ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Centre universitaire de santé / McGill University Health Centre

Montreal, QC

On-site survey dates: September 15, 2013 - September 20, 2013

Report issued: October 4, 2013

ACCREDITATION CANADA
AGRÉMENT CANADA

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

Accredited by ISQua

About the Accreditation Report

Centre universitaire de santé / McGill University Health Centre (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2013. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

Accreditation results are based on information provided by the organization. Accreditation Canada relies on the accuracy of this information to plan and conduct the on-site survey and produce the Accreditation Report.

Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only. Accreditation Canada does not release the report to any other parties.

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

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

A Message from Accreditation Canada's President and CEO

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

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

Your Accreditation Specialist is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

Table of Contents

Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

Centre universitaire de santé / McGill University Health Centre's accreditation decision is:

Accredited (Report)

The organization has succeeded in meeting the fundamental requirements of the accreditation program.

1.2 About the On-site Survey

- **On-site survey dates: September 15, 2013 to September 20, 2013**

- **Locations**

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

  1 Administrative Services (2155 Guy)
  2 Lachine Campus Hospital
  3 Montreal Chest Institute
  4 Montreal Children's Hospital
  5 Montreal General Hospital
  6 Montreal Neurological Hospital
  7 Royal Victoria Hospital

- **Standards**

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

  System-Wide Standards

  1 Leadership
  2 Governance

  Service Excellence Standards

  3 Case Management Services
  4 Managing Medications
  5 Cancer Care and Oncology Services
  6 Operating Rooms
  7 Reprocessing and Sterilization of Reusable Medical Devices
  8 Organ and Tissue Donation Standards for Deceased Donors
  9 Organ and Tissue Transplant Standards
  10 Surgical Care Services
  11 Critical Care
  12 Emergency Department
  13 Point-of-Care Testing
  14 Infection Prevention and Control
  15 Ambulatory Care Services
  16 Biomedical Laboratory Services

17 Diagnostic Imaging Services
18 Hospice, Palliative, and End-of-Life Services
19 Laboratory and Blood Services
20 Long-Term Care Services
21 Medicine Services
22 Mental Health Services
23 Blood Bank and Transfusion Services
24 Telehealth Services
25 Organ Donation Standards for Living Donors
26 Ambulatory Systemic Cancer Therapy Services
27 Obstetrics Services

- **Instruments**

  The organization administer:

  1 Governance Functioning Tool
  2 Patient Safety Culture Tool
  3 Worklife Pulse Tool
  4 Client Experience Tool

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	81	5	0	86
 Accessibility (Providing timely and equitable services)	136	5	0	141
 Safety (Keeping people safe)	710	89	7	806
 Worklife (Supporting wellness in the work environment)	204	8	1	213
 Client-centred Services (Putting clients and families first)	372	9	5	386
 Continuity of Services (Experiencing coordinated and seamless services)	93	1	2	96
 Effectiveness (Doing the right thing to achieve the best possible results)	1128	90	7	1225
 Efficiency (Making the best use of resources)	102	8	0	110
Total	**2826**	**215**	**22**	**3063**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (95.5%)	2 (4.5%)	0	34 (100.0%)	0 (0.0%)	0	76 (97.4%)	2 (2.6%)	0
Leadership	43 (93.5%)	3 (6.5%)	0	84 (98.8%)	1 (1.2%)	0	127 (96.9%)	4 (3.1%)	0
Ambulatory Systemic Cancer Therapy Services	42 (91.3%)	4 (8.7%)	0	93 (94.9%)	5 (5.1%)	0	135 (93.8%)	9 (6.3%)	0
Diagnostic Imaging Services	58 (86.6%)	9 (13.4%)	0	54 (90.0%)	6 (10.0%)	1	112 (88.2%)	15 (11.8%)	1
Obstetrics Services	63 (100.0%)	0 (0.0%)	0	75 (100.0%)	0 (0.0%)	0	138 (100.0%)	0 (0.0%)	0
Infection Prevention and Control	44 (83.0%)	9 (17.0%)	0	36 (81.8%)	8 (18.2%)	0	80 (82.5%)	17 (17.5%)	0
Ambulatory Care Services	36 (100.0%)	0 (0.0%)	2	71 (95.9%)	3 (4.1%)	1	107 (97.3%)	3 (2.7%)	3
Biomedical Laboratory Services	14 (87.5%)	2 (12.5%)	0	34 (94.4%)	2 (5.6%)	0	48 (92.3%)	4 (7.7%)	0
Blood Bank and Transfusion Services	36 (100.0%)	0 (0.0%)	6	15 (100.0%)	0 (0.0%)	2	51 (100.0%)	0 (0.0%)	8

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Cancer Care and Oncology Services	29 (100.0%)	0 (0.0%)	0	74 (100.0%)	0 (0.0%)	0	103 (100.0%)	0 (0.0%)	0
Case Management Services	24 (96.0%)	1 (4.0%)	0	73 (98.6%)	1 (1.4%)	0	97 (98.0%)	2 (2.0%)	0
Critical Care	26 (86.7%)	4 (13.3%)	0	73 (79.3%)	19 (20.7%)	1	99 (81.1%)	23 (18.9%)	1
Emergency Department	31 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0	126 (100.0%)	0 (0.0%)	0
Hospice, Palliative, and End-of-Life Services	29 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	134 (100.0%)	0 (0.0%)	0
Laboratory and Blood Services	74 (92.5%)	6 (7.5%)	1	83 (87.4%)	12 (12.6%)	0	157 (89.7%)	18 (10.3%)	1
Long-Term Care Services	24 (100.0%)	0 (0.0%)	0	71 (98.6%)	1 (1.4%)	0	95 (99.0%)	1 (1.0%)	0
Managing Medications	65 (86.7%)	10 (13.3%)	1	44 (89.8%)	5 (10.2%)	3	109 (87.9%)	15 (12.1%)	4
Medicine Services	27 (100.0%)	0 (0.0%)	0	65 (94.2%)	4 (5.8%)	0	92 (95.8%)	4 (4.2%)	0
Mental Health Services	30 (96.8%)	1 (3.2%)	0	68 (95.8%)	3 (4.2%)	0	98 (96.1%)	4 (3.9%)	0
Operating Rooms	62 (89.9%)	7 (10.1%)	0	26 (86.7%)	4 (13.3%)	0	88 (88.9%)	11 (11.1%)	0
Organ and Tissue Donation Standards for Deceased Donors	35 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	115 (100.0%)	0 (0.0%)	0
Organ and Tissue Transplant Standards	58 (98.3%)	1 (1.7%)	0	77 (96.3%)	3 (3.8%)	0	135 (97.1%)	4 (2.9%)	0
Organ Donation Standards for Living Donors	40 (100.0%)	0 (0.0%)	0	76 (100.0%)	0 (0.0%)	0	116 (100.0%)	0 (0.0%)	0
Point-of-Care Testing	27 (71.1%)	11 (28.9%)	0	28 (62.2%)	17 (37.8%)	3	55 (66.3%)	28 (33.7%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Reprocessing and Sterilization of Reusable Medical Devices	36 (90.0%)	4 (10.0%)	0	55 (93.2%)	4 (6.8%)	0	91 (91.9%)	8 (8.1%)	0
Surgical Care Services	28 (93.3%)	2 (6.7%)	0	52 (81.3%)	12 (18.8%)	1	80 (85.1%)	14 (14.9%)	1
Telehealth Services	30 (100.0%)	0 (0.0%)	0	37 (100.0%)	0 (0.0%)	0	67 (100.0%)	0 (0.0%)	0
Total	**1053 (93.3%)**	76 (6.7%)	10	1678 (93.8%)	110 (6.2%)	12	2731 (93.6%)	186 (6.4%)	22

* Does not includes ROP (Required Organizational Practices)

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Case Management Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Hospice, Palliative, and End-of-Life Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Managing Medications)	Unmet	4 of 4	2 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Case Management Services)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Hospice, Palliative, and End-of-Life Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Leadership)	Unmet	2 of 4	0 of 0
Medication Reconciliation At Admission (Ambulatory Care Services)	Unmet	0 of 5	0 of 2
Medication Reconciliation At Admission (Ambulatory Systemic Cancer Therapy Services)	Unmet	1 of 5	0 of 2
Medication Reconciliation At Admission (Cancer Care and Oncology Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Case Management Services)	Unmet	1 of 3	1 of 2
Medication Reconciliation At Admission (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Emergency Department)	Unmet	2 of 4	1 of 1
Medication Reconciliation At Admission (Hospice, Palliative, and End-of-Life Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Long-Term Care Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication Reconciliation At Admission (Medicine Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Mental Health Services)	Unmet	2 of 4	1 of 1
Medication Reconciliation At Admission (Obstetrics Services)	Unmet	3 of 4	1 of 1
Medication Reconciliation At Admission (Surgical Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Ambulatory Care Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Ambulatory Systemic Cancer Therapy Services)	Unmet	0 of 5	0 of 0
Medication Reconciliation at Transfer or Discharge (Cancer Care and Oncology Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Case Management Services)	Unmet	2 of 3	2 of 2
Medication Reconciliation at Transfer or Discharge (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Emergency Department)	Unmet	2 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Hospice, Palliative, and End-of-Life Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication Reconciliation at Transfer or Discharge (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Mental Health Services)	Unmet	2 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Obstetrics Services)	Unmet	3 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Surgical Care Services)	Met	4 of 4	1 of 1
Surgical Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Surgical Checklist (Operating Rooms)	Unmet	0 of 3	0 of 2
Surgical Checklist (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Surgical Checklist (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Hospice, Palliative, and End-of-Life Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Unmet	0 of 1	0 of 0
Two Client Identifiers (Managing Medications)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Managing Medications)	Met	1 of 1	0 of 0
Heparin Safety (Managing Medications)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Ambulatory Care Services)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Ambulatory Systemic Cancer Therapy Services)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Hospice, Palliative, and End-of-Life Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Long-Term Care Services)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Managing Medications)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Surgical Care Services)	Unmet	0 of 1	0 of 0
Medication Concentrations (Managing Medications)	Unmet	0 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Narcotics Safety (Managing Medications)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Antimicrobial Stewardship (Managing Medications)	Met	4 of 4	1 of 1
Hand Hygiene Audit (Infection Prevention and Control)	Unmet	1 of 1	1 of 2
Hand Hygiene Education And Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Hospice, Palliative, and End-of-Life Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Surgical Care Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Case Management Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, and End-of-Life Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Surgical Care Services)	Met	3 of 3	2 of 2
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care and Oncology Services)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Organ and Tissue Transplant Standards)	Unmet	1 of 2	1 of 2
Venous Thromboembolism Prophylaxis (Organ Donation Standards for Living Donors)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Surgical Care Services)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Centre universitaire de sante/McGill University Health Centre (MUHC) is commended on preparing for and participating in the Qmentum program. The MUHC is commended also, on its commitment to quality improvement and patient safety by its active participation in the accreditation process. The organization is building on its tradition of excellence in clinical care, research and inter-professional teaching. The various sites can celebrate many successes in their work, making the accreditation process comprehensive and by welcoming the surveyor team. In addition to having the opportunity to meet with a range of internal and external stakeholders during the on-site survey, the surveyor team was provided with written, verbal and visual evidence to confirm compliance/non-compliance with the standards. Staff members and clients were readily available to answer questions and to demonstrate their skills and knowledge.

The board of directors has set the tone for a high-performing organization. In addition to being present at introductory and governance discussions, board members actively participated during the on-site accreditation survey. Since the previous accreditation survey, the board has allotted time at its retreat to use as a forum for evaluation of its collective work. As well, the board oversaw the recruitment and selection of the new chief executive officer (CEO). The board has a mix of designated and selected members. There are approximately 16 new board members that have been in their role for 18 months. The board receives information and reports in a timely manner to prepare for committee and board meetings. Board members indicate they are engaged in their work as a board, with examples of their involvement in twenty-one committees, sub-committees and councils. Progress is being made to address 49 recommendations from the Baron Report.

While there are frameworks and processes for clinical and research ethics currently, organizational ethics for administrative and board decision-making within an ethical framework is not in place. There is support for a vision of a MUHC Centre for Applied Ethics which would help create a comprehensive approach to ethics.

Going forward it will be important for the board to ensure that the operations at MUHC are maintained at a high level, while successfully transitioning to the new site and managing changes. The transition office and resources will be an asset to this effort. The new MUHC redevelopment project at three sites is intended to create the environment for staff, patients and families to achieve the best care for life. The pace of construction of the Glen site and the pace of change and transition for the MUHC is staggering. The organization has established strong relationships both internally and external to the MUHC.

A MUHC users' committee executive has been established representing the various sites' user committees. The patient engagement committee works with the users' committees to represent the interests of users to help support quality of services, performance and safety. The users' committees have participated in conferences and annual meetings in order to provide the patient's voice to discussions. There are many accomplishments of which the users' committees are proud. The MUHC has shared a vision of patient engagement and values the input to the perspective of the patient. A liaison position to facilitate coordination, teaching, coaching and preparation for new users' committee members is suggested.

Patients have voiced their concerns to the users' committee that they are afraid of the divestment of non-tertiary care in the future. It would be helpful to ensure there is membership from the users' committee to every Mission and Grand Project of Optimization, for their value both as a communication vehicle as well as a feedback loop.

While it can be said there is never enough communication, the MUHC has implemented a number of strategies to improve communication, especially during this time of change and transition. The communication span of the MUHC is large, including approximately two thirds of the Quebec geography as part of the Réseau Universitaire Intégré de Santé (RUIS) integrated university health network. More proactive communications and the use of social media are being used, with facebook and twitter accounts for a variety of specialized uses.

New information systems have been implemented and have provided more detail for managers for their financial and logistic reports, but have at times, created additional anxiety with the layers of change and coping. More information system modules will be rolled out over the next several months for human resource functions.

For emergency planning, the organization has done significant work to update their code orange policies which included an extensive code orange exercise involving all community partners. The code purple for over-capacity protocol has been improved and all services affected are working towards improving patient flow. The pandemic plan is more of a broad document that has provincial information but not hospital-specific plans including roles and responsibilities. Next steps include development of a hospital-specific pandemic plan, with clear roles and responsibilities.

