity of Services (Experiencing coordinated and seamless services)	68	0	0	68
Effectiveness (Doing the right thing to achieve the best possible results)	696	12	2	710
Efficiency (Making the best use of resources)	72	1	0	73
Total	**1891**	**27**	**23**	**1941**

Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	91	0	0	91
Effective Organization	100	4	1	105
Infection Prevention and Control	103	0	0	103
Ambulatory Care Services	115	1	4	120
Cancer Care and Oncology Services	110	0	0	110
Critical Care	105	1	3	109
Diagnostic Imaging Services	102	2	0	104
Emergency Department	102	2	3	107
Hospice, Palliative, and End-of-Life Services	132	0	2	134
Long Term Care Services	121	0	0	121
Managing Medications	132	2	1	135
Medicine Services	103	1	0	104
Mental Health Services	107	0	4	111
Obstetrics/Perinatal Care Services	117	0	2	119
Operating Rooms	100	1	0	101
Reprocessing and Sterilization of Reusable Medical Devices	93	3	3	99
Surgical Care Services	96	5	0	101
Telehealth Services	62	5	0	67
Total	**1891**	**27**	**23**	**1941**

Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

All Required Organizational Practices (ROPs) have been met by the organization. There is no follow-up required.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Planning and Service Design

Developing and implementing the infrastructure, programs and service to meet the needs of the community and populations served.

Surveyor Comments

The strategic plan of the SHSC was completed in 2008 and is updated annually by conducting an external scan and a review of the strategic plan. This has created a dynamic process for strategic planning. The next major strategic plan and review of mission, vision and values will be undertaken for release in 2011. The board is actively involved in the process and takes ownership of the strategic plan.

The scope of services reflects seven programs and four strategic priorities. The seven programs are: Brain Sciences, Holland Musculoskeletal, Odette Cancer Centre, Schulich Heart Centre, Trauma, Emergency and Critical Care, Women and Babies and Veterans and Community Care. The four strategic priorities are: cancer, heart and stroke, high risk maternal and newborn health, and major trauma. An example of program scope and strategic priority is the Schulich heart program, where there is a redesign underway that will consolidate the program in one area for improved integration and continuity.

The organization uses a three armed balanced scorecard to monitor the implementation of the annual operational plan. There is an ongoing review of the goals and objectives, gaps are identified and action plans are developed to close the gaps.

The organization is actively engaged in the community to promote health and well being. Examples include the PARTY program to teach youth about injury prevention, and INVIGORATE, to teach seniors about personal safety and mental health outreach programs.

Many outreach initiatives are program based, and each of the seven priority programs conducts at least one outreach program per year. This is known as the speakers program. The programs are advertised using community based methods and attendance is excellent, averaging about 350 attendees. Most initiatives are interdisciplinary. The audience is asked about ideas for future initiatives. Examples include diabetes education sessions and Alzheimer disease.

Service planning is a continuous process. There are at least three programs that are widely based and these are the burn program, the trauma program and the more recently developed STEMI program. It is more difficult to define the community because many patients are attracted to the hospital due to the branding in high priority areas, so patients come from outside of the traditional catchment area. Sunnybrook undertakes to remove barriers to access such as language and culture. The organization uses information developed by the Local Health Integrated Network (LHIN) to identify health needs of the community. It conducts community forums and is embarking on a new program that will add information by way of "virtual" focus groups. Encouragement is offered to continue to develop the process to better understand the needs of the local community.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization's community needs assessment is maintained in a format that is up-to-date and easy to understand.	1.2	↑
The organization's leaders use information about the community to plan its scope of services.	2.1	↑

Resource Management

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

Surveyor Comments

The governing body has clearly defined policies, procedures and processes for the allocation of resources. A formal evaluation scan of the community and stakeholders was completed two years ago and involved the ministry, LHINs, surrounding hospitals and referral centres and representatives of community sectors. The resultant information was useful in identifying strengths and areas for improvement for the Sunnybrook Health Sciences Centre. The board and senior leadership team demonstrate the implementation of the strategic plan across the organization and make it operational, with operating plan development and management at all program levels. Ongoing evaluation of achievement of the plans is in place.

Visits to various programs identified that front line managers are involved in resource management. Financial reports are reviewed on a monthly basis. Staff are involved in identifying capital equipment that is required to meet the specific needs of their respective populations. The addition of the woman and babies program required specialized equipment for the coronary care unit to respond to the codes involving newborns.

The SHSC uses a multi year 'rolling' operating plan. This plan is revisited every year. A decision tree format has been established that enables the senior leaders to have a high level focus on the resource allocation to the four strategic priorities that include cancer, heart and stroke, high risk maternal and newborn health and trauma. The layers of this document assist all the team to be continually aware of resource utilization at multiple levels across the organization.

The board audit committee has oversight responsibility for monitoring the utilization of resources at a corporate level. The organization has had a balanced budget since 2002. Financial performance is reviewed on a regular basis, at all levels.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

The board orientation program defines the competencies, skills and attributes, including the specialized skills and experience required for the composition of the board. Role profiles are in place for the chair of the board of directors, vice chair, chairs of committees and individual board members. There are processes in place for the recruitment and selection of board members. The governing body uses a matrix to readily identify the skill set required when recruiting new board members.

The staffing processes are noted as being reviewed and assessed to ensure that staff are used to their fullest capacity. One unit is testing the utilization of a registered practical nurse (RPN) on evening and nights in addition to the RN staff. This area had been previously staffed with all RNs.

A senior leadership team performance management program has been developed and it was implemented in 2009. The program is comprised of performance and compensation program components for senior leaders. This includes required competencies, 360 performance evaluation, performance goals, professional development plan, community leadership, strategic workforce plan and compensation program. This program enables the alignment of multiple components to create a single process that manages, measures and ensures the ongoing development of the individual. This is seen to be an innovative program. This program should be considered for publication following an evaluation of the program's effectiveness in promoting the ongoing development of the senior leaders at SHSC.

Performance reviews are to be completed every two years. The completion rate is approximately 60 percent. Although some areas are up to date in completing the reviews, this is not consistent across the organization. An electronic tool is under review at this time, and it is expected to assist in improving the completion rate.

The organization is complimented on winning the "Employee Champion Award" from the Ministry of Education for the development of a student volunteer program that is based on an experiential learning program. The students attend school part time and volunteer part time.

Twelve hundred (1200) volunteers donate their time to the Sunnybrook Health Sciences Centre.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Effective Organization		
The organization has a confidential process for staff, service providers, and volunteers to bring forward complaints, concerns, and grievances.	8.6	
The organization's leaders implement policies and procedures to monitor performance.	12.9	

Integrated Quality Management

Continuous, proactive and systematic process to understand, manage and communicate quality from a system-wide perspective to achieve goals and objectives.

Surveyor Comments

The SHSC is clearly committed to fostering a culture of safety and quality for patients and employees. This is evident across the organization and is reflected in clinical care, education and research programs.

There is an integrated quality, risk, performance improvement, safety model in place, with co leadership, both medical and administrative. Patient relations and ethics are also integrated into the area.

There is an energetic and committed board committee that is charged with the quality mandate. The board receives a quality and patient safety quarterly report, which includes the data, targets, benchmarks, trends and appropriate interpretations.

Clinical areas report that they are able to develop local initiatives as well as undertake corporate projects.

Patient Safety Walkarounds with senior leadership have been held since 2005. Clinical staff members appreciate the involvement of senior leadership in this area. These rounds are now the focus of an evaluation project in conjunction with the Centre for Patient Safety.

The organization, the Hospital for Sick Children and the University of Toronto have collaborated with the Centre for Patient Safety, which has generated a number of initiatives. Initiatives include a certificate in Patient Safety and quality improvement. Staff report having done this program and appreciated it.

There are a number of other areas where SHSC has demonstrated close collaboration in quality and safety initiatives with partners such as the Ontario Hospital Association (OHA), Canadian Patient Safety Institute (CPSI) and the Local Health Integrated Network (LHIN).

Failure modes and effects analysis (FMEA) was conducted with respect to the order, collection and transportation of blood specimens from the emergency (ER) to the core central laboratory for clinical pathology.

There is recognition that there are many indicators being collected for the balanced score card. To address this, a task force group of both board and staff has reviewed the score card and has recommended fewer and more strategic indicators. This will be rolled out shortly.

The process for medication reconciliation on admission and transfer is in place in the Aging and Veteran's Care area.

There is a complex committee structure that oversees the direction and implementation of quality and safety initiatives. Many of these are driven by and required of legislation. However, it is suggested that there be an inventory of committees, and their mandates to ensure that there is no duplication and diffusion of priorities and/or effort. Reporting structures of these committees should also be reviewed to ensure that feedback loops are complete. This should be undertaken in light of the new Ontario legislation to be deposited. There needs to be a continuing emphasis, throughout, on multi/inter disciplinary quality/safety initiatives.

Sunnybrook has distinguished itself with its leadership in quality and safety. The organization should consider reviewing the reporting structure of the quality department so as to reinforce the philosophy and resultant message that quality/safety issues are constantly a priority and considered at the most senior management level

The organization should continue to maximize patient input into quality and safety processes.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

The accountability for reasonableness approach has been adopted as the framework for ethics decision making.

The ethics team has provided excellent information for hospitals on accessing ethics. This includes a document on guidelines for ethics consultations as well as a customer friendly pocket tool.

There are ongoing regularly scheduled ethics rounds. Ethics also is presented during the orientation of staff and medical residents.

The SHSC website has an excellent section on its ethics framework, which includes its annual report. This speaks to the transparency of the organization.

Clinical staff report that they know where to go for ethics consultation.

The ethics team is justifiably proud of a new database that has been developed, which provides data on many elements of the ethics consultations. The information provided serves as a basis for education and quality improvement initiatives.

The ethics group does thorough evaluations on a program basis. It then develops plans to address the gaps. For example, the evaluation of the trauma, emergency and critical care ethics support has led to a couple of innovative improvements.

The ethics strategic advisory group is comprised of members of the senior leadership team and members of the ethics group. They meet four times a year and discuss difficult issues such as uninsured patients and unfunded drugs. This is an excellent initiative in that it is bringing an ethics perspective to the management table, which underlines the organization's commitment to living its values.

The Research Ethics Board (REB) receives 500 submissions a year and has about 1400 ongoing projects. This group has put an emphasis in recent times on the quality assurance processes in the research processes, and education for its investigators.

The team is encouraged to find ways to maximize feedback from patients and community on the various ethics processes.

No Unmet Criteria for this Priority Process.

Communication

Communication among various layers of the organization, and with external stakeholders.