Community partners are actively involved in planning for the repatriation of patients and beds to help support the transition of the MUHC. They are working hard to establish and plan for the right level of care for the right patient. There are already a number of success stories shared by MUHC partners. Stories include a telehealth agreement between Quebec and France that featured the Nunavik services supported by MUHC. Partners report an open and good working relationship with the MUHC and look forward to the time when things will settle.

The leadership of MUHC has undergone much turmoil, with simultaneous media, budget and change management issues. Financial stewardship has been a challenge. Ensuring allocations are aligned to strategic directions and the Grand Projects of Optimization are important going forward. Quality and safety are a focus of the organization and in addition to the provincially required external risk assessments and audits, the organization uses indicators and survey results to plan improvements.

Leadership is encouraged to address a number of policies and agreements that are dated a decade ago or longer. Policy and procedure version control and document management requires attention, particularly where outdated paper copies are relied on in clinical areas. Staff members report challenges in searching for electronic versions and currently, computer access in some clinical areas is limited.

The missions are established and would benefit from a higher level of decision-support for quality improvement and performance measurement. Managers and supervisors are ready and willing to assist their staff members in facilitating patient care. They do their best to work within the constraints they are given in terms of their budgets and the age of the facilities and equipment for their work.

Staff members report that MUHC is changing too fast and there is anxiety with closures and staff reductions that have an impact on a number of services. When communication is not clear and constant, rumours can act as a substitute for factual information. Several communication strategies have been used, and more attention will be required going forward over the next few years. Change management training has been provided to help build resilience in the organization, as it continues to evolve and change. This will become increasingly important towards 2015.

Worklife opportunities have been established to help employees be at their best in order to provide care. Some examples include courses on mindfulness, work-life balance and access to an employee assistance program. Staff members have access to and utilize education and professional development, and evidence of this is noted in the number of programs, courses and grants received. Staff members are well-trained and credentialed where applicable and in general, staffing levels are adequate to ensure patient care.

Volunteers play an important role in patient care and they provide both a great deal of emotional support when they can. Some of the patients that were interviewed said that they felt more comfortable talking about their conditions to non-medical staff, as they did not use medical terminology. Patients said that they do not always want to hear about the solutions that are presented to them by the medical staff rather, they simply want someone to talk to, someone who has the time to be empathetic and listen, and volunteers assume this role.

Space utilization is maximized despite limitations and aging infrastructure at many sites. In the various service areas, a team approach is evident, with collaboration amongst health care disciplines to best support the patient and family. More effort is needed for ensuring the full partnership desired in the mission executive across the MUHC. Building capacity and a commitment to the next generation of care providers is a noted strength of MUHC, with approximately 5,000 students and trainees every year.

Staff members have access to medical libraries online which is available across the MUHC. Evidence-based practice pathways and guidelines however, have not been widely implemented in service areas. Safety has been established as a priority. Ongoing vigilance is required to sustain good practices and improve safety by implementing required organization practices.

Co-operation among services facilitates rapid access to support services when they are required. Care is both patient and family centric and often, staff members will go out of their way to involve family members to accommodate their requests. Patient care involves providing both physical solutions and emotional support and the latter is emphasised on the many care areas. Empathy is a large part of the treatment regime.

The MUHC has used a number of reliable and validated tools to measure patient satisfaction and patient experience. The information is used as one of the measures to improve quality through the eyes of the patient and family.

Feedback from patients and families during the on-site survey was positive. Statements like: “I could have been seen sooner at another hospital but I chose to come back here even though I had to wait longer”, and “these people are miracle workers” were reported to the surveyor team. Patients and families feel that they are active participants in the patient care and by the constant feedback that they are given.

Section 2 Detailed Required Organizational Practices Results

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication Reconciliation At Admission The team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	· Ambulatory Systemic Cancer Therapy Services 9.14 · Obstetrics Services 9.5 · Medicine Services 7.5 · Case Management Services 7.6 · Mental Health Services 7.6 · Emergency Department 8.3 · Ambulatory Care Services 8.3
Medication Reconciliation at Transfer or Discharge The team reconciles the client's medications with the involvement of the client, family, or caregiver at interfaces of care where the client is a risk of medication discrepancies (transfer, discharge), when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	· Obstetrics Services 12.3 · Ambulatory Systemic Cancer Therapy Services 16.3 · Medicine Services 11.3 · Mental Health Services 11.3 · Case Management Services 11.4 · Emergency Department 11.5 · Ambulatory Care Services 12.2
Two Client Identifiers The team uses at least two resident identifiers before providing any service or procedure.	· Long-Term Care Services 8.8
Dangerous Abbreviations The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	· Managing Medications 10.2
Surgical Checklist The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure.	· Operating Rooms 6.8
Medication Reconciliation As An Organizational Priority The organization reconciles clients' medications at admission, and transfer or discharge.	· Leadership 15.7

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Medication Use	
Medication Concentrations The organization standardizes and limits the number of medication concentrations available.	· Managing Medications 3.4
Infusion Pumps Training Staff and service providers receive effective training on infusion pumps.	· Ambulatory Systemic Cancer Therapy Services 5.8 · Managing Medications 19.4 · Operating Rooms 2.3 · Surgical Care Services 4.4 · Critical Care 4.4 · Medicine Services 4.4 · Ambulatory Care Services 4.5 · Long-Term Care Services 4.5
Patient Safety Goal Area: Infection Control	
Hand Hygiene Audit The organization evaluates its compliance with accepted hand-hygiene practices.	· Infection Prevention and Control 6.5
Patient Safety Goal Area: Risk Assessment	
Venous Thromboembolism Prophylaxis The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	· Organ and Tissue Transplant Standards 12.1

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
4.11	The organization's policies and procedures for all key functions, operations, and systems in the organization are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

The MUHC is proud of its history of academic research, teaching and technology while providing care to patients and families. Six hospitals and a research institute make up this commitment to blending care today and care for tomorrow. As an academic health centre, MUHC is the McGill RUIS (Integrated University Health Network) serving a wide population and geographic area. There are seven foundations supporting the facilities that comprise the MUHC.

The mission, vision and values are currently in a process of review, appreciating the current pressures faced by the organization and the challenges in transitioning some services to a new site. The needs of the community and the needs of the staff members are considered in planning and there is spirit of rebuilding with a new board, a new chief executive officer (CEO) and action plans and construction to address transition and space issues. A redevelopment group is committed to clinical governance and care to provide quality care while meeting budget reductions with increased efficiencies. That said, staff members report being tired of change and cutbacks and the morale is recognizably challenging.

At the mission level, the model includes a medical department chief, an associate director of nursing, an administrative director, a financial advisor and a quality advisor. Some missions may also have other roles, such as communications and/or development office support. The collaborative approach and transparency in sharing results has helped establish and meet some challenging targets with regards to fiscal management and transition planning to new sites. In addition to organizational goals, each clinical mission sets strategic goals and operations objectives, based on the global priorities. The clinical missions include committees such as mission table, medical advisory committee, nursing executive committee, therapeutic and allied health services committee and clinical operations.

The operational committee ensures priorities are met including: dash board indicators and Logibec computer information system implementation and the automation of financial, human resource and administrative

systems. In order to address new obligations since the 2007 clinical plan was approved, there is extra effort required of all staff members, physicians and leadership to be ready for 2015 and beyond.

Health promotion and prevention support is provided at a local level with programs such as smoking cessation, and nationally by partnerships with groups like the Canadian Association of Pediatric Health Centres (CAPHC). As well, MUHC provides access to care for northern territories and international support with the World Health Organization (WHO) conferences. The MUHC is responsive to the needs of the community, for example, patient engagement and education videos have been posted on the MUHC website. There has been a positive response and number of “hits” to the website as well as an increase in the use of social media. A self-management program for chronic disease called: "My toolkit", has increased patient autonomy with their care and decreased the burden on the health facilities. The MUHC staff members and leadership shared many examples of using the literature and learning and leading best practice.

Operational plans are enacted at the mission level, where clinical quality and financial considerations are embedded. The mission teams report that clinical indicators have helped them improve awareness and efficiency. Going forward, the MUHC will be partnering with other hospitals and services to decant some ambulatory and inpatient beds. The transforming care at the bedside (TCB) has engaged patients, staff members, physicians and leadership in re-designing work and leading improvements. All projects are prioritized across the organization. Resource planning is included in operational plans however, fiscal and human resource limitations continue to be a challenge. One example shared concerned the use of agency nurses at Lachine Hospital. Although gains have been made in reducing agency use of other categories of care givers, agency registered nurses (RNs) are still commonly used.

An emergency department (ED) mental health short-stay, and thoracic surgery and bariatric surgery have been identified as needs for the future. The organization has put in place a geriatric nurse practitioner, a stroke nurse and a psychiatric liaison nurse, which are seen as important in the design and response to needed services.

Some of the ideas expressed as opportunities by the clinical leadership include improving patient flow and trajectory, more timely data and continued improvement in patient experience. The leadership appreciates the challenges and is keeping 'an ear on the ground' for tolerance for change. Leadership is making a concerted effort to provide more face-to-face opportunities for interaction in order to engage staff members and physicians, volunteers and patients.

3.1.2 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
1.3	The governing body approves, adopts, and follows the ethics framework used by the organization.	!
3.1	The governing body uses the ethics framework and evidence-informed criteria to guide decision making.	!

Surveyor comments on the priority process(es)

The board is congratulated on the commitment to the accreditation process. In addition to board member presence at introductory and governance discussions, board members actively participated in priority process tracers for resource management, communication and integrated quality management. Since the previous accreditation, the board has allotted time at its retreat to use as a forum for evaluation of their collective work. As well, the board oversaw the recruitment and selection of the new chief executive officer (CEO).

As mandated by government, there are 21 members of the board, and only four members have been on the board for greater than 18 months. In addition to the provincial mandate for membership, the board balances the required skill sets with those positions that are remaining. The board has the following committees and sub-committees: governance and ethics; vigilance; research ethics; audit; finance (sub-committee); quality and risk management (COQAR); safety (sub-committee); users'; real estate; human resources; Lachine Hospital and nominating. The board also has ad hoc clinical operations, ad hoc organizational structure and commutations. The councils of the board include: council of physicians; dentists and pharmacists; council of nurses; multidisciplinary council; council for services to children and adolescents; council of non-clinical personnel and advisory council, Montreal Neurological Hospital.

All new board members receive orientation with the board chair and are provided with a detailed reference manual. Board members described attending quality and accreditation conferences to better understand their roles and responsibilities, particularly for patient safety and accountability. The board members described their discussions at meetings as open and honest and being able to face the turmoil. When required, the board has implemented ad hoc committees to address areas of particular concern.

The Baron Report has provided 49 recommendations for the MUHC for improved financial and administrative accountability. The new board of MUHC has made significant strides in responding to the recommendations, with the implementation of new policies, financial reports and dashboards. One example is a policy enforcing expenditure limits. The board is able to discuss the challenges and hold public meetings to field questions and post responses.

Organizational ethics is not currently addressed for administrative and board decision-making within an ethical framework. There is support however, for a more comprehensive approach to ethics, with the potential for a MUHC Centre for Applied Ethics being considered. The board has some recent experience with a precursor to an ethics framework, with its use of an "Accountability for Reasonableness" framework as part of the clinical activities priority setting (CAPS) exercise.

The board can receive hard copy board packages or can access the package electronically via a secure portal. Board members report they have adequate lead time to prepare for meetings. The board also receives ongoing presentations from staff members, which they feel are helpful.

The six Grands Projets d'Optimisation (GPO – Grand Projects of Optimization) are a response for the need to improve the efficiency, effectiveness and performance of the MUHC. The board works at ensuring the need to balance the budget does not compromise quality and safety of patient care.

There is planning underway to create vision, mission and values statements going forward beyond the move of some facilities to the Glen site in 2015. The board includes patient representatives and a patient experience strategy. The board and leadership are commended on their demonstration of extraordinary leadership during the difficult times they have faced.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Strategic priorities are integrated with financial planning. The board, leadership and all levels of the organization understand their role in resource management. Financial policies are available on the intranet, as are the budget process and tools. Financial advisors conduct monthly discussions with associate directors to stay current with fiscal pressures and variances. The transition to the Logibec electronic system requires ongoing education for managers that were used to receiving paper-based reports. Currently, finance and materials management modules are implemented, with a plan for payroll and scheduling implementation in January 2014. Directors and managers report feeling comfortable with the budget process and appreciate the dashboard that they review along with their department statistics.

The McGill University Health Centre (MUHC) has undergone significant budget reductions. Phase one required a savings of $28.8 million, which involved the reduction of many full-time equivalents (FTEs) and required the mobilization of the entire organization toward the goal of cost savings. Phase two includes the Grand Project of Optimization for a savings of $21.4 million. The plans are established and include savings such as $6 million from the operating rooms, $4 million from ambulatory care, and $2.7 million from the laboratory. These are extremely challenging times for the organization's leadership given the need for significant budget cuts coupled with the transition planning for site moves.

There are a number of committees from the board level with the audit committee to the director level and sub-committees structured to address budget and performance. The board expressed satisfaction with the financial reports received and has worked to ensure the reports are in a format helpful to them. This was described as an improvement over having: "tons of data and no information" and the board is pleased with the progress being made by MUHC in: "re-building a great institution". Dashboards are used to help communicate information in a clear and concise manner. New managers are provided with orientation and education to the electronic financial information. Managers are able to drill down to see the details of their cost centres. There is a perceived increase in the involvement of physicians and surgeons in working through case costing, surgery volumes and equipment and future initiatives in funding for procedures.

Some financial decisions and expectations come from the province. At an organizational level, leaders work with their stakeholders, physicians and staff to make the best allocation decision in an environment of fiscal restraint. The finance department works closely with the quality department and clinical groups to analyze utilization, quality and fiscal performance.

An audit is required every four years and the board oversees the selection following a call for proposals, assessing experience and price of the contract. Annually at the June board meeting, a recommendation to the board is made. The board has recently approved a policy in reducing expense allocation, in keeping with the need for fiscal restraint.

Some areas of concern for the budget include: cardiology as a result of supplies and volume funding; the Lachine Hospital and information systems and logistics. However, it was shared that: "with crisis comes opportunity" and that the relationship between finance and clinicians has improved with more fulsome

discussions and outcomes. The current fiscal situation has increased the need for creative solutions and more openness and awareness of resources. The challenge is to sustain the required fiscal prudence and to implement and realize the savings projected, with 40 percent in fiscal 2013/14 and implementing the plans for the remaining savings prior to 2015.