Surveyor Comments

Twelve of the partners interviewed, with seven via teleconference, and five in person at the Community Partners focus group described their relationship with SHSC as exemplary. The partners ranged from distant hospitals to local rehabilitation/convalescent centres to academic linkages with the university to emergency medical (EMS) services.

All partners described open and easy communication with the organization and cited a number of innovative and fruitful partnerships. They recounted the diligent work of SHSC individuals in collaborative efforts in areas of clinical care, teaching and research. This extended to the CEO, members of the senior leadership team, physicians and other staff.

The organization was called, among other things, "an exceptional partner" and an "open, willing and flexible partner". Specific examples were many and included among others, the strong leadership role in quality improvement in cancer services with Cancer Care Ontario, joint partnership in the Patient Safety Centre, leadership in telehealth, joint research projects, and close work with rehabilitation/convalescent centres to streamline care.

The information management team manages a large fleet of equipment, including 5000 computers and 150 applications. The team supports both Blackberries and I Phones.

Information management is a very customer focused team. With one eye on strategic priorities and the other on front line clinicians, this group is providing both standard and innovative approaches to information management. Innovative initiatives include regular client service rounds and a dedicated solution team. Projects of note include the electronic discharge summary system, which recently won an award. The service rounds were cited by a clinical area as being very helpful and a good improvement.

Physicians are closely involved in planning and developing of information systems. Staff report that the Smart page system has improved communication with physicians.

The SHSC is a leader in the area of privacy issues and is called upon to provide leadership and services to other organizations.

Training and education for information systems is available via a number of modalities. Depending on the scope and nature of the application, the most appropriate method is chosen, be it classroom, e learning, or individual training.

Both communications and information services elicit feedback from a number of sources, and were able to illustrate examples of using this information to improve services.

The organization obtains feedback from stakeholders using a number of approaches, including focus groups, one on one interviews, and meetings

The SHSC has a lecture series for the community, which includes topics such as heart disease and injury prevention.

Communications and communication strategies are well integrated into the organization. One example is the integration of the women and babies program, which was well supported by the communications team. Another example is the excellent kit and training that has been prepared to support the upcoming customer service program.

The website, both intranet and internet are well designed and customer friendly.

A range of publications for patients and community is available. These include newsletters, pamphlets, and handbooks.

The organization is still heavily paper based. This results in a number of redundancies with both computer and paper systems. This is related to test ordering, laboratory values and administrative systems such as for staff scheduling. The team is well aware of this issue and has a plan to address it.

There were some comments about response time for repair calls for the computers in very busy clinical areas, in that response is not as quick as needed.

Communication has stated that addressing diversity is a challenge.

No Unmet Criteria for this Priority Process.

Physical Environment

Providing appropriate and safe structures and facilities to successfully carry out the mission, vision, and goals.

Surveyor Comments

The organization identified that a high risk item is its core infrastructure. A facilities condition assessment study showed that upgrades are needed in electrical, piping and boiler systems. The organization is working hard to mitigate the risks associated with this problem. This includes a good level of awareness and communication about needs for upgrades. Information is appropriately shared with the senior leadership team, board and government.

The plant operations staff are using range of tools available for preventive maintenance (PM) to keep on top of issues, including infrared testing for hot spots among others. Priorities are being set and revised and a ten year plan is being developed. Projects have addressed some of the issues. For example, work has been completed on a 28 million dollar Honeywell project with upgrades to generators, chiller, boiler, and transformer. Phase 2, involving another 5 million dollars will commence soon.

Clinical space in a number of areas is outdated. Of particular note is the dialysis unit. Despite recent efforts at a facelift and efforts to improve safety, it still lacks adequate and well organized space. The unit is spread out and results in the need for increased resources for the number of dialysis stations. Expensive equipment is stationed in hallways, as there is no other space. The technical room for equipment repair is very crowded. A plan has been submitted for a new physical plant. A visit to another floor similarly showed clutter, small rooms, and an open medication cart in the corridor. The Holland site campus space is not as restricted.

Formal customer satisfaction surveys for plant operations were carried out in 2007 and 2008. It is important to continue to gather this information and develop improvement strategies. The compliments/complaint data in 2010 shows that there are areas for improvement, as there were 851 compliments and 361 complaints, for a total of 1212 comments.

Plant staff are well equipped to handle some environmental issues internally such as flood issues, There is a flood response kit, staff are certified in water remediation, and work closely with risk management and infection control.

Plant managers show a good understanding of the quality cycle. Subsequent to a power failure, and a departmental debrief, improvements in the response were suggested and will be implemented. Specifically, an overhead announcement of power failure will be done, generators are tested weekly and "kicked in".

All front line plant operations staff use handheld devices, which results in work orders being quickly transmitted, as well as an organized way to address geographic challenges.

The good preventive maintenance (PM) program includes beds and wheelchairs.

Environmental services is working with infection control on infection outbreaks.

There is a plan is to set up a central equipment room for a systematized cleaning of stretchers, wheelchairs, and there will be a bar coding system attached.

There is a plan to introduce micro fibre technology in all patient care areas. This has been shown to be effective in infection control.

Competency testing for environmental staff is carried out.

There is a well developed and implemented emergency response team.

The Sunnybrook Green program is a very strong and unique initiative that encompasses many elements. As a result of its creative initiatives, SHSC has won a number of awards including being one of Canada's 100 Greenest employers, and the Canadian Council on Health Service Executives (CCHSE) energy and environmental stewardship award.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

The organization has shown itself to be a leader in emergency preparedness. This is evidenced in the very elaborate and detailed preparation for the G20, which involved many partners such as the City of Toronto, EMS, LHIN, police and so on, and close collaboration with these groups.

Pandemic planning was done before many other organizations and as a result, it served as a model for others. This program was updated in 2009.

There was a thorough review and implementation of codes on integration of the women and babies program at the Sunnybrook Hospital site. This involved the development and implementation of a number of different codes.

Numerous participants have undergone chemical biological radioactive nuclear (CBRN) training.

Sunnybrook has a detailed emergency management plan that details current status, future plans and goals, and a detailed timeline to achieve these goals.

Due to the size of the organization and its sites, fire drill training takes on many facets including on line training, quizzes, as well as face to face training. At the Sunnybrook Hospital site, data are not collected in a systematic manner so as to know which areas have not done their drills. This is not an issue for the Holland site where the staff do regular drills and follow ups are completed. The organization should address the systems/resources necessary to ensure that all areas are carrying out regular drills with appropriate follow up.

The organization should review the frequency and distribution of evacuation drills and ensure that they are being carried out as needed.

No Unmet Criteria for this Priority Process.

Patient Flow

Smooth and timely movement of clients and their families through appropriate service and care settings.

Surveyor Comments

High occupancy rates are a continuous problem at Sunnybrook Hospital site since the new ER department opened 18 months ago. Prior to that time, occupancy usually was about 95 percent, with occasional surges. Since the new ER department opened, the average number of cases treated increased by 20 percent from 110 per day to 130 per day. Admissions also increased from 21 per cent of emergency visits to 23 percent of visits. At the same time, the number of patients admitted with cancer related diagnoses increased as the cancer program expanded. On the day of the patient flow tracer, occupancy was at 109 percent, with 29 patients admitted to the ER department.

There are two major areas of bottleneck, the critical care units and increased unit/ward activity. Other problems include an average of 46 alternate level of care (ALC) patients and similar problems in other regional hospitals. Occupancy problems are exacerbated during peak demand periods like influenza season. All efforts are made to cancel a minimum number of elective patients, particularly those undergoing major surgery; however, cancellation does occur with a troubling frequency.

There are some measures in place to attempt to ameliorate the problem of overcrowding in the ER department, but these do not necessarily improve the overall occupancy problem. Measures taken include an active bed management system with experienced triage personnel and support from team leaders on the nursing units including the critical care units. An effort is made to discharge early and a notification system is in place for housekeeping to prepare a bed area for a new admission. A sophisticated bed management system is used and if conditions change, the triage department and team leaders know immediately.

The organization is working with community partners to optimize patient flow. The CCAC is embedded in the organization, and transfers to long term care, home care and other non hospital settings are in place. Patients requiring rehabilitation are identified early and all necessary bureaucracy is completed. There is some opportunity for repatriation of some patients to the Baycrest Centre for Geriatric Care. A clinic has recently opened that allows intravenous (IV) antibiotics to be administered outside the hospital setting for patients without the support to do so at home. The regional geriatric program is successful in proactively preventing admissions of the frail elderly.

The team at the Sunnybrook Hospital site is encouraged to examine the possibility of expanding the use of care maps, using early discharge protocols and developing discharge areas for patients ready for discharge. There may also be repatriation possibilities in referral hospitals for tertiary and quaternary care. It is also important to re examine admission criteria in the ER department and review admission and discharge criteria in the critical care units.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Emergency Department		
The team has strategies in place to effectively manage overcrowding and surges in the Emergency Department.	2.3	↑
The team quickly recognizes overcrowding in the Emergency Department and follows protocols to move clients elsewhere within the organization.	6.3	↑

Medical Devices and Equipment

Machinery and technologies designed to aid in the diagnosis and treatment of healthcare problems.

Sunnybrook Hospital Site:

The sterilization and reprocessing (CSR) department is an active participant in the selecting and buying of equipment for new programs or program expansions. The new women and babies program initiated in September 2010, required year long planning for instrumentation and staff training. The addition of this new service required the addition of new staff to the department to meet the increased volumes.

Flash sterilization has been significantly reduced. One piece of equipment has been flash sterilized over the past six months and was for one single piece of equipment. There are documentation processes in place for any equipment that is flash sterilized.

There is a comprehensive education and competency program in place for both sites for the sterilization and reprocessing staff. The Sunnybrook Hospital site department has an on site educator. All staff are required to be certified and competencies are evaluated every two years. The team is encouraged to move toward an annual review of competency assessment.

Policies and procedures are current and on line for easy access by all staff. There is a hard copy version for access if required.

Holland site:

Flash sterilization occurs infrequently and records are kept when this does occur. The date of the last flash sterilization was January 2010 and was due to a dropped piece of equipment.

Both the Sunnybrook Hospital site and Holland site need to ensure that hand washing sinks have the appropriate handles for wrist, knee or foot operation or electric eye controls.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Reprocessing and Sterilization of Reusable Medical Devices		
The organization conducts baseline and annual competency evaluations of staff members involved in reprocessing and sterilization.	2.5	
The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	3.5	
The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	5.2	↑

Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Ambulatory Care Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The SHSC receives more than one million ambulatory care visits annually. Through evaluation of the types of patients presenting at the facility, a one stop shop approach for the ambulatory care population has been developed. This includes modalities of diagnosis, treatment and follow up.