3.1.4 Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.10	The organization's leaders implement policies and procedures to monitor staff performance that align with the organization's mission, vision, and values.	!

Surveyor comments on the priority process(es)

Human resources planning and work-life culture and safety are important to the McGill University Health Centre (MUHC). Some of the strengths shared by leadership and staff include innovation, the value of employees and the caring relationships that span between and amongst staff and patients. The relationship with the unions has been described as good. While there are approximately 3,000 grievances outstanding, there is effort going forward to involve unions in discussions and planning during challenging times.

The MUHC has been recognized on the short list of top employer status as a result of wellness support for employees as well as life-long learning opportunities and professional development. Staff members spontaneously report that they are proud of the support MUHC provides for education. Many managers, approximately 40 and 10 emerging health leaders have participated in a leadership course offered by McGill University. Some leaders have had the opportunity to take the executive training for health care improvement (EXTRA) program. This education has promoted and supported the engagement of clinical personnel and decision makers in monitoring specific quality and performance indicators. The organization shared many examples of grant funding and innovative partnerships to help support staff development.

The Grand Projects of Optimization (GPO) have necessitated the reduction and reallocation of staffing and funding. The number of positions lost has resulted in 'bumping' in the unionized process which is stressful for staff. Union representation has been embedded into work groups. Communication of difficult messages has occurred to support the management team. Even amidst difficult times, there is humour for example, statements such as: “change is good, you go first.” There is currently a moratorium on hiring, requiring reduced emphasis on recruitment. Retention is reported as strong and many staff members report returning to MUHC from other organizations where they have worked. Lachine Hospital has made strides in reducing the agency-based personnel however, there is still a substantial use of agency registered nurses.

The Director General’s Awards Gala was extremely well-received by staff. The award included acknowledging 10 individuals and one team for exceptional contributions to patient care, research, teaching and technology assessment. The criteria for awards included altruism, impact and initiative.

The Logibec information system has been implemented for financial reporting and logistics. A plan is in place for human resource modules to be implemented in December 2013.

Performance appraisals have not been completed for many years. Most employees have not had a formal performance appraisal, which means the MUHC is similar to other organizations in Quebec. A new pulse 360-degree appraisal has been developed and is ready for pilot, but has yet to roll out. The span of control

for managers varies with some small and some very large clinical units. With the transition plan and harmonization of services it is hoped to help balance workload in the future.

Based on the feedback from the Worklife Pulse Tool, the MUHC has implemented priorities of workforce engagement and wellness activities. One example shared was a course available on mindfulness. As well, staff members report having access to an employee assistance program (EAP). An improved web page is in progress. Exit interviews have been conducted using a tool that was established 18 months ago. Feedback is provided to managers in a confidential manner for them to be aware of opportunities for improvement in staff satisfaction.

The campaign for immunization for influenza occurs annually and the MUHC has achieved an approximate rate of 40 percent. Workplace safety requires improvement, with the introduction of safety needles and blunt needles for drawing up medications.

Volunteers are currently managed in the various facilities they support, with some managers responsible for more than one site. There is some interest in reviewing the approach to volunteer management in the future. The spirit of the volunteers is palpable. Volunteers are provided with orientation and ongoing training. They describe care providers as 'miracle workers', that they are proud to support. There are awards celebrations, which the volunteers appreciate very much.

3.1.5 Priority Process: Integrated Quality Management

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
15.7	The organization reconciles clients' medications at admission, and transfer or discharge.		ROP
	15.7.3	There is a documented plan to implement medication reconciliation throughout the organization.	**MAJOR**
	15.7.4	The plan includes locations and timelines for implementing medication reconciliation throughout the organization.	**MAJOR**

Surveyor comments on the priority process(es)

McGill University Health Centre (MUHC) integrated quality plan includes: prioritization of improvement initiatives; the description of the structure; roles and responsibilities of the various committees and positions trusted with improving quality and safety. Supports such as resources, processes and tools are provided to help support staff members in their quest for quality. The process used to develop the quality plan was top-down and bottom-up from front lines to the committee of quality and risk (COQAR) for quality and risk of the board. Internal and external reports from inspections by colleges have helped provide insight into the quality plan. All clinical missions are included, from small to large scale initiatives.

There are some ongoing organization-wide initiatives such as the implementation of the patient engagement framework, patient experience strategy, transforming care at the bedside (TCAB) and the national surgical quality improvement program (NSQIP).The six Grands Projets d'Optimisation (GPO – Grand Projects of Optimization) is in response to the need to improve the efficiency, effectiveness and performance of the MUHC. Layered with the need to balance the budget, clinicians have identified indicators to ensure quality, safety and access to care is not jeopardized. One example of success shared by MUHC is the cancer care mission quality and performance improvement office. This office was established in 2006 to improve performance with measurement of indicators and improvement projects.

It is impressive that every month the chair of the board COQAR meets with the associate director of quality, patient safety and performance to review information and prepare for the committee meetings.

The patient safety culture survey conducted by the organization in 2010 and 2013 indicated that supervisory leadership for safety was a dimension that required improvement. An action plan has been devised to develop an ongoing middle management and physician education program. This program is to support the culture of safety, incident reporting, disclosure, critical event analysis, effective communication and a non-punitive culture.

While the rate of incident reports has increased in the past few years, there are challenges with the paper-based system in terms of staff members not always taking the time to complete the forms, and managers being too busy to follow-up in a timely manner. Most incidents reported are related to medications followed by falls and diagnostic tests. New tools have been developed for proactive risk identification for

both clinical and non-clinical applications. These prospective risk assessment guides include a step by step approach. Disclosure of adverse events remains low, ranging from approximately between 11 and 26 percent. The incident report, disclosure and other policies require updating and revisions, and an over-arching policy document management program is suggested.

Medication reconciliation has been in various stages of planning and implementation at the MUHC for a few years. Pilot studies are still underway for transfer and discharge and a plan for roll-out is expected in October 2013.

As part of the annual quality patient safety and performance report a number of questions are posed such as: is safety of care getting better?, is access to care getting better?, and is the productivity (efficiency) getting better? Data key performance indicator achievements include the development of research groups, publications, and metrics of recovery and cost-effectiveness. Operational indicators are located on the intranet so that transparent information is shared.

When asked what adjective or description could be used for quality improvement at MUHC, staff and board members responded with words of : “passion; patient experience and well-being; openness and transparency; standardized; common language; focus; reducing risk, omnipresence and rigor and innovation.” In fact, it is by way of innovation that projects such as the executive training for health care improvement (EXTRA) have been adopted by staff and physicians. Promoting and supporting the engagement of clinical personnel and decision makers in monitoring specific quality and performance indicators has helped the MUHC and other organizations in Quebec.

There are many examples of creative approaches to clinical care improvements such as: “Be Line Wise” which strives for central line elimination of infections and thromboses and transforming care at the bedside (TCAB) with facilitator support and measurement. The improvement: “ticket to ride” ensures adequate handover of information on oxygenation when patients leave the emergency department for radiology investigations.

Staff members are recognized with the Challenge Q + awards program : "fast forward to quality with you." In partnership with the Quebec Blue Cross, these awards promote and reward a culture of quality with a $150,000 award for an improvement project conducted by an inter-disciplinary team. This quality award is presented by the chair of the board and a vice-president from the Quebec Blue Cross.

The support of the transition office has been a large contribution to quality improvement. The analogy of running a race has been used to help understand the approach to rallying for transformation, which begins with a team starting the race through to a marathon. The MUHC has established itself and is setting its quality pace for the long run.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The principle-based care and decision-making process at McGill University Hospital (MUHN) is well-aligned with the clinical and research mission of the organization as demonstrated in the code of ethics. This code is publicly available via the internet, entrances and/or units. The main focus is directly centred towards excellence in patient care confirming the direct link to the vision of the organization. In total, there are seven principles that govern and guide team members to create a positive and healing environment.

The team of clinical ethics is a small group of professional ethicists. The team's main objectives are to provide ethical support and guidance to clinicians, patients and their family members as needed on a 24/7 case consultation basis where the ethicist is present within one hour. Following the consultation, a formal review process with a report is made available. The number of requests has increased considerably over the years to the point where the team is concerned in its capacity to continue to offer the service in a timely and effective manner.

Concerning organizational ethics, there is vivid interest towards this emerging need. More difficult and transparent decisions need to be addressed in a health care system that is in constant evolution at all levels for resource allocation and restrictions, access to care, financial viability, and so on. This third aspect of ethics would be an asset to the organizational structure as proposed in the annual report.

Insofar as respect to ethics in research, the framework is extensive and comprehensive. It includes an impressive number of sub- committees by specialty, with membership that is extensive and well-balanced. The team is proud of the development of online research submissions. The average time to respond to a request is between four and six weeks. Research grants and bursaries are on the rise and the team is proud of this accomplishment. This team is currently in transition, as the team lead position has recently been vacated. Nonetheless, the foundations are solid, enabling the team to continue to meet the demands.

3.1.7 Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
11.3	The organization's leaders implement, review, and update policies and procedures to support the collection, entry, use, reporting, and retention of information.	!

Surveyor comments on the priority process(es)

The McGill University Health Centre (MUHC) has worked closely with external stakeholders, which are described as their community. The organization has established a pattern of communication with all levels of government, department agency and municipal stakeholders. The MUHC values the relationship with the donors and foundations. The MUHC has been extremely successful with various research grants and competitions.

Patients were described as the: "intrinsic fabric", of MUHC and users of the services are integrated to maximize communication. The MUHC users' committees work closely with the missions with which they are involved and are a sounding board for input and communication. The users' committees have participated in conferences and annual meetings in order to provide the patient voice to discussions. Many organizations have implemented a formal role for patient liaison, with success in better two-way communication.

Partner institutions, such as McGill University and other hospitals have had a long and strong history of collaboration with the MUHC. One recent example of how the partnership commitment is shared is the McGill academic health network affirming belief in freedom to express faith release, published on September 16, 2013. This release was signed by the Dean of the Faculty of Medicine, the director general and chief executive officer of MUHC, the executive director of the Jewish General Hospital, the interim director general and chief executive officer of St. Mary's Hospital Centre and the executive director of the Douglas Mental Health University Institute.

The communication span of MUHC is large, including approximately two thirds of the Quebec geography as part of the Réseau Universitaire Intégré de Santé (RUIS). More proactive communications and the use of social media are being used, with facebook and twitter accounts for a variety of specialized uses. The communication plan includes 12 key indicators which help support the MUHC current and future work.

The difficult times the MUHC faced in the media during the past two years, along with the fiscal challenges and simultaneous information systems and other changes have been described as: "the perfect storm" by the leadership. However, there is considerable hope for the future to seek out good news stories and highlight the talented work that the MUHC produces in clinical care, teaching and research.

Internally, the MUHC uses a number of strategies to communicate with staff members, physicians and volunteers. Electronic and paper approaches are used, appreciating computer availability and preferences. Effective communication has been used for manager sessions, town halls and public information sessions. The MUHC is responsive to questions and concerns by listening, conducting focus groups and responding with

detailed information and data. The online 'straight talk' provides replies to questions within 48 hours. Another creative idea used was to share key information using an 11 by 17 inch place mat in the cafeteria for the tables.

A number of information system changes have already occurred and more are planned for the future. Outdated mainframe systems are being transitioned to the Oacis system. There are many aspects of feeder systems and modules such as admitting and registration of patients that are still planned. For staff members, there is some frustration with the combination of electronic and paper records, particularly because they have been awaiting a clinical information system for many years. Staff members report that intranet policy retrieval as cumbersome, and there outdated paper copies of policies available in clinical units. The review, updating and document management of policies has been a challenge. Numerous policies are outdated and a thorough document management system is required and tentatively planned for the future.

Staff members have access to best practice and research information with the online medical library which is available on all desktops at MUHC. A train-the-trainer model had been used to advance usage of literature to support decision making, along with support from the transition office. The communications department also utilizes best practice approaches by way of think tanks for public relations and collaborative relationships with other health centres.

There is public reporting on quality indicators and the leadership, along with board members has embarked on 'walk rounds' to create additional dialogue and learning.

3.1.8 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Four sites were visited during the on-site survey namely: Montreal General, Montreal Chest Institute, Royal Victoria and Montreal Children's hospitals. At the Montreal General Hospital site, a geothermal project has been completed. This four million dollar project allows heat from the ground to be transformed into energy to heat the building. There is only one other hospital in Quebec that has implemented this innovative system.

At the Montreal Chest Institute site, the medical air system is being updated. For oxygen, there are two reserves of liquid oxygen as well as a tap on the system to which a mobile reserve could be plugged-in, in the event of a simultaneous failure.

At the Montreal Children's' Hospital site, there are two new boilers in-situ. Redundant systems are checked at all sites on a regular weekly basis according to policy.

The plumbers, electricians, technicians and engineers maintain valid licenses by their profession. The facilities department at Montreal Chest and Montreal Children's sites have a comprehensive electronic record of all facility equipment and systems. This electronic record/system identifies preventive maintenance, immediate repairs, assignments, time spent on different assignments, turn- around times, and it even sends out a client satisfaction survey when a job is completed. Daily assignments flagged by the system are available for staff members to conduct preventive maintenance. Urgent requests for repairs are also handled by this system and are prioritized among the team. All surveys reflecting a 'not satisfied' response have a detailed follow-up by the logistics managers. There are safeguards in the logistics system that will flag a second call for a repair to a first level supervisor and a third call to an executive level for resolution.

The cleanliness of the buildings varies across sites and locations within the sites. Some areas are cluttered and messy and others, even with space challenges, are neatly organized. Only a few handwashing stations were noted in the basements of all sites visited including by the elevators. The housekeeping team is investigating software that can assist with analysis of turnover times in bed cleaning as well as monitoring other key indicators.

Way finding is an issue at all sites visited according to patients and families that were interviewed. At a number of main entrances there is an information booth where the employee or volunteer is able to direct patients to their destination. Once past the information desk however, and from observing the traffic in the corridors the surveyor noted staff members are not intuitively noticing if a patient, family or visitor is struggling to find their way. In other organizations, there is a larger presence of volunteers at strategic times of the day to assist with way finding. Once asked for directions however, staff members are friendly and helpful.