There is strong leadership in the ambulatory care programs.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Odette Cancer Centre:

Competency assessments are required for every staff member when they rotate to a new diagnostic assessment modality in the radiation therapy program. This ensures that all staff maintain competency in their skills. These assessments are signed off by the program manager.

Holland Orthopaedic and Arthritic Centre:

This centre has shown a leadership role in the changing of the model of care delivery for orthopaedic patients. The establishment of an advanced practice physiotherapist (APP) role has led to collaboration between the orthopaedic surgeons and physiotherapists in managing the assessment and follow up care of patients having total hip or knee replacements. The scope of practice has been extended for the specially trained physiotherapists practice under medical directives and they can order diagnostic tests, when assessing the patients that have been referred to the clinic or in the follow up process.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

Odette Cancer Centre:

In response to client no shows the team developed a "teleminder" program that automatically contacts a specific population, for example, patient for the pigmented lesion clinic, to remind them of their appointments that are six months apart. Because there was a large number of patients not returning for follow up, this program was introduced in January 2010 and significant improvement has been noted.

Medication reconciliation is under discussion at this time and plans are made for assessment at the time of initial visit and if any changes have been made.

The Odette Cancer Centre has an electronic order entry system that all the oncologists use. This is a comprehensive program that allows all staff to be immediately informed of the patients' current treatment plans, progress and test results.

Client access to their records is available via the "My Chart" program, which allows the patient to access records electronically from anywhere. Clients sign up for the access from health records.

Holland Orthopaedic and Arthritic Centre:

The guide for patients having hip or knee replacement is a comprehensive patient information guide that is easy to understand. Patients noted that the compact disc (CD) "Teaching Series", included with the booklet was very helpful.

Medication reconciliation is completed for all patients as they are admitted to the organization. These medications are reviewed at the initial assessment and again at the pre operative two week visit to determine if there have been any changes.

A "coach" program has been developed that allows a patient to choose a family member that will be in attendance for the patient orientation program, education sessions and actively involved in the care plan for the patient.

The "working condition program" is a collaborative third party payer program with WSIB. This program provides access to regional evaluation and assessment services.

Schulich Heart Centre:

The centre’s ambulatory laboratories and clinics provide leading edge and innovative, high quality patient care. The interdisciplinary team is supportive, respected, engaged, and focused on research, best practice and excellence in patient outcomes. Teamwork is a priority for this program and was identified by staff as its main strength. This program is world renowned and has attracted international physicians to become members of the team. One staff member reported feeling very privileged to work at SHSC. There have been many innovative procedures and advancements in technology developed and implemented. Patient outcomes are measured. Patient satisfaction is very high and staff and patient education is a priority.

Patient and staff safety is deeply embedded into all areas of this program. The TAVI laboratory has implemented the surgical checklist and the catheterization laboratory is in the process of also implementing a modified surgical checklist. Consistent infection control practices were observed during the tracer. The teams respect the relatively new policy on, no food or drinks and no jewellery in clinical areas.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team receives clients at the service area in a manner that respects their privacy and confidentiality.	6.2	

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Client records are complete and communication is further enhanced with the use of the electronic recording of treatment plans, goals, and progress.

The physician development of the electronic order entry program at the Odette Cancer Centre is noteworthy.

The SHSC is a leader in its application of evidence based practice and using research to apply best practices. This was evidenced in many areas at both the Odette Cancer Centre and the Holland Orthopaedic and Arthritic Centre.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

There is evidence of the use of two client identifiers in the ambulatory care programs.

The Odette Cancer Centre has pictures of the patients that appear on the electronic record, with patient permission, as an additional measure to check the correct identification.

No Unmet Criteria for this Priority Process.

Cancer Care and Oncology Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The team works very closely with the CCAC, discharge planning, the different rehabilitation facilities, long term care (LTC) facilities and all other agencies to ensure the continuum of care of their patients. Team members work very closely together, frequently review their goals and objectives and adapt the services provided to the needs of the patients. This interdisciplinary teamwork is just as evident in the outpatient department as in the inpatient units.

The outpatient area is organized around four different programs namely: systemic therapies, radiation oncology, surgical oncology and patient and family support. This last program is the most recent addition to the care provided and is only two years old. It includes palliative care as a member of the team and the team is working on increasing the visibility of the support to the patients and families.

All oncology orders in the outpatient department are electronic and have been for almost twenty years. The SHSC is moving to having electronic physician order entry on the inpatient units for oncology this February. The introduction of a new chemotherapy reservation manager (CHARM) system was driven by long wait times for the patients, poor satisfaction by the patients, reduction of same day chemotherapy, changes in the clinic space and staffing, and worries about patient safety. In the end, the team wanted safe nursing and pharmacy practices. This new system is able to provide the next available appointment, based on nursing time required for the delivery of the treatment, the patient needs and acuity, the unit and staffing capacity and finally, blood work and clinic/pharmacy mix time.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

There is a very strong interdisciplinary team in place with occupational therapy (OT), physiotherapy (PT), social work (SW), speech pathology, chaplain, dietary, pharmacy, physicians and nurses. In the inpatient units, the team works more closely with the general practitioners in oncology, who are based on the units and are the physicians that have day to day responsibility for the care of the patients.

The RNs on the inpatient units are all certified by the advanced practice nurse (APN) and many of them have the CNA certification and/or the certification provided by the De Souza Institute. There are also numerous sessions internally and the topics vary based on the needs of the clinical staff; for example, there were sessions in November on end of life care. There are lunch and learn and workshops, and on occasion, outside speakers will be invited to present.

There is an intensive orientation for the new members of staff, lasting up to six weeks.

The performance appraisals are done on approximately 60 percent of the staff members.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The most responsible physician (MRP) will refer back to the patient's primary physician to provide a summary of the care given by the team.

There is a computer based program called OPIS and it stands for oncology patient information system. This program was designed and developed twenty years ago by Cancer Care Ontario (CCO) to meet the unique needs of scheduling and data reporting for the outpatient cancer programs. Patient disease information and demographics are registered in the hospital system and in OPIS when patients are referred to the cancer centre. There is interface between the two systems, and this OPIS system is used for clinic visits, chemotherapy and radiation. All the data that need to be reported to CCO is extracted for the OPIS system.

The inpatient units have access to the OPIS system to review where patients are in their treatment regimen. There are two pharmacists assigned to the inpatient area and they act as a resource for the patients, families, physicians and other clinical providers. Medication reconciliation is done fully on oncology patients.

Pain assessment is consistently done on every patient. They can refer the patient to the pain team of physician, APN, RN if the management of pain is not optimum.

Infection prevention and control (IPAC) has been working closely with the units to provide education in the form of workshops, retreats, and increasing the number of hand hygiene outlets.

Although emotional distress of the patient and family is assessed, the latest patient satisfaction surveys indicate that patients and their families were not satisfied with the emotional support provided to them. An extensive analysis of the data from the survey was done and reported to the clinical staff members. This is now the main focus of the team to be addressed. A research study is now under development, with a principal investigator, and the main focus is on providing emotional support to patients, families and staff.

If there is a complaint from a patient or family member, they are directed to the manager or to the patient advocate.

There is a transfer accountability form that is used for all transfers that are either intra or inter hospitals.

The outpatient team is in the process of developing the patient education assessment resource learning (PEARL) centre, which will provide classes for the patients, modules on e learning and the offerings will be multi lingual.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

All processes and procedures are evidence and research based, and this is the culture in the oncology team and for the organization.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

There is a comprehensive incident reporting system that provides extensive data to the managers and directors to review trends.

No Unmet Criteria for this Priority Process.

Critical Care

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The critical care team has to the extent possible made the best use of the physical environment to ensure that it provides high quality critical care to their patients. Privacy and appropriate space for managing patients with end of life care plans is challenging for the team. The situation of high occupancy rates is something that the leadership team must routinely address. The burn unit was toured during this tracer and the team has made a conscious decision to not redirect patients that might otherwise need to be transported to the United States for burn care. The critical care team worked with its sister hospital to address surge capacity issues during recent potential periods of high patient volume.

Team goals are coordinated and aligned with the corporate strategic priorities. Staff meetings are conducted weekly so staff have access to quality, safety and best practice updates.

It was very apparent during this survey that all units in the trauma, emergency and critical care research program (TECC) work in a collaborative manner and collectively value high quality and safe patient care, including the importance of innovation and research applied to clinical practice. The TECC team is in the unique position of having members with vast international experience. There is standardized orientation, recertification and implementation of best practices, documentation standards and the innovative staffing model known as the critical care nursing resource team (CCNRT).

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

Most of the critical care areas were visited during the survey. The inter professional collaborative teams are commended for their focus on patient and family outcomes, quality and patient safety initiatives and quality improvement activities. Daily rounds are conducted.

Each of the critical care units has an active staff-led education practice council. The various committees and councils and working groups help engage staff and encourage decision making and empowerment of the staff. As a result of collaborative leadership in the TECC team and daily meetings to address staffing issues, agency staff have virtually been eliminated.

Daily goals were documented for patients and topics/issues for rounds were also documented. Staff reported that there is a variety of ways in which support is provided for them when it is required following traumatic incidents. Support for ethical dilemmas and situations is available for staff. While not all staff were able to articulate the ethical framework, it is evident that staff are knowledgeable about the process of accessing this type of support.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

This team is an extraordinary group of specialized critical care staff and physicians who are dedicated to their patients and families. There is a high level of pride and commitment to their team and to the Sunnybrook corporate brand in general. Incorporation of research, science and innovation is evident in all critical care areas surveyed. Implementation of best practices was a theme throughout the tracer.

While clinical pathways and clinical practice guideline are not specifically implemented in the units, pre printed orders and clinical protocols are used to reduce clinical variation and to ensure that best practices are used in patient care plans. The team is implementing several of the Safer HealthCare Now! bundles and is developing protocols for deep vein thrombosis (DVT) prophylaxis, sedation interruption, early enteral nutrition, and pressure ulcer risk assessment. The SHSC is home to Ontario's busiest rapid response team.

Critical care is not the team selected to be responsible for the medication reconciliation required organization practice (ROP) but is part of the three year roll out plan. The patient health record is very comprehensive and streamlined. Team priorities and family issues and concerns were easily identified. Inter professional documentation was thorough and consistent.

The team has been trained recently to provide care for maternal patients that experience complications during the labour, delivery and their post partum period.