All sites have a great deal of clutter in the halls in the basement, as well as on the patient care units. The staff members do the best they can to meet fire regulations by ensuring all items are at least kept on one side of the hallway in a consistent manner. At the Royal Victoria Hospital site, in the oncology department, a cardboard container was being used for the disposing of cyotoxic waste, and it was overflowing and had no lid. The small refrigerator was full and there were multiple closed cardboard containers in the hall awaiting

pick-up. The housekeeping senior manager is aware of the issue and has increased the number of pick-up times but apparently, more adjustments are needed. Risk management leadership is urged to conduct a risk assessment of this issue. An ongoing issue witnessed by a number of surveyors conducting clinical tracers was the state of the medication refrigerators on some of the units. When asking housekeeping staff regarding who is accountable, apparently it is the unit that is accountable for ensuring these refrigerators are cleaned regardless of their purpose. It would be worthwhile to monitor this concern over time.

The building services team at MUHC has applied for and received certification in building environmental standards from the Building Owners and Managers Association (BOMA).

3.1.9 Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Infection Prevention and Control		
14.1	The organization has policies and procedures that meet federal, and provincial or territorial, guidelines to identify and respond to outbreaks and pandemics.	!
14.2	The policies and procedures for identifying and managing outbreaks and pandemics are available to staff, service providers, volunteers, clients, and families.	!
14.5	The policies and procedures include defined roles, responsibilities, and accountabilities for staff, service providers, and volunteers who are involved in identifying and managing outbreaks and pandemics.	
14.6	The organization coordinates its planning for pandemics and outbreaks with its overall planning for disasters and emergencies.	
14.7	The organization communicates information about outbreaks and pandemics to its partners, other organizations, and the community.	
Standards Set: Leadership		
14.5	The organization's leaders regularly test the organization's all-hazard disaster and emergency response plans with drills and exercises to evaluate the state of response preparedness.	!

Surveyor comments on the priority process(es)

The organization has an emergency preparedness committee that has put considerable effort into ensuring that employees are prepared in the event of a disaster. A comprehensive multi-site code orange exercise was conducted in 2012 and involved several municipal partners including fire, police and municipal representatives. The emergency preparedness plan was updated following this exercise and changes were made. Multiple staff members and physicians in the emergency departments at McGill University Health Centre (MUHC) were involved and express that they are now prepared for a code orange situation. The emergency preparedness plans are comprehensive and readily accessible for all staff. The Montreal General Hospital, Royal Victoria Hospital and Montreal Children's Hospital played key roles in this disaster exercise.

There is no specific hospital comprehensive pandemic plan for the organization. A master plan was developed based on provincial expectations in 2006. Work needs to be done to ensure that all staff and service providers understand roles and responsibilities in a pandemic situation.

The organization works closely with public health (PH) to identify and manage infectious disease outbreaks. Some process changes were made following H1N1 to improve patient care in the future and were embedded in the emergency preparedness plan.

Regular internal audits/inspections take place at all sites relative to fire prevention. Following these inspections, reports are generated to ensure follow-up takes place where required. Templates with key indicators are completed to ensure consistency among all sites at the hospitals. A recent code red exercise was conducted in the operating room (OR) setting to ensure that protocols are appropriate and mock code red exercises are conducted regularly.

Regular meetings are held to review all other code situations and any follow-up required to improve processes. Staff members in key areas of the hospitals have received non-violent crisis training to ensure they have the ability to respond to code white situations. Staff training that has been completed is kept in the electronic system. The organization needs to continue to practice code situations as not all units were able to indicate that they had participated in a mock code exercise for their service area. The organization is encouraged therefore, to continue practicing mock codes at all sites and track progress. Code orange training and planning need to expand to other areas of the hospital and provide role clarity for all departments. Disaster boxes should be regularly checked and reviewed to verify that appropriate supplies are available and staff members have ready access to the supplies including the locked shower facilities at the Montreal General Hospital.

The upcoming expansion provides an opportunity for the MUHC to ensure appropriate decontamination areas are available for emergency patients in the event of a disaster.

3.1.10 Priority Process: Patient Flow

Assessing the smooth and timely movement of clients and families through service settings

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
11.5	The operating room team contacts clients or follow-up service providers to help evaluate the effectiveness of the procedure and the post-surgical transition, and makes improvements to its services as appropriate.	!

Surveyor comments on the priority process(es)

McGill University Health Centre (MUHC) has been working with clinical and non-clinical teams to improve patient flow in the health system. There are many inter-related initiatives underway such as surgical pathways, patient transport optimization and harmonization of practice within transition projects.

A recent revision of the capacity management protocol and over-capacity procedures has helped enforce the need for improvement of access and through-put of patients. A code purple is called when the system is at 130 percent occupancy. If necessary, a second code purple is called and services targeted include housekeeping, transport, radiology and all areas affected by the need for admissions.

There is a decision-making algorithm and daily bed rounds that occur at 0845 hours, with additional bed rounds on Fridays at 14:45 hours. Radiology and surgery have been identified as key areas where there is bottleneck. Space has also been identified as a limitation to initial assessment and off-loads from Emergency Medical Services (EMS).

There are protocols in place for diverting ambulances. As well, peaks and needs have been identified and pre-booking and establishing levels of required transport have helped in response. Nursing supports in the emergency department for geriatric, stroke and cancer patients have been seen as a positive. Part of the transforming care at the bedside (TCAB) initiative has been a module on patient admission and discharge. White boards for communication of an expected discharge date have engaged the patient as an active participant in discharge planning. The TCAB has also supported the single interdisciplinary admission process of mental health patients and reduced the time from four and a half hours to one hour. The MUHC is embarking on using tools in the National Surgical Quality Improvement Program to help improve surgical outcomes.

In the emergency department improved access to antibiotics and a decreased length of stay has been achieved for cancer patients with febrile neutropenia.

At the Montreal Children's Hospital an important factor has been to bring everyone to the same level of understanding for the need for timely discharge. Pediatric inpatient areas and the intensive care unit (ICU) are piloting the Institute for Healthcare Improvement (IHI) bed huddles to improve communication and discharge planning.

There are plans to implement the Logibec electronic bed board in fall of 2013. As well, there are ongoing discussions with partners at Centres de santé et de services sociaux (CSSS), rehabilitation areas, palliative care and long-term care to improve access to alternative care settings.

3.1.11 Priority Process: Medical Devices and Equipment

Obtaining and maintaining machinery and technologies used to diagnose and treat health problems

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.1	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization reviews and approves the team's set up and policies and procedures for cleaning and reprocessing.	
8.2	If the team does not have access to the resources needed to safely clean and reprocess diagnostic devices or equipment at the point of use, the team sends them to the medical device reprocessing department or an external provider.	!
8.4	The team follows the organization's policies and procedures and manufacturers' instructions to contain and transport contaminated devices and equipment to the medical device reprocessing department or external provider.	
8.5	The team ensures the staff involved in cleaning and reprocessing diagnostic devices and equipment are qualified and competent.	
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
8.8	The team follows the organization's policies and procedures and manufacturer's instructions to select appropriate cleaning, disinfecting, and reprocessing methods.	
8.9	The team follows the organization's policies and procedures and manufacturer's instructions for cleaning and reprocessing diagnostic devices and equipment.	!
8.11	The team has a process to track all reprocessed diagnostic devices and equipment so they can be identified in the event of a breakdown or failure in the reprocessing system.	
8.12	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization oversees the team's compliance with the organization's policies and procedures on cleaning and reprocessing.	
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		

1.3	The team works with others in the organization to limit the use of flash sterilization to emergencies only, and never for complete sets or implantable devices.	!
2.4	Supervisors and staff members involved in reprocessing have completed a recognized course in reprocessing and sterilization.	
3.1	When planning and designing the layout of the medical device reprocessing department, the organization considers the volume and types of reprocessing and sterilization services, flow of devices and equipment, and traffic patterns.	
3.4	The medical device reprocessing department has a specific, closed area for decontamination that is separate from other reprocessing areas and the rest of the organization.	!
4.10	The team tracks changes to policies, SOPs, standards of practice, and manufacturers' instructions using a document control procedure.	
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.5	Staff members apply proper hand hygiene technique before beginning and after completing work activities, as well as at other key points to prevent infection.	!
11.4	The organization maintains a dedicated bank of neurosurgical and ortho-spine devices.	!

Surveyor comments on the priority process(es)

Four sites were visited with regard to medical devices and reprocessing: Montreal General Hospital, Lachine Hospital, Montreal Children's Hospital and Royal Victoria Hospital. The senior manager responsible for reprocessing and sterilization is responsible for only five of six sites so it is difficult to claim standardization and oversight over the whole organization. The senior manager is also not responsible for reprocessing in diagnostic imaging or in services at the Women's pavilion. A review has been done regarding the processes in the Women's pavilion and a number of reprocessing actions do not meet standards. It is recommended that this function be overseen by central reprocessing and that it becomes the accountability of the organization-wide senior manager.

Provincial procurement legislation does not easily allow for standardization of equipment unless the plan is to replace a whole fleet. A request for proposal (RFP) is published, with the organization's requirements and a competition process is followed using weighted criteria for decision making. It is important then that all RFPs include the ability to continue to purchase the preferred equipment for the contract period without the need to start over.

Education standards in medical reprocessing were identified as an area for improvement at the previous accreditation survey. Since then, any new staff members hired from outside the organization must have college level certification in reprocessing. A new educator has developed a comprehensive orientation program for new staff. There is however, a gap in theoretical knowledge between those with college certification and those with years' of experience and strictly in-house training. New staff members require

qualified preceptors so two processes have been initiated. Thirty-three of 100 senior staff members to date have completed the 1000 hour online certification course. For those that have not had the opportunity, a comprehensive in-house education program is progressing to bring the theoretical knowledge of senior staff members to a similar level as those employees that have completed the certifications.

Medical devices can now be tracked by asset number, date of purchase, preventive maintenance performed and other important indicators that allow the team to trace equipment repair history throughout a lifetime. There is a committee that includes representatives from medical devices, reprocessing, infection control, occupational health and safety as well as clinicians. This committee makes recommendations to the organization's operations committee as to which capital equipment purchases should be purchased and what can wait, based on a number of factors. If a piece of equipment is approved for replacement, there is a detailed procedure conducted by biomedical staff. A new asset number is issued for the newly purchased equipment and either the biomedical engineer either takes the old piece of equipment out of service if appropriate, or indicates on the tracking system that it is obsolete and will be removed if it requires any further repairs.

The evaluation of the new preventive maintenance program is anecdotal as the system has not yet completed one year of operation. The senior manager has sent out targeted surveys to high users of medical equipment to garner some real time information. The Lachine Hospital site equipment monitoring process is an anomaly in many respects in that this is the only location where newly arriving equipment is sent directly to the area requiring it without a safety electrical check by biomedical engineer. There is an assumption that the vendor checks the equipment for safety prior to shipping. Once a week, a biomedical supervisor visits and any requests for repairs are sent out to an external service for repair.

Some selected single use items are reprocessed by contracted third party vendors. All policies in the medical reprocessing area have been reviewed and updated in May 2013.

The Montreal Neurological Hospital, Royal Victoria Hospital, and Montreal Children's Hospital all have an automatic injection system for dispensing the correct amount of detergent at the sink washing station, and this is in place and functioning.

Reprocessing of Endocavitary Ultrasound Probes:

Accreditation Canada's Standards for the Reprocessing and Sterilization of Reusable Medical Devices are not being followed when endocavitary probes undergo high-level disinfection (HLD) in the ultrasound departments. Most notably, the HLD at one site is being done in the ultrasound examination room. Cidex ortho-Phthalaldehyde Solution (OPA) is being used without special ventilation. There is no process to track a reprocessed device in the event of a reprocessing failure, and the staff members in diagnostic imaging (DI) that carry out the reprocessing have not demonstrated their competence by taking a formal course and completing an examination or quiz.

3.2 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Organ and Tissue Transplant

- Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients

Organ Donation (Living)

- Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures

Episode of Care - Ambulatory Systemic Cancer Therapy

- 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.

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Surgical Procedures

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Blood Services

- Handling blood and blood components safely, including donor selection, blood collection, and transfusions

3.2.1 Standards Set: Ambulatory Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for ambulatory care services are measurable and specific.	
Priority Process: Competency		
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.5	Staff and service providers receive ongoing, effective training on infusion pumps.	ROP
4.5.1	There is documented evidence of ongoing, effective training on infusion pumps.	**MAJOR**
Priority Process: Episode of Care		
8.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	ROP

8.3.1	The team provides documented rationale for the selection of target clients or populations to receive formal medication reconciliation.	**MAJOR**
8.3.2	There is a demonstrated, formal process to reconcile client medications at the beginning of service, and periodically as appropriate for the client or population receiving services.	**MAJOR**
8.3.3	The team generates or updates a comprehensive list of medications the client has been taking prior to the beginning of services (Best Possible Medication History (BPMH)).	**MAJOR**
8.3.4	The team documents any changes to the medications list (i.e. medications that have been discontinued, altered, or prescribed).	**MAJOR**
8.3.5	The team provides clients and their providers of care (e.g. family physician) with a copy of the BPMH and clear information about the changes.	**MINOR**
8.3.6	An up-to-date medications list is retained in the client record.	**MAJOR**
8.3.7	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
12.2	The team reconciles the client's medications with the involvement of the client, family, or caregiver at interfaces of care where the client is a risk of medication discrepancies (transfer, discharge), when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	ROP
12.2.1	The team provides documented rationale for the selection of target clients or populations to receive formal medication reconciliation, and the risk points during service delivery where reconciliation will be conducted.	**MAJOR**
12.2.2	There is a demonstrated, formal process to reconcile client medications at interfaces of care where the client is at risk of medication discrepancies (transfer, discharge), and periodically as appropriate for the client or population receiving services.	**MAJOR**
12.2.3	The team documents any changes to the medications list (i.e. medications that have been discontinued, altered, or prescribed).	**MAJOR**
12.2.4	Upon transfer or discharge, the team provides clients and their providers of care (e.g. family physician, next provider of care) with a copy of the up-to-date medications list and clear information about the changes.	**MAJOR**
12.2.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Ambulatory care service covers a broad array of services on multiple sites. Ambulatory care areas at Montreal Neurological Hospital, Montreal Children's Hospital and The Montreal General Hospital were part of this on-site survey. All areas visited are working diligently to align the scope of services with the organization's strategic directions and the missions of McGill University Health Centre (MUHC). Clinical missions defined by service area guide the teams when making change. The teams are encouraged to develop goals and objectives that are specific to the service. This will promote goals and objectives that are measurable and specific.