The critical care team has a plan to implement a best practice guideline for delirium. The plan includes assessment and management, with a target date of January or February 2011. While medication reconciliation is being implemented on this unit, it is not consistent and not all components of medication reconciliation are in place. Due to the acuity and ventilation status of critical care patients, they were not directly interviewed. However, family members were involved in the tracer. There is a high level of satisfaction and gratitude for the level of expertise and caring provided to the family. One family member spoke about his plan to donate to the hospital as a small gesture of thanks for the care that his loved one has received from the care team.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team uses a delirium screening tool to assess clients for delirium.	10.8	

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Intensivists and interdisciplinary team members, including medical students, residents and fellows work in collaboration to provide high quality critical care and burn care to their patients and families.

Privacy and confidentiality was observed to be maintained. The incorporation of research and best evidence into practice is a priority for this team. Furthermore, this team is dedicated to the development of new knowledge for critical care and burn management.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

There is a strong culture of transparency and patient safety in the critical care units. Critical care indicators are posted in public areas for staff, families, visitors and volunteers to review. Critical care indicators are available on the public website for stakeholders to review.

Adverse events and QCIPA reviews have resulted in quality improvements to create a safer clinical environment for patients.

The team has presented many quality improvement initiatives and research studies at conferences and scientific symposiums.

No Unmet Criteria for this Priority Process.

Diagnostic Imaging Services

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Critical incidents are reviewed by the programs in the diagnostic imaging service.

No Unmet Criteria for this Priority Process.

Diagnostic Services - Diagnostic Imaging

Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

Diagnostic imaging (DI) services at the Sunnybrook Hospital site is an effective service offering a full range of services to patients and physicians at the hospital. There are more than 350,000 examinations undertaken annually in seven major areas. These are general radiology, nuclear medicine, interventional radiology, CT scanning, MRI scanning, ultrasound, and mammography. The service is efficient and effective. Radiology supports the strategic plan of the organization in the areas of clinical care, research and education.

The greatest asset of the service is the people. The staff are engaged, well trained, open and reflect transparency. It is clear that patient focused care is a primary concern. There are 32 radiologists, 18 nurses and 150 technical people. Adequate support staff are present in all areas. There are four major business practices that contribute to the effectiveness of the service. Staff have been cross trained in their areas and can manage a broad range of cases. The department has developed service contracts and liaisons that ensure that the down time of imaging equipment is minimal. All equipment undergoes preventive maintenance every six months. The department works with vendors to ensure that the equipment is up to date and well maintained. The practice is as efficient as possible given the space, time and financial conditions.

Quality of practice is assured via the audit and safety program. The program is divided into four areas namely; standards, care delivery, safety and CQI. In each of the areas, the program links to accreditation standards and the goals and objectives are aligned accordingly. The safety program is enhanced by safety walkabouts. A survey of physicians using MRI and CT services was recently undertaken. The department has completed the analysis of the program and plans to make changes as determined by the survey. Likewise, an annual patient satisfaction survey is undertaken, resulting in appropriate changes.

Several areas for improvement have been identified. It is important to improve the delivery system for critical reports. It is also important to set the system up so that receipt of a critical report is acknowledged. Booking of both patients and staff is decentralized. The efficiency of the service could be enhanced by the purchase or development of a centralized booking system. The use of order sets that contain clinical information for imaging procedures would improve the service further.

Errors and adverse events are infrequent in all areas, with the exception of interventional. When they occur, they are reported and the information is used to improve the service. Patient complaints are usually related to wait times and are managed locally, but the team is aware that support is available as needed. The major safety and risk concerns include wrong orders, duplicate orders, and incomplete clinical information.

Wait times for service are carefully monitored. Priority 1, 2 and 3 are almost always completed within the recommended wait time. Priority 4 in several of the areas fluctuates, but individuals on the list are monitored to ensure that if the status or needs change, the service is offered as required.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies and verifies the education and competency of staff involved in reprocessing of diagnostic imaging equipment and devices.	7.4	
The team informs the referring medical professionals immediately following unusual, unexpected, or urgent findings.	11.3	↑

Emergency Department

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

During the survey, the staff reported that they are involved in decisions that impact on the emergency department (ER) and feel comfortable when sharing their ideas and solutions to issues. Staff are encouraged to become involved in working groups and activities related to unit goals and objectives. The committee structures and working groups are very effective at ensuring that quality and safety issues are addressed.

The operations and medical leadership team is commended for its approach to engaging staff and physicians in process improvement activities. For example, the department chief has created a sophisticated team of medical director positions, administrative leads and education leads. There is a variety of committees and work teams in which ER staff can participate.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The inter professional collaborative team is made up of an enthusiastic group of professionals that address the complex and acute needs of the patient and family population.

The trauma, emergency and critical care team has been working together since the winter to reduce the use of agency staff. The team's leadership meets daily to review staffing needs and to plan strategies to address them. Staff are reassigned to various areas within the ER to meet the demands of the department as they occur. New staff receive a comprehensive orientation and may attend an ER education program as part of their orientation. There is a professional development program in place. Staff meetings are held weekly and minutes are emailed to the team.

Staff and physicians report a high level of satisfaction with the operations and medical leadership of this program. Staff contributions are recognized in various ways. For example, there is a star of the month that is chosen by staff members based on a nomination process. Staff and physicians are kept apprised of new issues, policy changes and other necessary information by brief and concise emails. Many staff reported that they have received recent performance appraisals. The ER department leadership team has included chart reviews as part of the performance appraisal process.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The trauma and emergency (ER) program is comprised of a highly effective, dedicated and compassionate group of professionals. The regional trauma program is well respected and is a role model for managing complex and seriously acute trauma patients. There is a trauma team that responds to a special code when the Sunnybrook Hospital site receives a trauma patient. The ER department nursing staff support the trauma room and must reassign staff from other areas of the department when a trauma patient presents, given the unpredictable nature of this program.

The ER department has experienced a 30 percent increase in visit volumes, which is significant. The ER is subsequently challenged with associated wait time issues, such as admitted patients being held in the department and related issues. There are many initiatives and process improvement projects underway to address these issues both within the department and also as corporate initiatives, demonstrating that the program is not alone in trying to resolve the wait time issues and patient flow. The team is encouraged to review the arrival at emergency process that is, time waiting for greet and/or triage nurse assessment, from a patient perspective. Some patients have experienced difficulty knowing where they should present themselves, and where they wait for triage assessment during times when the first assessment RN is not scheduled. There are also some challenges at the registration area that impact on privacy and confidentiality while patients wait to be registered. The team is encouraged to review the registration process to improve patient confidentiality and privacy. The triage nurse makes all attempts to reassess patients in the waiting room within appropriate Canadian Trauma Acuity Scale (CTAS) reassessment time lines. Patients are not consistently informed of expected wait times. Patients are assessed and isolated as required, based on IPAC policies. The staff and physicians are very responsive to process improvements that have been implemented to improve patient flow, improve the quality of emergency care and implement of best practices.

Staff and physicians report that they are proud of their teamwork and ability to respond to and embrace change. Additionally, it was reported that the leadership empowers staff to make simple and effective change without complicated approvals. They speak about process improvement activities with authority, experience and pride in their ability to make a difference. Rapid rounds occur weekly. Physician assistants have become members of the inter collaborative team and are highly valued in the role they have in the delivery of effective emergency medicine. Staff wear panic buttons and receive training in both non aggressive crisis intervention and reducing workplace violence.

The location of security provides little immediate support for staff and this should be reviewed, as the safety of staff as well as patients and visitors must be assured.

The team would benefit from incorporating principles of diversity and cultural competency into their goals and objectives to ensure that patients and families have appropriate access to care while addressing special religious and cultural needs, and to communication vehicles such as patient brochures in various languages. The team is also encouraged to review the paging system used to call patients for registration, as it currently impacts on patient confidentiality and privacy. Providing patients with a short but unique number to be used as their identifier might be an alternative strategy as a suggested alternative. Patients and families generally reported, when interviewed during the tracer, that they are very pleased with the quality of patient care they receive and are impressed with the customer service level of respect and dignity afforded to patients by staff and physicians. Care was reported to be first class and world class. The emergency was not the unit identified where the medication reconciliation for clients with a decision to admit and transfer was to occur;however, it is part of the three year roll out plan.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Staff report a high level of satisfaction with the information technology available in the ER department The physicians have access to protocols and patient related information and this has significantly improved over the years to the current innovative state.

The ER department dashboard is available on line and the drill downs provide additional information to enable prompt decision making.

There is widespread use of pre printed order sets, protocols and medical directives as appropriate. Research is incorporated into the daily practice, and research and innovation was evident throughout the clinical tracer in the department.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Staff and physicians are provided with several venues to discuss quality and safety issues related to the emergency department and patient care. Patients and visitors reported that staff verify identification both verbally and via the armband.

Hand hygiene was witnessed appropriately throughout the tracer. There is a culture of transparency regarding critical incidents and disclosure of events to patients and families. Process improvements as a result of the QCIPA reviews were shared. A culture of safety was palpable throughout the ER department.

The impact on admitted patients being held in the emergency is a concern for the team, senior leadership, board of directors and in the rest of the hospital. While significant improvements have been achieved, the organization is encouraged to continue to be vigilant and work on initiatives to improve patient flow.

There have been many new programs and new initiatives implemented and the TECC team in particular is working together to improve the quality of care for their patients. Patient satisfaction with staff communication, attitude, caring and quality of care is high. There are many fewer complaints than typical emergency departments and concerns typically relate to wait times.

No Unmet Criteria for this Priority Process.

Hospice, Palliative, and End-of-Life Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The program's acceptance criteria are that the patient must have a do not resuscitate (DNR) form signed and that they are expected to be terminal within three months. There are no age limits on the patients that they accept, except that they must be 19 years of age or older. If in three months time the patient's condition has changed, that is, it has improved, then the status is reviewed fully and they hold a family conference and discuss with them discharge to a longer term palliative care organization. The bulk of the patients, between 85 and 90 percent have malignant tumours.

During the week of the survey, the program's services were expanded by adding an additional eight beds. There is a palliative consultation team of a physician, an advanced practice nurse, a chaplain, and a social worker, which can be contacted by the inpatient and outpatient units at the Sunnybrook site for all patients that would benefit from the service.

The program has links to a large network across Toronto and this network is accessed for some patients that have to be transferred from their program, or do not meet the admission criteria.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The teamwork is very evident in this environment, and they do rounds on all the patients every Wednesday and all the members of the team are present. They are collaborative in their approach and they provide support to one another. There is good "chemistry" on the team, and members have worked hard at understanding each other's role and continue to do so. Every member's opinion is valued. Even the patient's voice is evident during the rounds, as they are asked their input in advance, using the Edmonton assessment tool and this information in included in the rounds.