Triage systems are in place at all hospital sites to ensure the most urgent patients are seen when required. Significant improvements have been made in this area to ensure patient care is a high priority. Ambulatory services meet bi-weekly with nurse clinicians from different specialities to discuss common issues and quality issues related to services at all hospital sites. The teams at all sites ensure that newly diagnosed patients are seen quickly to avoid hospital admissions whenever possible.

Preventive maintenance records are maintained by the biomedical department. This ensures that appropriate records for all ambulatory care areas are maintained in a central location which in turn, ensures that consistency is maintained.

Strong integrated teams focus on high-quality care and there is promotion of one-stop shopping for all patients. The Montreal Chest Institute's clinical triage process for the management of patients with chronic disease prevents emergency department visits and hospital admissions, with the use of a unique day hospital environment. Many ambulatory care areas are supported by nurse clinicians and clinical nurse specialists to promote evidence-based practice for the team and to support patients with chronic diseases.

Priority Process: Competency

There are appropriate interdisciplinary teams in the ambulatory care settings at McGill University Health Centre (MUHC). Nurses within these environments are experienced and their expertise provides excellent support to the complex patients treated. A competency based orientation has been developed for nurses in ambulatory care areas and this ensures consistency in training. Mentorship is provided to all new staff members, especially in the complex clinic setting such as diabetes. Ongoing education is available to staff members for complex medical conditions. Diabetes nurses and other speciality nurses obtain certification when appropriate. The teams are encouraged to continue to evaluate their functioning as they move towards new models of care in the future.

Performance reviews are not completed on a regular basis and doing this would provide consistent feedback to all team members. All staff members indicated that informal feedback on performance is provided by their supervisors.

Infusion pump training occurs during orientation however, ongoing effective training on infusion pumps needs to take place.

Priority Process: Episode of Care

Triage systems exist in all ambulatory care service areas at the McGill University Health Centre (MUHC). A focus has been placed on emergency diversion and also admission avoidance in all speciality areas. Unique ambulatory care programs such as the diabetes program at Montreal Children's Hospital and the day hospital at the Montreal Chest Institute ensure that patients have options outside of hospital admission to manage their chronic disease. The teams strive to provide same-day treatment for clients that require care. The teams have developed comprehensive patient care plans and action plans for patients to encourage self-management of chronic disease.

The teams continue to work with community agencies and practitioners to update information related to the service availability. Work has been done to ensure that clients receive the right care in the right environment.

Medication reconciliation is formalized in select ambulatory care settings. The teams are encouraged to continue with implementation of medication reconciliation for all medical units. The ambulatory care teams are encouraged to establish appropriate target populations to receive formal medication focusing on clients where medication therapy is a significant component of the care.

Priority Process: Decision Support

It is noted that the organization is undergoing an extensive exercise to scan patient records in preparation for the electronic health record. Although there is some concern about this it is recognized by the teams that it will result in a more comprehensive health care record. Many ambulatory care areas have converted to this new process and see the benefits for the patients in the care continuum. It was noted that in some ambulatory care areas "shadow charts" still exist. The organization is strongly encouraged to continue to work towards a comprehensive chart to provide for all patients. Potential safety risks are possible if current patient information is not available to all care providers.

Some services such as gastroenterology are in the process of adopting provincial guidelines for colorectal screening and this will provide the team with best practice benchmarks and information that is required. The other services in ambulatory care have numerous clinical pathways, and physician order sets for common conditions such as diabetes. There is documented evidence of the use of research-based and evidence-based clinical pathways to enhance care for patients with chronic conditions. The team is encouraged to continue to the development of clinical pathways and order for medical conditions as appropriate in the ambulatory care settings.

Priority Process: Impact on Outcomes

The ambulatory care teams have various clinical pathways based on the population being served. The interdisciplinary team makes changes to care plans and assesses patients for safety risks as part of every clinic visit. All team members are active participants in rounds and especially related to patients with chronic conditions. The plan of action for patients with chronic conditions such as congestive obstructive pulmonary disease (COPD) and asthma ensure that patients and families have the tools to deal with challenges related to their disease process.

Patient satisfaction is monitored in a variety of ways in the ambulatory care settings. All teams were able to provide examples of changes made as a result of surveys conducted with patients. The teams are encouraged to share their satisfaction tools so that a more formal tool could be developed in the future.

Patient safety is a priority and risks such as falls and other safety issues are part of the assessment process for this patient group. All ambulatory care teams are encouraged to participate in the roll-out of the transforming care at the bedside (TCAB) project at McGill University Health Centre (MUHC). This will further define the safety focus for each of the teams going forward.

3.2.2 Standards Set: Ambulatory Systemic Cancer Therapy Services

Unmet Criteria			High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy			
7.1	The team receives and documents the client's informed consent before providing services.		!
9.14	When medication therapy is a significant component of care, the team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.		ROP
	9.14.2	There is a demonstrated, formal process to reconcile client medications at the beginning of service, and periodically as appropriate for the client or population receiving services.	**MAJOR**
	9.14.3	The team generates or updates a comprehensive list of medications the client has been taking prior to the beginning of services (Best Possible Medication History (BPMH)).	**MAJOR**
	9.14.4	The team documents any changes to the medications list (i.e. medications that have been discontinued, altered, or prescribed).	**MAJOR**
	9.14.5	The team provides clients and their providers of care (e.g. family physician) with a copy of the BPMH and clear information about the changes.	**MINOR**
	9.14.6	An up-to-date medications list is retained in the client record.	**MAJOR**
	9.14.7	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
16.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.		ROP
	16.3.1	There is a demonstrated, formal process to reconcile client medications at referral or transfer.	**MAJOR**
	16.3.2	The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	**MAJOR**
	16.3.3	The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	**MAJOR**

16.3.4	The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	**MAJOR**
16.3.5	The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	**MAJOR**
Priority Process: Clinical Leadership		
2.1	Team members work together to develop goals and objectives that are measurable and specific to the delivery of ambulatory systemic cancer therapy services.	
2.5	The team has sufficient space to accommodate its clients and to provide safe and effective services.	
4.3	The organization has a process to identify and address the maximum workload assigned to each team member.	
Priority Process: Competency		
3.5	Sufficient workspace is available to support team functioning and interaction.	
5.8	Team members receive ongoing, effective training on infusion pumps.	ROP
5.8.1	There is documented evidence of ongoing, effective training on infusion pumps.	**MAJOR**
5.11	Team leaders regularly evaluate and document each team member's performance and competency in an objective, interactive, and constructive way.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
	The organization has met all criteria for this priority process.	
Priority Process: Medication Management		
11.2	The team uses computerized physician order entry (CPOE) or Pre Printed Orders (PPO) when ordering systemic cancer therapy medications.	!
11.4	The team does not accept verbal or telephone orders for an entire cycle of systemic cancer therapy medications.	!
11.9	The team does not use abbreviations or dashes when ordering systemic cancer therapy medications.	!

Surveyor comments on the priority process(es)

Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy

The ambulatory systemic cancer therapy team is from the Montreal Children's (Pediatric), Montreal General (Adult) and Royal Victoria (Adult) hospitals. All these sites were visited during this accreditation process. All sites have an integrated interdisciplinary team, including volunteers, where a common vision is shared and centred towards the most beneficial episode of care for these group patients. Family members are also included during treatment plans. Relationships are professional and respectful, with a lot of humanity in trying to achieve a sense of peacefulness in a difficult period.

Access to ethics consultations is available as the need arises. Staff members are also aware of the presence of this service, including how to access this resource.

Coordination of services for chemotherapy, blood work, radiology, radiotherapy, and so on is supported by nurses, administrative assistants and by informatics tools when the medical orders for treatment are received by these sites. In parallel with this process, allied health professionals are also called upon to participate actively in an integrated care plan to reduce barriers, offer support and other needs as they arise or are identified. In the adult programs, when there is an increase of volume in one site, a corridor of services are available from one centre to another with the objective of not to delay care. Care plans are well-documented at each of the sites.

Informed consent processes are not integrated in the adult population at Montreal General and Royal Victoria sites. Encouragement is offered the team to integrate this step into their processes.

Risk management is a high priority throughout the episode of care at all sites. Many processes are in place such as patient education sessions, double validation of chemotherapy, identity (ID) identification and central line prevention of infection. Nonetheless, there is no formal medication reconciliation process in place in the adult settings. In the pediatric counterpart, there is a medical review at the initiation of care. Abbreviation usage is still noted in all charts reviewed by the surveyor team, even if there is a policy regarding this issue. The team is encouraged to formalize this process in a timely manner.

Collaboration and partnerships are well-established in the community with the local community services centres (CLSC) in various regions of the territory. The transfer of information is well-designed such as for blood sampling protocols. Home care clinical processes have been in place for many years now, with the CLSC providing training with new protocols.

Priority Process: Clinical Leadership

Data reporting is well-established with these teams. This information is utilized for the deployment and access of care. Many partnerships are in place including the Rosy Cancer Centre for quality care.

Each of the teams entertains a good relationship with senior management. When issues arise they follow the organizational hierarchy.

Supplies and equipment is representative of the needs to deliver services. The down side here is there is insufficient space to ensure a worksafe environment.

In regards to staffing processes there is almost no turnaround of personnel. Workload measurement is based on experience and length of treatment. Members have mentioned the need for a more precise tool, especially for nursing care, where nursing hours/patient intensity of care (soins) would be an asset. Encouragement is offered the team to continue exploring this avenue.

Recognition of staff and incentives are a priority and available in many forms. This includes education, participation to national conferences, Canadian Nurses Association specialty certification, poster presentations as well as others.

Infusion pump training is done during orientation only. There is no process to ensure maintenance of competence. Encouragement is offered the team to develop a risk management process that would include maintenance of competence of intravenous (IV) pumps.

Teams are currently busy with the planning for new processes associated with the new MUHC location. Teams are involved in design planning, harmonization of practices, equipment management, and other things. Details of these project charts indicate an incredible amount of detail including estimated workload hours. The teams are concerned on its ability to integrate and sustain this workload on an already 'full plate'.

Priority Process: Competency

The interdisciplinary approach is present and embedded in all teams visited during the on-site survey. Communication is the driver and a shared value, and in discussion this was confirmed as staff members mentioned they are well informed.

Roles and responsibilities are defined and respected. It is evident there is a sense of belonging and engagement, as noted during the exchanges with staff members and physicians, patients and family.

Priority Process: Decision Support

There are still shadow charts for regular ambulatory o oncology. There is a willingness to develop an electronic chart in the near future in concert with the new hospital.

Research and integration of evidence-based medicine is integrated in all care processes.

Priority Process: Impact on Outcomes

Falls prevention and venous thrombosis are well integrated. Team members are aware of processes in regards to event reporting including sentinel events.

Quality indicators such as for central line infection (CLI) rate, vancomycin resistant enterococci (VRE), methicillin resistant staphylococcus aureus (MRSA) and others are recorded and shared at all levels and aligned with the organizational quality improvement portfolio.

Priority Process: Medication Management

Each of the sites has a de-localized pharmacy directly in the outpatient oncology units. Pharmacy is an asset in validating medication orders, preparation and education to staff members or patients.

Electronic prescription and protocols have been recently introduced and are seen as a positive outcome. The team is encouraged to continue with this process and to develop quality indicators to ascertain if the change has brought the numbers of medication errors in regards to prescription down versus the written process.

There is ongoing concern and frustration, and despite many requests and intervention from management, cytotoxic waste is not managed appropriately by the environmental services at the Royal Victoria Hospital site. At this site there is continued overflow of waste disposal bins during the workday and/or at the beginning of the next workday. Encouragement is offered the environment services team to correct this matter as soon as possible.

3.2.3 Standards Set: Biomedical Laboratory Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Laboratory		
4.4	Laboratory staff who are responsible for specific procedures have access to the relevant SOPs. ISO Reference: 15189-07, 5.4.2, 5.5.3.	
4.7	If tests are performed outside the laboratory, the appropriate individual applies the same processes and procedures as used in the laboratory.	!
6.3	When monitoring point-of-care testing, the laboratory performs quality control checks on each analysis.	!
7.12	The laboratory provides reports to the appropriate individuals within the agreed upon turnaround time. ISO Reference: 15189-07, 5.8.2, 5.8.11.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Laboratory		

The staff members of the laboratory at McGill University Health Centre (MUCH) have put considerable effort into the harmonization and consolidation of practices among the different sites. They face many challenges as they go forward with the move to the new site and the renovation of the two remaining sites. The culture of continuous quality improvement is constantly growing and adapting to the changing organizational needs.

A manual that describes the procedures for collection of samples is available online however, not all staff members are aware of its existence. At the Royal Victoria Hospital emergency department the presence of a dedicated phlebotomist has increased the quality of the specimens obtained, thereby improving patient care and satisfaction. The procurement sites do not provide adequate privacy and are not designed to properly accommodate individuals with disabilities. The laboratory is encouraged to provide oversight to the blood procurement procedures in other areas of the hospital.

Since the acceptance and rejection criteria have been implemented, compliance with accurate requisitions and the level of patient confidentiality has been improved. The availability of order entry in all patient care areas would greatly reduce the amount of re-labelling specimens when the order is created in the laboratory.

The laboratory has developed quality indicators for many procedures. The pathology laboratory would benefit from establishing a target for turn around times and sharing this information with the staff.

There is a laboratory utilization committee that reviews impémentation of new testing and ordering patterns. External pressures and priorities have taken precedence over already planned activities.

3.2.4 Standards Set: Blood Bank and Transfusion Services

Unmet Criteria	High Priority Criteria
Priority Process: Blood Services	

The organization has met all criteria for this priority process.

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

The Transfusion Medicine service is staffed by experienced, knowledgeable and dedicated technologists. The Transfusion Safety Officers work to create a network of technologists, nurses and physicians that provides an efficient and safe transfusion service. The charts with the information on the different blood products, the steps in administering products and recognizing transfusion reactions are a great resource that is appreciated and used by the nursing staff. The witness attestation process encourages the patients to be involved in their own care and safety. The Massive Transfusion Protocol for providing products to manage massive bleeding patients is implemented. The very positive comments received from physicians in audits of the process indicate that it is effective in providing blood products in a safe and timely manner.