The team develops its own goals and objectives and will highlight a topic for the year. For example, the most recent was safety and the focus was on the controlled analgesia (CAD) pump safety and producing a check list to facilitate the review of all that is required when caring for a patient that had this pump for pain management. As their next project, the team wants to develop a pre and post therapy evaluation to assess effectiveness. The team provides many different therapies for the patients including recreation, art, music, and pet therapy, as well as the more traditional therapies like pharmacological pain management and positioning.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The members of the team maintain their efforts to raise awareness of their patient population by showcasing their work to the rest of the organization. In October 2010, the team had a week where they presented 25 posters to the employees of SHSC, explaining the work that they do on this unit. They also held a palliative care awareness day that was celebrated across the organization.

When a patient is accepted into the program, they are given the opportunity to come to the unit for a tour and to familiarize themselves with the environment. If they do not choose to come to the unit in advance, they can view pictures of the unit on the intranet and in a brochure.

Support is provided to the staff when they face difficult situations. There are facilitated debriefing sessions at which a member of the ethics team is invited, and the chaplain or social worker will do one on one counselling.

There are numerous educational opportunities and the staff members are supported to attend as appropriate.

The manager has a plan in place to have all the performance appraisals completed by February 2011.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

There is a return link to the referring provider, with a commitment to having a family conference within three business days of admission to the service.

The assessments are recorded and as part of the assessment, they also include cultural preferences, religious customs and family requests. Also part of the assessment is that if the patient is a veteran, they will ensure that the Canadian flag ritual is included as part of end-of-life practices.

The FAMCARE survey is given to each patient or family member, although the members of the team are keen to develop a more appropriate tool that will provide better information.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The falls prevention program is excellent and clearly visible throughout the unit. It is targeted to the most appropriate patients.

There are safety briefings at the beginning of every shift.

No Unmet Criteria for this Priority Process.

Infection Prevention and Control

Infection Prevention and Control

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents.

Surveyor Comments

Reducing infections and improving outcomes in infection prevention and control (IPAC) is a corporate priority. There have been significant investments in a vernicare system, micro fibre cloths to address issues that reduce the transmission of nosocomial infections. The IPAC team is proud of its accomplishments and has long been considered a leader in the province for SHSC's approach to IPAC practices. In fact, the province adopted the approach that the organization developed for assessing and monitoring the four moments of hand hygiene. The organization demonstrates a true process improvement philosophy when infection rates are higher than targets. For example, it has implemented a c. difficile (CD) intervention bundle to address an increase in CD and has reported a significant reduction in infection rates for October 2010, with CD reduced to three cases.

There is evidence of excellent collaboration between clinical programs, the sterilization/reprocessing department, food services, both retail and inpatient, OHS and IPAC. The education tools for staff are accessible on the intranet and during orientation. There has been a corporate policy to eliminate the wearing of rings and wrist jewellery in the organization in addition to restricting food and drinks in clinical areas. The organization is commended on its implementation of this infection control practice.

The organization is commended for the surgical site infection (SSI) tracking, which can occur up to a year following certain surgical procedures. Two IPAC leaders are members of the Provincial Infectious Diseases Committee (PIDAC) and therefore, bring current research and leading practices to the organization. Clinically useful information guides have been developed to ensure policy and process is translated easily into practice. Innovations in infection control extend beyond the IPAC team. For example, in the critical care ICU, the team has implemented various infection control practices such as restrictions on jewellery and lab coats worn in the unit, and a red zone to visually delineate clean and dirty zones.

While the organization and specifically, individual units, have demonstrated improvements in hand hygiene compliance, it will be critical to continue to be vigilant and encourage achievement of results at or greater than the set target. The IPAC team developed an infection control portal, which is the central hub of infection control information for this large team, which improves communication and capacity in the team. This is a practice that many large organizations would benefit from, to encourage the dissemination of useful information and practices. The daily surveillance report is an excellent communication tool to ensure that all patients that require isolation are monitored and evaluated.

The organization is encouraged to enhance the hand hygiene signage at the Sunnybrook Hospital site's main entrance, which is the atrium, to demonstrate the organization's commitment to hand hygiene to patients, visitors and staff. The organization would also benefit from an assessment of the location of hand sanitizer stations across the facility, as there are many locations where hand sanitizers are difficult to locate or not easily accessible.

No Unmet Criteria for this Priority Process.

Long Term Care Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The Veteran's Care Centre provides comprehensive healthcare services to Canada's war veterans. The facility provides long term care (LTC) and complex continuing care to 500 veterans. There is a focus on ensuring a safe and senior friendly environment. This Veteran's Care Centre is the largest veteran's care facility in Canada, and it has a contract relationship with Veteran's Affairs Canada.

There is a defined mission and vision for the centre, with a focus on the residents and their families for achieving the best possible life experience. The team is involved in an"e-coaching initiative with Dartmouth College in New Hampshire. The team has established an objective for the team, which is: "to make a difference in resident's quality of life, by giving support physically and emotionally; thus, providing best life experience for our veterans."

An environmental scan has been completed and outlines the major issues facing the program and ongoing planning.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

One of the guiding principles of the organization is maintaining a model of inter professional collaborative care.

Education of the interdisciplinary team is seen as a priority. The focus of the education is to ensure reflective practice, professional excellence and continuing competence. The information is provided in a calendar format. Staff have had input into the type of education such as the addition of case based presentations.

There are processes in place and staff education has begun to address Bill 168, workplace violence.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

An inter professional approach is used in the assessment of all residents . Family involvement is a key concept in the care of the resident. Rounds are conducted every two weeks and a full assessment is completed at least annually. Assessments will be completed at any time the condition of the resident/patient changes. Documentation of the assessments is excellent. Interdisciplinary charting is in place. A pressure ulcer assessment is completed on all residents/patients and is repeated on a regular basis.

The transfer of information is excellent. All staff returning from breaks are given a verbal update on each of the residents as to where they are located such as reading in the dining room or up in the chair .

There are committee structures in place for both residents and family members to bring issues forward for discussion. The residents' council will focus on issues brought forward by the residents themselves. The family advisory council is made up of family members and focuses on issues brought forward by the families. One issue that was brought forward was the dissatisfaction with the laundry services for the veterans. The committee was involved in the review of three different laundry companies and was involved in making the final selection.

There is a pharmacist assigned to each of the units in the facility.

The team is encouraged to test the evacuation of the units on a regular basis. This is to ensure that staff are aware of the proper lifting and transport techniques. Student volunteers make excellent "patients" to test these lifting and movement techniques.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

All documentation is multidisciplinary in nature and up to date. Charting is by exception and daily care is documented on flow sheets. Access to education sessions is excellent. An annual calendar is produced that outlines sessions available throughout the year.

Involvement in research activity is high and results in changes to practice. Two examples of research applied to practice include the partners in veteran's care program, and the development of recreation and creative art therapy quality indicators.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

There is an extensive safety program at the Veterans Care Centre. There is an assigned safety representative from every unit that meets monthly. Resident rooms are assessed for safety every three months.

The Veterans Care Centre achieved an overall patient satisfaction score of 96.8 percent, thus being the highest scoring facility in Ontario.

There are numerous examples of quality improvement initiatives at the unit level. The implementation of a "tidy box" system for watches, glasses, an hearing aids had reduced the volumes of missing articles. Loss of hearing aids was the most problematic area. Following the implementation of the tidy box, the loss was reduced to zero after one year.

No Unmet Criteria for this Priority Process.

Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

The SHSC has a strong and effective medication management system. All nursing units have access to clinical pharmacy and the assigned pharmacist is an integral part of the interdisciplinary team. The staff have a strong awareness of adverse drug events, drug interactions and drug safety. The pharmacy committee is an active committee with 27 members representing all programs and there a high attendance at monthly meetings. All additions and potential additions to the formulary are reviewed by the committee. The committee is empowered to place conditions on new and expensive medications. The number of concentrations available is agreed to by the pharmacy committee. The SHSC is currently managing shortages of about 150 medications. To date, the pharmacy has been able to accommodate all needs despite the shortages. All communications from the Institute for Safe Medical Practices (ISMP) are distributed to clinical staff. Labelling changes or identification of medications is driven by recommendations from ISMP, or as a result of a review of errors and near misses.

Patients are encouraged to supply their own medications that are not part of the formulary. This permits continuity of medication use, reduces the likelihood of confusion and removes a source of error. Medications are dispensed using a robotic system. There are approximately 2.1 million doses dispensed from the pharmacy, with approximately two errors per month. Most of the errors are end of run duplications and are detected in the dispensing area prior to distribution to the units.

Drug administration protocols are uniform across the organization. The process is well understood by nursing personnel and is carefully adhered to by the staff. Drug errors and adverse reactions are identified, reported and investigated. There are approximately 500 near misses or errors reported monthly, most of which do not result in harm. The aggregate information is used to improve processes. Major adverse events are reviewed as sentinel events. A recent example is three episodes of nephrotoxicity caused by vancomycin in patients with renal failure, resulting in acute kidney injury. The investigation is directed at the system and changes are planned to mitigate risk in future renal failure patients that require vancomycin. The investigation is being led by an advance practice nurse and involves staff that were or may be directly involved, including bedside nurses, clinical pharmacists, laboratory personnel, physicians and the support of the quality department. The adverse events were disclosed to the patient. One event resulted in harm to the patient and a need for dialysis, with subsequent recovery of renal function.

Adverse drug events, near misses and hazardous medication related situations are reported on a web based system, which is anonymous. However, staff are encouraged to identify themselves so that the event may be used as a learning opportunity. Staff know that they can report in a blame free environment and that their report will result in appropriate action.

The Sunnybrook Hospital site is encouraged to expand the use of the "do not use list" of unacceptable abbreviations published by the ISMP. It is hospital practice that the list be used and compliance enforced. However, compliance is quite low, and better among residents than staff physicians. Education programs directed at physicians should be undertaken and senior departmental leadership should be engaged to improve the practice.

Medication carts are located in high traffic areas on several of the nursing units that were visited. This is a potential medication administration risk because the nurse may be easily distracted. It would be of value to locate the carts in a quiet area of the nursing unit to decrease the possibility of distraction.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization provides access to current protocols, guidelines, dosing recommendations, checklists, and/or pre-printed order forms for high risk/high alert drugs.	1.5	↑
In organizations without CPOE systems, prescribing medical professionals use standard, preprinted forms to order medications.	10.4	

Medicine Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

The occupancy is always at 100 percent and quite often, the unit is over capacity with some patients placed in the hallways. The scope of service is aligned to the needs of the patients with one unit namely, C-4, designated as the stroke unit for the whole hospital.

The team is going through the process of assessing the staff mix on the medical units and introducing the role of RPN into an all RN staff on the evening and night shifts. The introduction of that role will be evaluated in one year, with definite criteria.

The services provided to the patients are constantly evaluated. For example, on C-4, the plan is to cohort all stroke patients in one particular area of the unit so that the care can be provided in a more specialised manner. On B-4 and just two weeks ago, an intensive care area was instituted for ventilator dependent and monitored patients.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The unit (C-4) is a very busy unit that is used to overcapacity. Space is at a premium and clean supplies have to be stored in the corridors and hallways.

The interdisciplinary team is very evident on the stroke unit. There is respect and good communication among team members. The members of the team speak about feeling valued by their colleagues, which includes the physicians. The physicians are receptive to suggestions and opinions from the other members of the team.

The team has developed an excellent program with Ryerson University and the Ontario Stroke Network of north/east GTA, with the funding coming from HealthForce Ontario. The program is broken down into six different modules: namely, neuro stroke assessment, leadership in stroke care, client stroke rehabilitation recovery, brain structures and cognition, critical appraisal of evidence, and health promotion and paradigms. At the completion of the six modules, the participants will receive a certificate. Any organization in Ontario has access to the curriculum via Telemedicine Ontario. The curriculum was developed from consultation with more than 200 providers and clients.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.5	

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

A comprehensive pathway for stroke cases has been developed. It is a 20 page, seven day document that clearly outlines the care that is required on each day until the projected day of discharge. Stroke rounds are being done daily on all stroke patients and bullet rounds occur daily on all other patients. For all stroke patients, the data are entered into the provincial system database so that information can be fed back to the organization and the team can assess how it is doing compared to the rest of the province.

There are numerous educational events that are provided to the health care providers and, more recently, all clinical staff have been educated on doing a swallowing assessment on the newly admitted stroke patient, using the “Toronto bedside swallowing screening test”. In this way, they can assign the most appropriate diet and if there are issues, then the patient can be seen by speech therapy. There are ongoing courses every Wednesday on monitoring of patients, which will eventually provide the clinical staff with the equivalent to the Critical Care Level 1 certificate.

There is use of an excellent tool called the “inter professional baseline assessment”, where all the information collected on admission by any of the allied health services is collected and available to all. They also use the Braden scale for potential skin breakdown and use the Montreal cognitive assessment tool as well.

The patient’s chart, kardex, bedside and large board at the nursing station is clearly marked for the following assessments (SPPICES) and where there are deficits. SPPICES is an acronym which stands for stability (risk of falls), pharmacy (patient taking medication), pain (any issues with pain management, incontinence (bladder and bowel retention), cognitive, eating (any dietary issues or issues with swallowing) and skin.

What the team in medicine services is most proud of, is the teamwork among the members and the holistic approach to care for all the patients. They also wanted to note the numerous initiatives that are geared toward improvement.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Medicine services do not have an automated health record but the diagnostic results are available electronically.

The stroke pathway was done based on evidence based guidelines and after doing an environmental scan.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

There is an excellent falls prevention program and the patients that are at risk are clearly identified on the patient board on the unit and the chart is also identified.

There is an excellent incident and sentinel events reporting system that allows the managers to drill down further for information.

No Unmet Criteria for this Priority Process.

Mental Health Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

This team is part of the brain sciences program and has aligned its clinical priority programs around the priorities of the organization. The program has general inpatient beds, eight adolescent beds, a psychiatric ICU, and an outpatient area that includes a transitional care clinic. There are also community outreach programs such as the community psychogeriatric services for the elderly (CPSE), the Sunnybrook psychiatric assertive community team (SUNPACT) and the, Youth Fresh Start program. The CPSE and SUNPACT programs are very successful at improving the mental health status of patients by keeping them at home or in the community and avoiding hospital admissions.

The mental health (MH) team has recently experienced a change in the patient care manager (PCM) role over the past few months. The current interim PCM has successfully implemented several important changes, which have had a positive impact on the culture and satisfaction level of staff. This PSM is commended for her energy and commitment to the team.

The team celebrated "Eid" on the day of the MH team's tracer. There are plans in place to hold more of these types of unit based events to improve staff morale and respect. There is an emphasis on owning change initiatives and for the RESPECT program, rather than "buying into the program".

The team monitors quality indicators and in particular, evaluates the health status of its patients to ensure that quality mental health services result in positive outcomes. The team is very proud of its ability to improve the lives of their patients. The inter professional collaboration in the team was described as a strength by the team and is indeed evident in the programs provided. The care plans reviewed were thorough, effective and individualized for each of the patients' plans reviewed. Goals and objectives are reviewed appropriately. The team has access to a variety of supports should they themselves require counselling.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The inter professional team consists of a variety of disciplines that work effectively together to provide high quality mental health services to patients. Weekly rounds are conducted and daily bullet rounds ensure that the patient's plan of care remains appropriate and that discharge barriers are addressed.

The team has spent the last six weeks developing its value statements and expectations for behaviours specific to the unit. This declaration is posted in the nursing stations. The team is very proud of this work and has contributed to enhancing teamwork and respect throughout the unit.

The team is aware of a process for reporting workplace violence. Continuous reinforcement of the RESPECT program and value declaration will enhance the effectiveness of this new initiative. The team has implemented an innovative strategy to preceptor medical students in crisis intervention education. This team worked with the University of Toronto (U of T) to gain support to have RNs become the preceptor for medical students, rather than this role being performed by residents. Positive outcomes were reported as a result of this innovation.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

The admission and assessment phases of care delivery by this team are comprehensive, patient focussed and effective. Occupancy rates are high and the staff work with the emergency department mental health team to address patient flow issues. It will be important to continue vigilance with patient flow issues related to this vulnerable group of patients as visit volumes increase and in patient occupancy continues to increase.

The team is working well with community supports and the ambulatory care programs to reduce inpatient admissions. A thorough suicide assessment is completed and documented on admission and daily throughout the patient admission.

Family involvement in the patient's plan of care, as appropriate is encouraged. The patient interviewed has experienced repeated admissions and reported a high level of satisfaction with the quality of care received and the interactions and support by the team.

The outreach programs, which includes psychiatrists are commended for their work at visiting patients in their homes/living arrangements.

The physical environment of the in patient unit is less than optimal and the staff work hard to ensure patients and staff are safe. A 5S de cluttering project might benefit the in patient area.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

Patient care is coordinated from the emergency department's crisis team and the PES unit, outreach programs, direct admission through the inpatient units, outpatient clinics and out into the community with Sunnybrook resources or community partnerships.

The team is well integrated with the Central Toronto LHIN hospitals and participates in several network meetings. The team is part of Access One, which is a central intake for mental health services.

There are no pre printed order sets used in the inpatient unit and the team is encouraged to consider their use in the mental health program.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The inpatient unit is a locked unit with security cameras that are monitored by staff and security. The staff wear code white buttons and are trained in non violent crisis intervention. The code white buttons are tested at the beginning of every shift. Staff and patients reported that they feel very safe working in the unit. Staff in the ER department and community outreach state that they feel safe and take proactive steps to ensure that they access assistance when they perceive that a threat might exist.

Staff perform regular and appropriate hand hygiene and hand sanitizers are visible and available in the in patient unit. The unit is assessed for risks to patients. Shower heads are safe, furniture is minimal, and harmful belongings are eliminated until discharge.

Patient assessments are very thorough and the team is commended for its comprehensive admission and ongoing documentation tools. The patient centred focus is excellent. On the next revision of the documentation record, it would be useful to include written documentation that the patient received verbal and written information about patient safety Currently, this documentation is found in various locations of the health record. Patient care plans are completed and high risk activities are assessed and documented. Patient identification bands are colour coded to visually identify privilege levels.

No Unmet Criteria for this Priority Process.

Obstetrics/Perinatal Care Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

There is a very busy labour and delivery unit and also a specialized ambulatory area with more than 6000 visits to the high risk pregnancy and foetal program. Many of the specialized clinics are run in collaboration with medical specialists such as endocrinologists, haematologists, general medicine and nephrologists.

There is an interdisciplinary team that functions in the program, with foetal medicine, radiology, ultrasound technology, nurse practitioner, and nursing members. The team works in very close collaboration with neonatology. The team reviews the statistics frequently to adjust the services that they provide. One example concerns a recent review of the repeated late losses by the team to see how to predict better, or amend their approach to care. The flow of care is constantly refined and a recent adjustment was moving the ultrasound suite to within the department to prevent the mothers having to go to different areas of the hospital and to improve the flow.

The team supports students and volunteers in the program. The team mentor students in nursing, art therapy, massage therapy, as well as medical students.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

The workspace is very new, only two weeks old at the time of survey and is quite magnificent. The area was built in anticipation of growing the program and currently, the team has closed delivery suites that can be opened when the funding becomes available.

The team members have access to Blackberries and a paging system called Vocera.

The orientation of new members of staff is extensive. Apart from the week long general orientation, the new member of staff is assessed by the nurse educator and her/his orientation is tailored to their needs. They are assigned a preceptor for the length of their orientation.

There is evidence of ongoing education provided to the care providers and this includes violence prevention, birthing, surgical intervention, high risk, foetal monitoring with yearly certification, and neonatal resuscitation also requiring yearly certification.

Performance appraisals are done.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

There are weekly meetings to discuss issues and also to review processes and procedures to ensure that they are standardized and revisions are done. Patients are seen within two weeks of referral if they are not urgent. Emergency cases are seen immediately. They keep open spots for ultrasound for the patients that need to be done on an urgent basis.

The foetal assessment is done and if a diagnosis is made of abnormality, then the patient is seen by a paediatrician. The patients are referred by their obstetrician or their general practitioner, or they can self refer and be triaged by the nurse practitioner in the program.

Medication reconciliation is fully done at all points that is, admission, transfer and discharge. There is a well established protocol for ante partum bleeding and pain assessment is the fifth vital sign in all areas of the program. They provide emotional support and counselling for the difficult diagnoses. Bereavement care is provided to the mother and the family.

Ethics issues are directed to the team of a neonatologist, a bio ethicist and the primary care provider. There is an ethical framework in place to guide the team members in their decision making.

At transition points, the transfer of accountability document is completed so that all the information required is available to the receiving unit. Client satisfaction surveys are done and all patients are asked to provide feedback, with a return rate of about 80 to 85 percent.