Transfusion Medicine is an area of the laboratory with great variability in patient testing results, the successful resolution of which relies heavily on experience and knowledge. The laboratory is encouraged to develop a plan for succession and knowledge transfer to ensure that the expertise is not lost during realignment of the workforce.

The team is to be commended on the implementation of a consent for transfusion. Because this is a new requirement, they are encouraged to conduct audits and address the outliers to ensure that compliance remains at an acceptable level.

Notification of transfusion is provided to some patients at time of discharge from the hospital. The care areas that have the Traceline computer system are able to generate a letter containing information on the type and amount of blood products transfused. The organization is encouraged to develop a process for notification of all patients receiving blood products. This was a recommendation of the Krever Inquiry into the problems encountered in the blood system in the 1980s.

3.2.5 Standards Set: Cancer Care and Oncology Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A culture of care and empathy exists in oncology services and this is reflected in the team's strategic initiatives. Clear goals and objectives related to cancer care have been established and are followed. Strong relationships have been established between oncology and other services, which results in a significant benefit to the care of both inpatients and outpatients.

The team has access to the supplies and equipment it needs to provide care and treatment.

Teaching is a significant aspect of the culture in oncology services. The medical residents interviewed during the on-site survey expressed an appreciation for the training that they are being given.

Priority Process: Competency

The successful use of a multidisciplinary team is a significant strength of the oncology service. Rapid access to care is provided by oncology's supporting services, including diagnostic imaging, laboratory, housekeeping, pharmacy and volunteer services.

The space allotted to the staff members and patients is adequate and contributes to successful patient care.

A significant amount of time is allotted to new staff members and volunteers for orientation to the oncology area, and this is appreciated by them. Team members are recognized for their contributions and there is a strong sense of support for any staff member that requires clinical or emotional assistance.

Additional staff members would be a welcome addition at some sites. Specifically, an external review of the service that was carried out two years ago recommended that two additional registered nurses (RNs) be hired to support oncology services at the Montreal Children's Hospital. An internal audit done at the same time recommended that the oncology service in ambulatory care be allotted a nutritionist and that a neuro-psychologist be added to the staffing to support oncology services across the board. It was also recommended that more hours be added to the safety officer's schedule. A lack of funding has precluded these recommendations.

Priority Process: Episode of Care

Medication reconciliation is a priority on the oncology units and the assistance provided by the pharmacists is recognized and appreciated by the nursing and medical staff.

A high degree of patient and family centric care is provided to oncology patients and their families. Massage therapy, yoga and meditation classes, support groups and other activities for both patients and families are available at the Montreal Children's Hospital. Patients and family are kept abreast of treatment progress and emotional support is provided to family members that require it. Staff members are aware of the importance of providing education to family members.

The team is given rapid access to support services such as diagnostic imaging and laboratory when it is requested.

Patients and family members that were interviewed expressed their appreciation for the care that is provided and they were especially appreciative of the rapid response time that is given by the nursing staff when they are called.

Priority Process: Decision Support

The team uses evidence-based guidelines to provide cancer care. The treatment guidelines are current. Research activities are an important part of the service and ethical protocols are met.

Priority Process: Impact on Outcomes

The safety of the already compromised oncology patients is recognized and a strong falls prevention program is in place. The importance of preventing infections is a primary concern and this is reflected in both the organization's policies and the staffs' culture. Risk of any sort to the patient is minimized where possible.

Staff members are aware of policies and procedures and of the importance of complying with them.

There is an ongoing exchange of information among the staff members and the information that is collected on patient treatments, outcomes and so on is well documented.

3.2.6 Standards Set: Case Management Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
8.9	The organization educates clients and families about their rights and responsibilities, and investigates and resolves any claims that these rights have been violated.		!
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
7.6	The team reconciles the client's medication at the beginning of service with the involvement of the client and family or caregiver when medication management is a component of care.		ROP
	7.6.1	There is a demonstrated, formal process to reconcile client medications at each visit if medications have been discontinued, altered or changed.	**MAJOR**
	7.6.3	The team conducts a timely comparison of the BPMH with medications prescribed, ordered, dispensed, or administered during service.	**MAJOR**
	7.6.4	The team communicates the BPMH and discrepancies requiring resolution to the appropriate health care provider, and documents actions taken in the client record.	**MINOR**
11.4	The team reconciles the client's medications at interfaces of care where the client is at risk for medication discrepancies (circle of care, discharge) with the involvement of the client and family or caregiver when medication management is a component of care, or as deemed appropriate through clinician assessment.		ROP
	11.4.1	There is a demonstrated, formal process to reconcile client medications at interfaces of care where the client is at risk of medication discrepancies (circle of care, discharge).	**MAJOR**
Priority Process: Decision Support			
7.8	The organization has a process to evaluate client requests to self-administer medication, if applicable.		
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The case management team for children with complex conditions is dedicated and the relationships between team members are fluid. They observe the trends and use the information to adapt their services to the emerging needs.

Patients and families are educated about their responsibilities, but there is no specific information or education done about their rights and the complaint process. The organization is encouraged to include the pertinent information about the complaint process to complete the actual information provided.

Every patient and family may access support 24/7. The equivalent of this specific approach is not yet implemented for the adult clientele. However, it is important to mention that programs do exist for adults clients. Oncology and neurology patients, for example, are followed by a specialized team and more closely by a clinical nurse specialist. Some programs, such as the one for multiple sclerosis, also have a two-year process to facilitate transition for teen patients reaching 18 years of age.

Another team is involved with geriatric patients, in emergencies and the hospital to implement a geriatric approach in the acute cares.

These teams have developed strong links to partners and community.

Priority Process: Competency

At the Montreal Children's Hospital site, the case management interdisciplinary team works with partners in the community such as Local Community Service Centres (CLSC) and Centres de santé et de services sociaux (CSSS) to organize home cares for complex cases, support families and prevent emergency visits for those children.

Priority Process: Episode of Care

This case management team for children requiring complex care is the reference for families and partners involved with the children. In 2009 large amount of documentation was developed for each of the programs including best practices and research. Some checklists might be added to standardize processes. The team is encouraged to adopt a review calendar for its documentation and to implement it.

It is interesting that patient and family receive a summary of the patient file. The file may be presented to any physician the children need to meet. This is much appreciated by families.

Because children are followed on an external basis, the hospital pharmacy service is not involved. These patients receive medication from different specialists and no global review of the medication is done. Moreover, the access to medication lists in the numerated file of the patient is not easy and the search for it creates delays. There is no pharmacist involved with the interdisciplinary team.

Priority Process: Decision Support

The organization provide to the team the information needed to assure adequate services to this specific clientele.

Priority Process: Impact on Outcomes

This program is appreciated by patients and families. All members have developed a strong relationship and confidence.

3.2.7 Standards Set: Critical Care

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for its critical care services are measurable and specific.	
2.8	The team works with its leaders and other organizational teams to plan for surge capacity in units dedicated to critical care services, particularly during predictable periods of high client volume (e.g. flu season), or during pandemics or other large-scale emergencies.	
10.4	The team has access to a service environment that promotes the comfort and well-being of the client.	
Priority Process: Competency		
3.10	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.3	The team orients new team members about the safe use of equipment, devices, and supplies used in delivering critical care services.	!
4.4	Staff and service providers receive ongoing, effective training on infusion pumps.	ROP
4.4.1	There is documented evidence of ongoing, effective training on infusion pumps.	**MAJOR**
4.5	The team monitors and meets each team member's ongoing education, training, and development needs.	
4.6	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
5.2	Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	
5.7	The team has a fair and objective process to recognize team members for their contributions.	
Priority Process: Episode of Care		
3.2	If the team offers outreach services in the form of a rapid response or medical emergency team, it defines the role of this team and communicates it to other teams in the organization.	

6.3	When offering outreach services, such as a rapid response or medical emergency team, the team provides other organizational teams with the standardized criteria it uses to determine whether critical care services will be provided.	
7.3	During the assessment, the team determines whether the client has an advance directive and records this in the client record.	
9.12	Where possible, the team accommodates the presence of the client's family members in the room when performing emergency procedures.	
12.7	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support		
14.1	The team identifies its needs for new technology and information systems.	
15.1	The organization has a process to select evidence-based guidelines for critical care services.	!
Priority Process: Impact on Outcomes		
2.3	The team identifies the resources needed to achieve its goals and objectives.	
5.3	The team has a process for identifying and reducing risks to team members while delivering critical care services.	!
15.4	The team shares benchmark and best practice information with its partners and other organizations.	
16.4	The team implements the Safer Healthcare Now Ventilator-Associated Pneumonia (VAP) bundle for all clients on ventilators.	!
17.3	The team compares its results with other similar interventions, programs, or organizations.	
17.5	The team shares evaluation results with staff, clients, and families.	
Priority Process: Organ and Tissue Donation		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Patient flow from the Montreal Neurological Hospital (MNH) to rehabilitation ceases during weekends because the rehabilitation facility does not accept transfers during that time. Staff members may receive information on Friday that the patient will be transferred on Monday. This creates a backlog of patients in surgical beds, and impairs the ability to transfer patients out of the intensive care unit (ICU) at weekends.

At the MNH site, progression towards the electronic medical record is slow. Laboratory work which is available on the hospital information system is transcribed by nurses onto a daily flow sheet. This is not productive work for nurses and introduces potential for human error when transcribing. In fact, there is little adoption of information technology in any of the surgical areas. It was identified by several services that the lack of a clinical database made it difficult to collect patient care statistics that would allow the services to measure and analyze outcomes which in turn, would help them identify opportunities to improve patient care.

McGill University Health Centre (MUHC) is advised to develop a robust pandemic plan. The absence of this puts the organization at risk if a major outbreak of infection occurs.

The ventilator associated pneumonia (VAP) bundle should be implemented as soon as possible at the Royal Victoria Hospital site.

Staff members were generally happy with the availability and state of equipment and technology to provide patient care. Equipment was repaired quickly.

It appears that in 2006, there were guidelines created by the Quebec Ministry of Health for hospitals to follow and develop a pandemic plan. It would appear that a comprehensive plan for the MUHC was not developed.

Montreal Children's Hospital (MCH) and Royal Victoria Hospital (RVH), neonatal intensive care unit (NICU):

The team provides Neonatal ICU services across two sites. The planned MUHC redevelopment will involve the relocation of these services from the MCH and RVH sites to the new Glenn site by 2015. As such, teams are engaged in advanced planning to reconfigure and transition services in 2015. The team has integrated medical practice across sites, with medical teams providing coverage across the continuum of care at both sites. Nursing integration has begun with the development of dedicated positions called harmonization nurses at both sites to facilitate this integration. The team has documented goals and objectives, while progressing with detailed and advanced transition planning. The Royal Victoria Hospital site has stabilized its staffing since the previous Accreditation survey. Retention of new recruits has been successful at 75 percent.

Priority Process: Competency

The family interviewed during the on-site survey spoke extremely highly of the team including doctors, nurses and specifically the social worker.

The critical care units all spoke of good support from pharmacy, which was a contradiction from the units which had minimal pharmacy support.

The need to make efficiencies to bring the budget in line was raised numerous times. Only the pediatric intensive care unit (PICU) at Montreal Children's Hospital seemed to be untouched. The other critical care units all raised the concern that budget cuts put increasing amounts of work on the staff nurses whether it be decreasing the nurse to patient ratio, reduction of an advanced nurse clinical practice (ANCP) position, loss of a patient attendant or a secretary. On already busy services, concerns were raised about increasing nursing workload.

Montreal Children's Hospital and Royal Victoria Hospital neonatal intensive care units:

The neonatal Intensive Care team is a mature interdisciplinary team that is involved both in planning, quality improvement and patient care. The team regularly reviews team functioning and identifies priorities for action and improvements.

The performance of team members is not evaluated on a regular basis. The team leadership is encouraged to formalize its process to ensure that team members receive feedback on their performance at regular intervals. Performance evaluations are being performed annually for all medical staff, although there is an opportunity to expand the current evaluation to include a complete 360 feedback process.

Priority Process: Episode of Care

At the Montreal Neurological Hospital (MNH), the team accepts all referrals to ensure service to more than three million people. The team does not have any trouble obtaining essential client information when patients are transferred from other hospitals and the team sends appropriate information when patients are repatriated. At the MNH, clients are not ever permitted to be present during emergency procedures.

Medication records are signed daily in the MNH ICU prompting the physician to review all medications on a daily basis as well as providing documentation of medications on transfer out of the ICU.

The crash cart in the post-anesthetic care unit (PACU) at the Montreal General Hospital (MGH) site is checked once a week. The MGH should canvass other PACUs and ensure this is appropriate and that indeed, they should not be checking it daily. Checking once a week may meet the standard of care but may not meet standards of practice.

Montreal Children's Hospital and Royal Victoria Hospital, Neonatal intensive care unit:

The team offers well-developed outreach support for neonatal care. The team provides support for the code pink rapid response team in the organization. Externally, the team provided the manpower for the neonatal transport team that provides service to the region.
Parents indicate that they are well supported during their child's admission period in the neonatal intensive care unit (NICU).
Although advance directives are not usually formalized in the clinical setting of the NICU, parents are consulted during the decision- making process and the discussion is documented in the patient record.

The team does not have a formal medication reconciliation process, although it has developed a customized format that is regularly integrated into the chart. It is suggested that the organization finalize the plan to adopt medication reconciliation in all clinical areas consistently.

Priority Process: Decision Support

The adoption of information technology at the Montreal Neurology Hospital (MNH) is much slower than at most hospitals this surveyor has observed in other facilities. Although the MNH does a lot of bench and translational research, there is not a lot of clinical research done. All clinical research is self-supporting and approved by the MNH research ethics board (REB).

At the Montreal Children's Hospital and Royal Victoria Hospital the neonatal intensive care unit team uses updated evidence-based protocols that reflect current research and best practice for providing emergency care. The team is actively involved in research activities which meet research and ethics standards and protocols.

Priority Process: Impact on Outcomes

In all four critical care units, staff members consistently use two patient identifiers before providing service. Patients confirmed that this practice was widely adopted by staff.

The team delivering Neonatal Intensive Care services at Montreal Children's and Royal Victoria hospitals are informed on how to identify, reduce and manage patient and staff safety risk. Clients confirm that they receive education via written materials and staff instruction.