They have a case cart system for sterilization and the transport is done in a segregated elevator for contaminated items.

Neonatal Intensive Care Unit (NICU):

The NICU is a 41 bed, level 3 unit divided into four identical pods. About 90 to 95 percent of the babies are born here, and the rest come to the Sunnybrook Hospital site via the transport team. The unit serves a catchment area of about 60,000 deliveries per year. The only treatment modality that is not provided is neonatal surgery, which is done at the Sick Kids Hospital.

There exists a very active retro transfer process, with a discharge coordinator that activates the process as soon as the infant meets the criteria for transfer, which is more than 32 weeks gestational age, not vented and tolerating feeds. The family is asked their hospital of choice, both first and second and then the discharge coordinator attempts to find the most appropriate bed. They track on a daily basis as to where there are available beds, who does total parental nutrition (TPN), who does central lines and who does eye follow up. There is a surge capacity protocol in place.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

There is a practice of consensus based practice rather than evidence based. This is mainly due to the penury of research in the practice. The services were part of the managing obstetrical risk (MoreOB) project. There is a quality committee that reviews all practices and processes.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Extensive education is provided to the mothers and their families. This is a big part of the nurse practitioner role. Breastfeeding education is held five days per week, all day, and there are evening classes for the mothers already discharged but are experiencing some difficulty.

All managers attended a workshop on crisis debriefing so that they can help following a sentinel event. Four of the nurses attended a workshop called “Resolve through Sharing” and are now on the bereavement resource team.

The planned C-sections are done on Mondays and Wednesday and on those days, 4 C-sections are done. On the other days they do three sections. Emergency C-sections are added on to the cases for the day. The booked inductions are in order of priority, based on the busyness of the day. Post delivery bleeding is an integral part of the checklist.

In the surgical room, the surgery checklist and the time out are done. Terminations of pregnancies are done for incompatibility with life, or on the basis of quality of life. This latter issue is often an ethics related one and there is an ethicist on call to help the family and the care providers with the decision.

No Unmet Criteria for this Priority Process.

Telehealth Services

Clinical Leadership

Providing leadership and overall goals and direction to the team of people providing services.

Surveyor Comments

Sunnybrook's telehealth services is an area that has been identified to take on a greater significance in the future than it has over the past couple of years. Traditionally, the major users here have been dermatology, pain, and endocrine disciplines. Going forward, telehealth is well positioned to support the strategic priorities of the hospital; namely, critical care, trauma, and burns and in fact, all programs that lend themselves to this model. With the advent of new leadership, technologies and patients in this area, telehealth can provide much needed "distance" support to these programs.

Between 1500 and 2000 clinical telehealth visits are done per year. This involves four clinical set ups. There are also 16 other set ups that are used for education.

The Telehealth network here, as in the rest of Ontario, is run by the Ontario Telehealth Network (OTN). As such, much of the processes, procedures and regulations are developed, governed, and organized by this group and enacted locally.

Those involved in Telehealth initiatives are very enthused about their present and future activities. Tele Burn is about to be initiated and offers great promise to burn patients across the province. Leaders should continue to develop and implement Telehealth opportunities, in line with overarching clinical strategies.

Currently, there are no formal feedback loops for the service to obtain user information. The OTN gathers this information, but does not share it with the constituent hospitals in a way that can be locally interpreted or used. It is suggested that SHSC work with the OTN to develop a more specific feedback mechanism.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization sets measurable goals and objectives for telehealth services to guide day-to-day telehealth activities.	2.2	

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

All the appropriate training and descriptions are in place.

No Unmet Criteria for this Priority Process.

Episode of Care

Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments

There exists a well defined needs analysis for initiation of new telemedicine initiatives.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

All the appropriate steps are taken to protect patient data.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

Currently, there are no formal feedback loops for the service to obtain user information. The Ontario Telehealth Network (OTN) gathers this information, but does not share it with the constituent hospitals in a way that can be locally interpreted or used. It is suggested that SHSC work with the OTN to develop a more specific feedback mechanism

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies and monitors process and outcome measures for its telehealth services.	13.1	↑
The team monitors clients' perspectives on the quality of its telehealth services.	13.2	

The organization uses the information it collects about the quality of its telehealth services to identify successes and opportunities for improvement, and makes improvements in a timely way.	13.3
The team shares evaluation results with staff, clients, and families.	13.4

Surgical Procedures

Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Surveyor Comments

The surgical services are located at both the Sunnybrook site and the Holland site. The scope of services represent the 4 priorities and the 7 strategic areas as well as community needs. Over 14,000 procedures are done annually. Of those, 70% of patients require inpatient management and 30% are day surgery patients.

Patient flow typically begins in the preadmission clinic (PAC). The PAC is a well-organized clinic that operates in a limited space, but is very effective. Patients are triaged according to severity of condition, complexity of surgery and co morbidities. A determination is made re: evaluation by anaesthesia and consultation by other services. About 80% of patients are evaluated by the anaesthesiologist and over 10% require additional consultation or intervention. The information for the day of surgery begins in the PAC. Patients receive teaching both verbal and written. The teaching material includes instructions on the patient role in patient safety, preoperative instructions and expectations for discharge.

Patients who are evaluated in the PAC enter 1 of 3 streams: same day admit, short term stay or day unit. Safety initiatives include double patient identification, double checking re: allergies and ensuring that the right patient is booked for the right procedure. Appropriate protocols are initiated as ordered. After transfer to the OR, site marking is done prior to entry to the OR and the Safe Surgical Checklist is done. Compliance with the SSCL ranges from 100% in ophthalmology to 91% in the gynaecology service. Debrief including sponge and instrument count, unexpected complications and transfer instructions are done prior to leaving the OR. Compliance with debrief is lower than with the SSCL. Transfer to the post-anaesthesia care unit (PACU) is done by the anaesthesiologist and nurse. Transfer of accountability is verbal and has proven to be effective; information gaps have not been identified. Transfer from the PACU to an inpatient nursing unit or the short stay unit (SSU) includes a verbal transfer using an SBAR format and a checklist. A PACU nurse accompanies patients transferred to critical care units. There is anecdotal evidence the communication method used is effective and since it has been adopted by the surgical services that miscommunication has been decreased. The SSU has increased from 6 beds to 14. This has had the effect of improving patient flow. The team is considering broadening the scope of patients eligible for SSU management (eg uncomplicated radical prostatectomy) to further capitalize on the concept. Nursing unit management includes discharge planning and patient education. Interdisciplinary care, BULLET rounds and staff engagement in learning are outstanding features of practice on the nursing units that were visited. Safety and continuous quality improvement are apparent on all units. Staff take pride in delivering safe, effective patient centred care.

The major challenge facing the surgical service is occupancy. All efforts are made to insure that the surgical lists are completed on time and on budget. Cancellations or delays are increasingly frequent as high occupancy and gridlock become more ubiquitous.The surgical service is an integral part of the "Drive to 95", the corporate wide effort to reduce occupancy to a manageable level. The executive of the surgical service meets weekly and the management committee meets monthly in an effort to ensure that the surgical service functions optimally. The PAC is small and crowded. It would appear that there is little room for expansion of this very effective service, but the staff are innovative and committed. Some challenges exist in OR booking, but the executive committee has sufficient data to insure that the various services book appropriately. The transition of the SSU to a more complex type of patient will be challenging particularly to ensure that the service is not overwhelmed with complexity. With the support of the surgical service leadership and senior management, the challenges can be met.

Holland Orthopaedic and Arthritic Centre

The Holland site is an 84 bed stand-alone facility that is amalgamated with SHSC. The hospital focuses on orthopaedic surgery and musculoskeletal rehabilitation. The hospital was built over 50 years ago and operates within the constraints of an antiquated physical plant. Despite the physical limitations, the care offered to the orthopaedic patients is innovative and of the highest quality. The culture of the organization is palpable upon contact with the hospital. The care offered is patient focused and interdisciplinary. The service has developed a unique screening and assessment model with screening done by an Advance Practice Physiotherapist and an assessment of co morbidities by nurses who initiate the investigation of the patients. The screening tools have shown that 20% of patients do not need surgery and that 10% do not wish to undergo surgery. Following consultation with the surgeon, patients are referred to the Patient Orientation Program. Patients are assessed by nursing and anaesthesia and given detailed education about their orthopaedic procedure.

Over 80% of patients elect regional anaesthesia, and the service has developed an area where blocks are undertaken. Prior to instituting the block, a mini-checklist is undertaken to verify the procedure. All the elements of the SSCL are done prior to incision.Compliance is 100%. Antibiotic coverage is also 100% since the introduction of the SSCL.

In an effort to improve patient flow, the Holland sit has introduced a program known as the "Drive for Four" Patients are informed that discharge is 4 days post-operative and this is reflected on the care map. The result of the program is a reduction of average length of stay from 4.8 days to 4.1 days.

The major challenges relate to the old infrastructure and the isolation of the hospital from other healthcare services.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Operating Rooms		
The team uses evidence-based client care maps or pathways to guide them through steps in the procedure, promote efficient care and achieve optimal client outcomes.	1.3	
Surgical Care Services		
The team uses a procedure-specific care map to guide the client through preparation for and recovery from the procedure.	7.1	
The organization has a process to select evidence-based guidelines for surgical care services.	14.1	
The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	14.2	
The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	14.3	
The team shares benchmark and best practice information with its partners and other organizations.	14.5	

Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.

Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization's services. The following tables summarize the organization's results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.

Governance Functioning Tool

The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
1	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	100	0	0	
2	We have explicit criteria to recruit and select new members.	100	0	0	
3	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	
4	The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5	Clear written policies define term lengths and limits for individual members, as well as compensation.	93	0	7	
6	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	88	0	12	
7	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	94	0	6	
8	We review our own structure, including size and sub-committee structure.	100	0	0	
9	We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10	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.	100	0	0	
11	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	94	0	6	

12	Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0	
16	Our governance processes make sure that everyone participates in decision-making.	100	0	0	
17	Individual members are actively involved in policy-making and strategic planning.	88	0	12	
18	The composition of our governing body contributes to high governance and leadership performance.	100	0	0	
19	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0	
20	Our ongoing education and professional development is encouraged.	93	0	7	
21	Working relationships among individual members and committees are positive.	100	0	0	
22	We have a process to set bylaws and corporate policies.	100	0	0	
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24	We formally evaluate our own performance on a regular basis.	88	0	13	
25	We benchmark our performance against other similar organizations and/or national standards.	65	0	35	⚠
26	Contributions of individual members are reviewed regularly.	67	0	33	⚠
27	As a team, we regularly review how we function together and how our governance processes could be improved.	75	0	25	
28	There is a process for improving individual effectiveness when non-performance is an issue.	50	0	50	✖

29	We regularly identify areas for improvement and engage in our own quality improvement activities.	71	0	29	⚠
30	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.	47	0	53	✖
31	As individual members, we receive adequate feedback about our contribution to the governing body.	69	0	31	⚠
32	We have a process to elect or appoint our chair.	100	0	0	
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	

Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.

Summary of Results

Number of survey respondents = 1759 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	9	12	79	
2 Good communication flow exists up the chain of command regarding patient safety issues	11	15	75	▲
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	75	13	13	▲
4 Senior management has a clear picture of the risk associated with patient care	17	20	63	▲
5 My unit takes the time to identify and assess risks to patients	7	12	81	
6 My unit does a good job managing risks to ensure patient safety	5	12	83	
7 Senior management provides a climate that promotes patient safety	9	17	74	▲
8 Asking for help is a sign of incompetence	91	4	5	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	92	3	5	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	17	19	64	▲
11 I am less effective at work when I am fatigued	8	9	83	
12 Senior management considers patient safety when program changes are discussed	11	26	63	▲
13 Personal problems can adversely affect my performance	25	19	56	▲
14 I will suffer negative consequences if I report a patient safety problem	80	11	8	

15	If I report a patient safety incident, I know that management will act on it	10	21	68	⚠
16	I am rewarded for taking quick action to identify a serious mistake	26	40	34	✖
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	36	27	37	✖
18	I have enough time to complete patient care tasks safely	20	25	55	⚠
19	I am not sure about the value of completing incident reports	66	17	17	⚠
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	51	20	29	⚠
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	29	25	46	✖
22	I have made significant errors in my work that I attribute to my own fatigue	77	13	11	
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	8	10	82	
24	I believe health care errors often go unreported	17	22	61	✖
25	My organization effectively balances the need for patient safety and the need for productivity	13	26	61	⚠
26	I work in an environment where patient safety is a high priority	6	12	82	
27	Staff are given feedback about changes put into place based on incident reports	20	25	54	⚠
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	13	23	64	⚠
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	18	27	55	⚠
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	11	21	68	⚠
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	63	21	16	⚠
32	My supervisor/manager overlooks patient safety problems that happen over and over	67	18	15	⚠

33	On this unit, when an incident occurs, we think about it carefully	8	18	74	⚠
34	On this unit, when people make mistakes, they ask others about how they could have prevented it	13	22	65	⚠
35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	8	16	77	
36	On this unit, when an incident occurs, we analyze it thoroughly	13	23	64	⚠
37	On this unit, it is difficult to discuss errors	63	19	18	⚠
38	On this unit, after an incident has occurred, we think long and hard about how to correct it	14	26	60	⚠
B. These questions are about your perceptions of overall patient safety		**% Good/ Excellent**	**% Acceptable**	**% Poor/ Failing**	**Priority for Action**
		Organization	Organization	Organization	
39	Please give your unit an overall grade on patient safety	65	31	4	⚠
40	Please give the organization an overall grade on patient safety	61	35	4	⚠
C. These questions are about what happens after a Major Event		**% Disagree**	**% Neutral**	**% Agree**	**Priority for Action**
		Organization	Organization	Organization	
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	5	21	74	⚠
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	9	28	63	⚠
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	13	27	61	⚠
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	14	38	48	✖

45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	12	22	66	
46	Changes are made to reduce re-occurrence of major events	5	19	75	

Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, 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.

The organization did not complete the required tool during the assessment period.

Indicator Results

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
GREEN	Sunnybrook Health Sciences Centre	Long Term Care (Long Term Care Services)	01/01/2010 31/03/2010	96
GREEN	Sunnybrook Health Sciences Centre	Long Term Care (Long Term Care Services)	01/04/2010 30/06/2010	100
GREEN	Sunnybrook Health Sciences Centre	Long Term Care (Long Term Care Services)	01/07/2010 30/09/2010	100
GREEN	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/01/2010 31/03/2010	100
GREEN	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/04/2010 30/06/2010	100
GREEN	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	100

Threshold for Flags
RED: < 75/100
YELLOW: >= 75/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection

Post-surgical infection rate is a key outcome measure that reflects process interventions.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Sunnybrook Health Sciences Centre	IP&C (Infection Prevention and Control)	01/01/2010 31/03/2010	7.9
	Sunnybrook Health Sciences Centre	IP&C (Infection Prevention and Control)	01/04/2010 30/06/2010	16

Surgical Site Infection

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Sunnybrook Health Sciences Centre	IP&C (Infection Prevention and Control)	01/01/2010 31/03/2010	92
GREEN	Sunnybrook Health Sciences Centre	IP&C (Infection Prevention and Control)	01/04/2010 30/06/2010	97

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care-Associated MRSA & C. difficile - C. difficile

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 10,000 patient days
GREEN	Sunnybrook Health Sciences Centre	IP&C (Infection Prevention and Control)	01/01/2010 31/03/2010	9.9
GREEN	Sunnybrook Health Sciences Centre	IP&C (Infection Prevention and Control)	01/04/2010 30/06/2010	6.9

Threshold for Flags
RED: > 80/10,000
YELLOW: <= 80/10,000 AND > 60/10,000
GREEN: <= 60/10,000

Health Care-Associated MRSA & C. difficile - MRSA

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 10,000 patient days
GREEN	Sunnybrook Health Sciences Centre	IP&C (Infection Prevention and Control)	01/01/2010 31/03/2010	4.5
GREEN	Sunnybrook Health Sciences Centre	IP&C (Infection Prevention and Control)	01/04/2010 30/06/2010	3

Threshold for Flags
RED: > 80/10,000
YELLOW: <= 80/10,000 AND > 60/10,000
GREEN: <= 60/10,000

Hospice, Palliative, and End-of-Life Services: Continuity of Care

This indicator will increase awareness in terms of the importance of having common tools across the organization to facilitate the continuity of care, and eliminate unnecessary duplication of services for hospice palliative clients and their families.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Continuity of Care: Pain Assessment Tool

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% clients where a common pain assessment tool was used
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	96

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Continuity of Care: Collaborative Care Plan

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% clients where a collaborative care plan is documented
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	0

Hospice, Palliative, and End-of-Life Services: Availability of Services

Availability of Hospice Palliative Service indicator measures the availability of hospice palliative care services by hospice palliative care staff members, consultants and volunteers to all potential and current clients and families, as well as referring organizations.

This indicator will assist programs in the availability and responsiveness of their hospice palliative care services to current and potential clients. It will be used to assess responsiveness to clients, and to ensure 24/7 access to services.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Availability of Services: Immediate Access by Staff (In-person) - Acute Care

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% coverage of hospice palliative care team services with 24/7 immediate access
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	100

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Availability of Services: Immediate Access by Staff (By telephone) - Acute Care

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% coverage of hospice palliative care team services with 24/7 immediate access
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	100

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Availability of Services: Immediate Access by Care Consultants (In-person) - Acute Care

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% coverage of hospice palliative care team services with 24/7 immediate access
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	100

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Availability of Services: Immediate Access by Care Consultants (By telephone) - Acute Care

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% coverage of hospice palliative care team services with 24/7 immediate access
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	100

Hospice, Palliative, and End-of-Life Services: Management of Pain

Degree and management of pain and symptom distress informs the organization about their clients' physical and psychological symptoms, and the adequacy and speed of symptom control.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Management of Pain: ESAS on Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% clients where ESAS is done on admission
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	58

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Management of Pain: Pain Burden on Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	Average pain burden on admission
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	4.5

Hospice, Palliative, and End-of-Life Services: Documentation of Client and Family Service Goals

Documentation of Client and Family Service Goals informs the organization about how close they are to ensuring that all clients and families are being given the opportunity to express their care goals and choices. This indicator will increase the focus on engaging in this dialogue with clients and families.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Documentation of Client and Family Service Goals

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% client files where client and family goals are documented
	Sunnybrook Health Sciences Centre	Palliative Care (Hospice, Palliative, and End-of-Life Services)	01/07/2010 30/09/2010	100

Next Steps

Congratulations! You have just completed your Qmentum on-site survey visit. Please note the following check list items that you need to attend to in the coming days and months.

- ☐ We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.

- ☐ In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.

- ☐ You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

Appendix A – Accreditation Decision Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. Population focus
2. Accessibility
3. Safety
4. Worklife
5. Client-centred services
6. Continuity of services
7. Effectiveness
8. Efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

Accreditation Canada High Priority Criteria

Accreditation Canada identifies high priority criteria by their alignment with several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for healthcare organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2010 Qmentum surveys are:

Option 1: Accreditation
An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

(a) 90% or more of high priority criteria met per standard section, AND
(b) Compliance with all of the Required Organizational Practices, AND
(c) Compliance with collection of all the performance measures,

If the organization is a CSSS, participating in the Joint Program with Conseil québecois d'agrément (CQA) and Accreditation Canada, the following additional criteria are required, which are specific CQA indicators relating to customer service and worklife:

(d) Compliance with ≥66.6% of Client Satisfaction Indicators AND
(e) Compliance with ≥66.6% of Employees Mobilization Indicators

Option 2: Accreditation with Condition: Report and/or Focused Visit
An organization will receive Accreditation with Condition: Report and/or Focused Visit if any of following criteria is met:

(a) More than 10% and less than 30% of high priority criteria unmet in any standard section,
OR
(b) Non-compliance with any one of the Required Organizational Practices
OR
(c) Non-compliance with the collection of any one of the performance measures

If the organization is a CSSS, participating in the Joint Program with CQA and Accreditation Canada, the following addition criteria apply:

(d) Compliance with less than 66.6% of Client Satisfaction Indicators,
OR
(e) Compliance with less than 66.6% of Employees Mobilization Indicators

The condition, i.e. submission of a report or focused visit; and timeframe, i.e. 6 months or 12 months; is based upon the nature of the recommendations. If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.

Organizations are required to submit follow-up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress, and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

For organizations that fail to complete a satisfactory focused visit within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

Option 3: Non-accreditation
An organization will NOT be accredited if the following conditions exist:

(a) One or more ROPs not in place
AND
(b) 30% or more high priority criteria unmet in one or more standards sections
AND
(c) 20% or more criteria unmet overall for all standards applied to the organization

Should an organization wish to have their non-accreditation status reviewed within 6 months post survey, they are required to complete a focused visit within 5 months. Organizations that fail to complete a satisfactory focused visit within the required timeframe will maintain a non-accreditation status.

If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.