The team uses the information it collects about the quality of its services to identify opportunities for improvement, sharing the results with staff members and their clients. Client surveys are used to obtain feedback on service delivery and the results are integrated into quality improvement initiatives.

Priority Process: Organ and Tissue Donation

The Montreal Neurological Hospital, Montreal Children's and Royal Victoria hospitals have well-established protocols for organ donation with documented success in retrieval, which is communicated to the staff. They are aware of their rates of missed opportunities and have a very good working relationship with the organ transplant coordinators.

Montreal Children's Hospital and Royal Victoria Hospital, Neonatal Intensive Care Unit (NICU):

The team works closely with the intensive care unit and with the organ recovery centres to establish effective transfer of potential organs from the NICU, which rarely occurs from this clinical area. Team members know how to access the written policy on neurological determination of death (NDD) from the ICU and consult with the ICU team for this process. Staff members receive regular training on the process they are required to follow to initiate and carry out the process.

3.2.8 Standards Set: Diagnostic Imaging Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
4.3	For nuclear medicine, the team designates separate waiting areas to segregate clients who have been injected with radioactive substances from other clients.	!
4.4	The client service area includes a space for screening clients which respects confidentiality issues prior to their diagnostic imaging examination.	!
5.2	The team labels and stores chemicals and solutions in compliance with WHMIS regulations.	!
11.5	The team confirms the client's identity, nature, and site of the procedure immediately before the interventional procedure.	!
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

Imaging units vary from state of the art to those that will soon require replacement. In the latter case, the staff members are making the best use of the equipment that they have to work with until replacements can be acquired. Access to imaging services and report turn-around times (TATs) are generally within established limits. Wait-times and TATs for imaging services are well documented.

Radiation protection is of primary importance to the imaging staff members and both patients and staff are well protected. Regularly scheduled preventive maintenance is carried out and documented on all imaging equipment.

Partnerships exist with other services and there is a general sense of co-operation among these services which benefits both inpatients and outpatients.

Oncology patients and those requiring an immediate diagnosis are given rapid access to imaging services and significant findings are immediately relayed to the referring physician.

Staff members are well aware of the importance of using two patient identifiers and they comply with this policy.

There is a lack of space in the diagnostic imaging departments at the Montreal General Hospital and Lachine Hospital sites. The waiting rooms are small and when they are full, patients must stand in the adjacent hallway. This crowding results in a lack of privacy at the patient registration desk as conversations between the clerical staff and the patients being registered are easily overheard.
Nuclear Medicine patients that have received an injection of a radionuclide at the Montreal General Hospital

site do not have a separate waiting room to sit in while they wait to be scanned. Two patients are simultaneously scanned in the same room in the ultrasound department at Lachine Hospital site and they are separated only by a curtain. The potential for their privacy to be compromised exists, as conversations between the patient and sonographer on each side of the curtain can be heard by the other.

3.2.9 Standards Set: Emergency Department

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
8.3	The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.		ROP
	8.3.1	There is a demonstrated, formal process to reconcile client medications for clients with a decision to admit.	**MAJOR**
	8.3.2	The team generates a Best Possible Medication History (BPMH) for clients with a decision to admit.	**MAJOR**
11.5	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.5.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	11.5.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			
Priority Process: Organ and Tissue Donation			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The adult emergency services at the Royal Victoria site and pediatric emergency services at the Montreal Children's site were evaluated during this on-site survey. The planned MUHC redevelopment will involve the relocation of these services from this site to the new Glenn site by 2015. As such, teams are engaged in advanced planning to reconfigure and transition services in 2015.

Royal Victoria Hospital Emergency Services:

The team monitors patient satisfaction, following up on the study undertaken in 2010 by Laizner, Stace and Rozintseva. The team collects information about its clients, and reviews data as part of the quality outcome evaluation.

The team works closely with infection control to manage risk of infection, recognizing the increased risk of infection from overcrowding. Nevertheless, there is significant overcrowding in the emergency room. The public intermingle with patients in the corridors where patients occupy fourteen established corridor beds. This practice of corridor beds allows potential access to patient information and increases the risk for breaches in patient privacy. Space is cramped and cluttered with equipment and supplies. The relocation to the new hospital in 2015 is expected to address this issue.

The team is encouraged to work with the laboratory team to ensure that point-of-care testing, appropriate to the clinical area, is established with the appropriate oversight by the laboratory.

Montreal Children's Hospital Emergency Services:

The emergency services are located in a well organized space. The team has had a leadership change in the past year, after a period of vacancy at this level. The newly restored leadership team has embarked on a refresh of the team's vision and mission, and determination of goals and objectives to guide the activities for this year. The team has formed a "dream team" of multidisciplinary members, whose focus is to identify strategies to improve service delivery in the new location.

The team recently reconfigured the medical model of service delivery in early 2013. The ongoing monitoring of performance metrics reveals a decrease in individuals that have left before being seen.

To ensure that team members have the required competencies staff members were provided with educational opportunities.

Priority Process: Competency

Royal Victoria Hospital Emergency Department:

Nursing staff that were interviewed indicated that they feel supported and are provided with opportunities for ongoing development. The organization offers mentorship programs, a staff development program (The Genesis Program) and a staff leadership program.

Pediatric care is regional, with emergency care offered mainly at the Montreal Children's and St Justine facilities. Notwithstanding, the team at Royal Victoria Hospital has put in place appropriate pediatric

equipment in a dedicated resuscitation area. Patients that present at this facility are stabilized and transferred to a pediatric facility.

Nursing performance is not regularly evaluated. There exists an opportunity for the team's leadership to ensure that its nurses receive regular feedback on their performance. Performance evaluations are being performed annually for all medical staff, although there is an opportunity to expand the current evaluation to include a complete 360 feedback process. There is no documented evidence of ongoing effective training on infusion pumps.

Montreal Children's Hospital Emergency Department:

This is a strong, well-organized team that has in place annual goals and objectives, systematic evaluation of performance metrics and ongoing transition planning for the relocation in 2015. The team receives education specific to delivering emergency services for children. Training in infusion pumps is well documented. Specialized training in areas such as workplace violence is provided for team members.

With the re-establishment of a complete leadership team there is an opportunity for the leadership team to ensure that all nurses receive regular feedback on their performance. Performance evaluations are being performed annually for all medical staff, although there is an opportunity to expand the current evaluation to a complete 360 feedback process.

Priority Process: Episode of Care

Adult emergency services at the Royal Victoria Hospital site and Pediatric Emergency Services at the Montreal Children's Hospital site were evaluated during the on site survey for episodes of care. Teams at both sites collect, track and benchmark their performance metrics. Both teams have well-established transition planning in place to manage the expected move to a new facility in 2015, and are conducting full reviews of their service delivery processes.

Royal Victoria Hospital site:

This team has adopted its own customized medication reconciliation process that is integrated with the Online Application and Classification Information System (OACIS) and which is integrated into the patient chart at discharge from clinical care in this area.

Montreal Children's Hospital site:

The team regularly evaluates its own performance and makes quality improvements. With the recent change in the medical model of care, this team has documented an improvement in the number of patients that leave without being seen.

The organization has the opportunity to finalize its plan to adopt medication reconciliation across all clinical areas consistently.

Royal Victoria Hospital site:

The team has an opportunity to refresh team education on organizational policies, such as the disclosure policy. Access to after hours ultrasound services was identified as a reason for delayed discharge. The team is encouraged to continue its work with the diagnostic imaging (DI) team to find solutions to improve this potential patient flow issue.

Priority Process: Decision Support

Adult emergency services at the Royal Victoria Hospital site and the pediatric emergency services at the Montreal Children's Hospital site were evaluated during this survey.

Both teams use updated evidence-based protocols that reflect current research and best practice for providing emergency care.

Both teams are actively involved in research initiatives. Research activities meet research and ethics standards and protocols.

Priority Process: Impact on Outcomes

Adult emergency services at the Royal Victoria site and Pediatric emergency services at the Montreal Children's site were evaluated during this on-site survey. Both teams actively review the safety risk to team members that deliver services in the emergency department. Staff members receive education on managing physically threatening, violent patients and workplace violence.

Reporting on sentinel and adverse events is consistently carried out and tracked. Staff members receive feedback on quality improvements that emerge from a review of these events.

The team has an opportunity to refresh team education on organizational policies, such as the disclosure policy.

Priority Process: Organ and Tissue Donation

Adult emergency services at the Royal Victoria Hospital site and pediatric emergency services at the Montreal Children's site were evaluated during this on-site survey. Teams work closely with the intensive care unit (ICU) and with the Organ Recovery Centre to establish effective transfer of potential organs from the emergency department, which rarely occurs from this clinical area.

Team members know how to access the written policy on neurological determination of death (DND) from the ICU and consult with the ICU team for this process. Staff members receive regular training on the process they are required to follow to initiate and carry out the process.

3.2.10 Standards Set: Hospice, Palliative, and End-of-Life Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It is clearly evident there is strong leadership on the palliative care areas. A culture of care exists with the medical and nursing leaders and this filters down to the rest of the staff. Housekeepers are included in this culture and they feel that they are contributing to patient care by keeping the environment clean to reduce the likelihood of infections.

Strong partnerships exist with other services. The team has measurable plans and goals and seeks to achieve them.

The organization supplies the tools that staff members require to carry out their care.

Priority Process: Competency

A strong interdisciplinary team is in place. Staff members work with service providers across the organization to provide care for palliative patients. Rapid access to services benefits patients. All professional staff members are knowledgeable in palliative care and are credentialed in their fields.

Orientation to the unit for new staff members is a priority and is appreciated by the new staff. Continuing education is ongoing.

Volunteers are considered to be an important part of the team and they appreciate the significance of their role.

Priority Process: Episode of Care

While excellent care is given to patients on the palliative care unit, their families are not forgotten. Rather, they are considered to be an integral part of the spectrum of care and much attention is devoted to them. They have almost unlimited access to the patient and are included in conversations between the patient and staff members if the patient wishes.

The nursing staff members respond quickly when patients request their presence and this is greatly appreciated by the patient.

The patient's psychosocial well-being is considered to be extremely important and psychiatrists and psychologists are available to assist when necessary. These specialists are also available to treat staff members that request their assistance during or following an emotionally difficult time on the unit.

Pharmacists dedicated to the oncology service are an integral part of the team and assist with, among other things, medication reconciliation which is well done. Access to medication and pharmacy assistance is available after hours.

Priority Process: Decision Support

Information technology pertinent to patient care is available to team members and they report that they receive a proper orientation to new systems.

Evidence-based guidelines are followed.

Priority Process: Impact on Outcomes

Patient care and outcomes are the priority of the staff members on the palliative care units. Assistance with difficult pain control is available from the oncologist's and hematologist's colleagues in anaesthesiology. A team approach to patient care exists and this has an extremely positive impact on care. Family members are instructed on what to expect regarding care, treatment and end of life.

Adverse events, when they occur, are documented and disclosed not only to the "hospital" but to patients and families as well. Incidents are followed up and are treated as learning opportunities.

3.2.11 Standards Set: Infection Prevention and Control

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
4.7	The organization reviews and updates its policies and procedures at least every three years, and as new information becomes available.	
5.4	Staff, service providers, and volunteers attend the IPAC education program at orientation and regularly thereafter.	
6.5	The organization evaluates its compliance with accepted hand-hygiene practices. 6.5.3 The organization uses the results of the audits to make improvements to its hand hygiene practices.	ROP **MINOR**
7.3	Information provided to clients and families is documented in the client record.	!
7.5	Staff, service providers, and volunteers encourage clients, families, and visitors to follow effective hand hygiene behaviour.	!
8.1	Staff and service providers store, prepare and handle food appropriately.	!
8.2	The organization stores and handles linen, supplies, devices, and equipment in a manner than protects them from contamination.	!
10.1	The organization has defined roles and responsibilities for cleaning and disinfecting the physical environment.	
10.2	The organization properly cleans and disinfects client and staff areas.	!
10.3	Staff and service providers have access to the organization's cleaning policies and procedures.	
10.6	The organization regularly monitors the quality of its cleaning and disinfection of the physical environment, and uses the information to make changes to policies and procedures.	
11.4	The team follows specific procedures to handle, clean, and disinfect mobile client equipment.	!
12.11	When transporting contaminated equipment and devices, the organization complies with applicable regulations, controls the environmental conditions, and uses clean and appropriate bins, boxes, bags, and transport vehicles.	!

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The infection prevention and control (IPAC) team is involved across the entire McGill University Health Centre. The committee is efficient and documentation is large and generally up to date. There are precise processes for all concerns and activities related to infection prevention and control (IPAC). The team follows indicators and informs the executive committee monthly, and every service is informed of their own performance. For a few years, the team has been systematically collecting and measuring data and positive results are beginning to show.

There are still issues with responsibilities to share about cleaning, disinfecting equipment and areas, and controlling quality of cleaning. At some sites such as Lachine Hospital or the Neurological Hospital, there is fluid communication between clinical and housekeeping services. In other hospitals, there are still grey zones that need to be clarified.

At all of the different sites, there are handwashing reminders and alcohol-based stations. In some areas, there are not enough of them to be easily accessible to staff members and service providers. The organization is encouraged to continue its efforts to provide sufficient numbers of alcohol stations in clinical, technical and public areas. Compliance with handwashing is a major issue for the organization across the sites of McGill University Health Centre (MUHC) and the efforts to clarify and implement systematic handwashing and the correct use of gloves must continue.

It is suggested to the organization that all soiled utility room doors be closed. It is suggested that the organization use a swing door instead of a door with a handle which might be contaminated, and ensure limited access to personnel with a clear indication on a poster in this regard.

There is another major issue with basements. For example, at Montreal Children Hospital this area was dirty, with used gloves on the floor and other garbage in corners, and the same was observed in some services like the laundry room. It is suggested that the organization find ways to improve the cleanliness of the facilities on an ongoing basis until the move to the new site is in two years.

3.2.12 Standards Set: Laboratory and Blood Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Laboratory		
6.2	The laboratory considers the size of the laboratory, volume of services, and the complexity of procedures when assigning staff. CSA Reference: Z902-10, 4.3.1.1, 4.3.1.2.	
6.3	The laboratory has enough staff to carry out the work. ISO Reference: 15189-07, 5.1.5.	
10.5	The laboratory reviews and updates the SOPs annually or more often if needed. CSA Reference: Z902-10, 4.6.1.6.	
12.6	The laboratory conducts and documents initial and regular testing of the LIS. CSA Reference: Z902-10. 21.4; Z902-10, 21.2.3, 21.3. ISO Reference: 15189-07, Annex B.7.6-7.7; 15189-07, Annex B.7.4.	
13.1	The laboratory has enough space and resources to perform its activities. CSA Reference: Z902-10, 4.5.1.4, 22.1.1, 22.1.7. ISO Reference: 15189-07, 5.2.1, 5.2.9.	
13.3	The laboratory's collection areas ensure client comfort and privacy, and accommodate disabilities. CSA Reference: Z902-10, 22.4.2. ISO Reference: 15189-07, 5.2.3.	!
13.6	The laboratory's equipment is located so as to optimize efficiency and minimize accidents and errors. ISO Reference: 15189-07, 5.2.1.	
13.7	The laboratory monitors and controls utilities and environmental conditions. ISO Reference: 15189-07, 5.2.4, 5.2.5.	
13.8	The laboratory separates incompatible activities and prevents cross-contamination. CSA Reference: Z902-10, 22.2.3. ISO Reference: 15189-07, 5.2.6.	!
13.9	The laboratory isolates activities requiring sterile techniques and performs these under aseptic conditions.	!
13.10	The laboratory controls access to and use of areas affecting the quality of activities. CSA Reference: Z902-10, 22.1.2. ISO Reference: 15189-07, 5.2.7.	!

13.11	The laboratory has separate space for record keeping, data entry, and other administrative activities.	
14.8	The laboratory is secure, with access limited to authorized personnel. ISO Reference: 15189-07, 5.2.7.	!
17.2	The laboratory carries out and records regular checks of temperature, humidity levels, and any other critical factors. CSA Reference: Z902-10, 9.4.4.	
18.5	The laboratory prevents the use of inappropriate, expired, deteriorated, and substandard supplies, reagents, and media.	
19.3	The laboratory uses sterile techniques as applicable to prepare supplies, reagents, or media.	!
19.4	The laboratory uses water of the highest purity, e.g. 18 megohms, as needed to prepare supplies, reagents, or media.	
20.1	The laboratory uses non-toxic detergent and the highest purity water to wash and rinse glassware and non-disposable plasticware.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Laboratory

There is a good working environment and collaboration amongst the staff members in the various laboratories. The team is well organized and enthusiastic and there is an appropriate mix of staffing to carry out the activities. There is a laboratory lead that is responsible for overseeing the clinical activities within and outside the laboratory.

The laboratory acts as a referral centre and provides complex testing for a number of external facilities. There are a large number of clinical specialists that provide expertise to both internal and external users. The team is encouraged to develop a succession plan to ensure the transfer of knowledge and expertise.

There is an effective training and competency assessment program. The management team meets annually with their staff members to discuss performance and develop action plans to address training needs. The laboratory complies with all laws and regulations and these documents are available online providing ready access for staff. There is a comprehensive external quality assurance program that provides staff members with feedback on their performance. The managers are encouraged to use this program as a continuing education tool for all staff.

There is concern from the staff members regarding the current practice of not replacing shifts for both short and long-term absences. The management is encouraged to develop a communication strategy to ensure that staff members are well-informed on the progress of the plans for moving to the new site.

Complaints are responded to in a timely manner. There is detailed documentation of the complaint and the subsequent actions taken, facilitating production of reports that are presented to the leadership team.

The department has developed standard operating procedures (SOPs) for most examinations. It is suggested that SOPs be created for all examinations, using standard document control protocol then, ensuring that they are available to staff members at all times in all locations.

The safety program is robust and staff members are aware of the requirements and regulations. Audits are done frequently and results are shared with the staff. The practice of handwashing in the test centres requires review and the proper protocol reinforced.

The physical environment has challenges, some of which will be addressed with the relocation to the new site however, some of those issues should be prioritized for improvement prior to the move. In the microbiology area media preparation at two sites there is no segregation of clean and contaminated activities. At the Royal Victoria Hospital, polymerase chain reaction (PCR) laboratory, all activities are performed in the same room.

In Lachine Hospital, the access to the laboratory is not restricted, which could pose a threat to the security of staff members working alone during evening and night shifts. In microbiology there is no shower, eye wash station or fire blanket. The centrifuge in chemistry is located directly under the shower.

Discussion with clients indicated that the level of satisfaction with the laboratory service is good.

3.2.13 Standards Set: Long-Term Care Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
4.5	Staff and service providers receive effective training on infusion pumps.		ROP
	4.5.1	There is documented evidence of effective training on infusion pumps.	**MAJOR**
Priority Process: Episode of Care			
The organization has met all criteria for this priority process.			
Priority Process: Decision Support			
14.1	The team maintains an accurate and up-to-date record for each resident.		
Priority Process: Impact on Outcomes			
8.8	The team uses at least two resident identifiers before providing any service or procedure.		ROP
	8.8.1	The team uses at least two resident identifiers before providing any service or procedure.	**MAJOR**

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Lachine Hospital and the long-term care (LTC) team are aware of the information about the residents and the community of Lachine. The organization is highly engaged and supportive of its surrounding community and the Lachine Hospital Centennial celebrations is one example.

Several team members report that they are seeing a change in the loss of autonomy of elderly patients being admitted to the facility. These changes, combined with an expressed need for new adequate equipment such as electrical ceiling lifts are having an impact on the care teams that are required to care for residents with more demanding needs.

As the McGill University Health Centre (MUHC) prepares for the reallocation of long terme care units, particular attention needs to be given to collaborative planning and decision making with teams as well as consultations with residents.

There is a waiting list for admission to the LTC units and some wait-times are extending 150 days. These wait-times are monitored closely on a region-wide basis. The use of transition beds, although effective in maintaining the flow of admission, results in the multiple moves of elderly clientele.

The significant reduction in using external staffing agencies has permitted the stabilization of the care teams and has been noted by residents. The management team is encouraged to continue on further building a stable interdisciplinary team of physicians, nurses and allied health professionals.

The residents met with during the on-site survey expressed great satisfaction with the help and support they are receiving and referred to the staff members as family. The team and the organization are commended for succeeding in creating a quiet and yet stimulating, clean environment conducive to home-like living.

Priority Process: Competency

The long-term care (LTC) team is commended for the many education initiatives that are available for staff. When questioned most staff members could list a series of activities that they have recently attended. Posters raising awareness on fall prevention, management of violence in the workplace and ethics are displayed and visible. Attendance of staff members at education sessions is monitored and reports can be obtained.

The LTC team meets regularly to discuss issues related to care and services. The policy on the reporting of incidents and accidents is followed. Attention needs to be given to the timeliness of documentation. Reports are available and are reviewed by the manager. Corrective measures are taken and education is offered. The presence of education facilitators contributes to building a no-blame culture of reporting and ongoing education in the work place.

There is work in progress to provide systematic opportunities for members of the LTC team to review and discuss these reports and be provided with feedback on the frequency and nature of such events. Management is encouraged to ensure that monitoring of staff training, education and development is incorporated into staff performance evaluation.

The scheduled replacement of infusion pumps available to the LTC unit could be an opportunity to introduce more systematic and ongoing training for staff.

Priority Process: Episode of Care

Care planning begins at pre-admission and families are provided with a complete information package prior to admission and with the opportunity to visit the facility. All information is reviewed at the time of admission. Several standardized assessment tools are utilized according to best practices and are used to assist the long-term care (LTC) team in conducting thorough evaluations. Formal reassessment occurs at regular frequency. Nursing care plans are updated according to changes in the condition of the resident. The team is encouraged to continue consistently documenting goals and measures as change occurs.

Policies and procedures are in place and implemented. Paper documentation that was consulted on-site is, in several cases outdated and inconsistent with the electronic version available via the intranet of the McGill University Health Centre (MUHC). Management is strongly encouraged to harmonize documentation of the policies and procedures and to ensure that content is made known to all staff including those of external agencies.

Many successes have been noted with regard to the dietary services particularly in changing the food reheating process, thus enhancing the resident's experience at meal time. Recreational activities are offered to all residents. The organization is aware and constantly working on adapting recreational activities to suit the various mix of resident needs.

Management is invited to raise awareness on the availability of ethics resources available across the MUHC sites to support the Lachine Hospital LTC team to deal with emerging ethics related-issues arising from increasing acuity of care.

Priority Process: Decision Support

Several evidence-based guidelines for long-term care (LTC) services are available and reviewed by the team. Education facilitators assist teams in the application of these guidelines.

The security and confidentiality of resident charts are physically maintained. The resident chart is organized and paper-based but the documentation required to record resident informed consent, and restraint daily monitoring, is not consistently up to standard.

Priority Process: Impact on Outcomes

Staff members from all professional groups are aware of risks to the wandering residents. The residents that present a risk of wandering are clearly identified in the facility and security measures such as stair case and elevator alarm are in place. The fall prevention program is in place. Education sessions are conducted with staff.

Observations made during the on-site survey indicate that staff members are not consistently making sure beyond doubt that, by using double identification, the right medication is provided to the right resident.

3.2.14 Standards Set: Managing Medications

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
1.4	Prescribing medical professionals and other service providers have access to accurate medication-related information specific to their client population/client care area.	
3.4	The organization standardizes and limits the number of medication concentrations available.	ROP
3.4.1	Medication concentrations are standardized and limited across the organization.	**MAJOR**
6.1	Medication storage areas are clean and orderly.	
6.3	Medications are stored in secure areas accessible only by authorized staff.	!
6.4	Medication storage conditions protect the stability of medications.	
6.5	The organization separates or isolates look-alike, sound-alike medications; different concentrations of the same medication; high-risk/high-alert medications; and discontinued, expired, damaged, and contaminated medications pending removal.	!
7.4	Medications for client service areas are stored in labelled, unit dose packaging.	!
7.5	Unit dose oral medications remain in the manufacturer's or pharmacy's packaging until they are administered.	!
8.1	The pharmacy establishes and follows a policy and process to monitor bulk chemicals which includes eliminating those that are not regularly used or that are considered dangerous.	!
8.2	The organization complies with the Workplace Hazardous Materials Information System (WHMIS) regulations for bulk chemicals in the pharmacy.	!
8.3	The organization securely stores cytotoxic agents in a segregated area with adequate ventilation.	!
10.2	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	ROP
10.2.7	The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	**MINOR**

11.4	The pharmacy computer system is used to perform dose range checks and to warn staff and service providers about low and high doses for high alert medications.	!
11.7	The pharmacy contacts the prescribing medical professional if there are concerns or changes with a medication order and documents the results of the discussion in the client record.	!
13.2	The pharmacy's policies and procedures for dispensing medications meet applicable laws, regulations, and professional standards.	
13.3	The pharmacy dispenses medications in unit dose packaging.	!
15.5	The organization has and follows a process to manage the return of medications to the pharmacy.	
19.4	Staff and service providers receive ongoing, effective training on infusion pumps.	ROP
19.4.1	There is documented evidence of ongoing, effective training on infusion pumps.	**MAJOR**

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The drug distribution system at McGill University Health Centre (MUHC) supports safe and efficient distribution of medications. This system includes: unit dose packaging of medications; automated dispensing cabinets to provide safe and rapid access to newly prescribed medications: and a computer generated medication administration record to support accurate dispensing. A number of these systems have been implemented in recent years and this investment in updating the medication system is recognized. The organization has also made significant progress towards the implementation of dose-validating specific-measurable-attainable-realistic-time sensitive (SMART) pumps. Encouragement is offered the organization to further improve the medication management system by updating sterile rooms, and implementing bar coding and computerized physician order entry (CPOE).

The organization is encouraged to continue to update and standardize the medication administration guidelines. The organization is also encouraged to continue to spread the appropriate use of abbreviations.

The pharmacy and therapeutics committee has a strong evidence-based process for medication review and resource management. The committee membership embraces their mandate to optimize patient care within the current financial restraints. Strong physician representation and engagement was observed.

The organization has implemented an antimicrobial stewardship program to optimize the utilization of anti-microbials and is leading the implementation of this program in other Quebec Hospitals. The interdisciplinary approach to this program has contributed to its success.

Pharmacists are valued members of the interdisciplinary team and effective team functioning among physicians, pharmacists and nurses was observed. Some teams do not have pharmacists and their absence is noticed.

A number of innovative information management systems are noted. These include: an electronic medication system at the Montreal General Hospital emergency department; nursing documentation at the Royal Victoria Hospital obstetrics services; computerized prescriber order entry at Montreal Children's Hospital, and medication reconciliation pilot systems. Alignment of these systems as the organization continues its journey towards an electronic health record will be valuable.

3.2.15 Standards Set: Medicine Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.1	The team works together to develop goals and objectives.		
2.2	The team's goals and objectives for its medicine services are measurable and specific.		
Priority Process: Competency			
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
4.4	Staff and service providers receive ongoing, effective training on infusion pumps.		ROP
	4.4.1	There is documented evidence of ongoing, effective training on infusion pumps.	**MAJOR**
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
7.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	7.5.1	There is a demonstrated, formal process to reconcile client medications upon admission.	**MAJOR**
	7.5.2	The team generates a Best Possible Medication History (BPMH) for the client upon admission.	**MAJOR**
	7.5.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	7.5.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	7.5.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP

11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
11.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
11.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Medicine services cover a broad array of services and all areas visited are working diligently to align scope of services with the organizations medical mission. The accreditation survey involved a visit to two medical units at the McGill University Health Centre (MUHC). All medicine services are encouraged to continue the journey to adopt the transformational care at the bedside project. This was well established at the Montreal Neurological Institute engaging staff and patients in the change process. The teams are encouraged to develop goals and objectives that are measurable and specific.

The medicine teams are committed to the services they provide to the patients in the region. The team has reviewed population health data and continues to strive to transition the acute patients back to the community when appropriate. The transition units have been developed at MUHC to provide options for patients when the acute care service is complete. The teams are responsive to the changing needs of clients and regular rounds are held to effectively plan discharges. White boards were observed on all medical units

to ensure timely communication to all members of the interdisciplinary team relative to plans for discharge. Discharges are delayed at times because patients are awaiting diagnostic tests and peripherally inserted central catheter (PICC) line insertions.

Space is a challenge at the Montreal General Hospital site resulting in some clutter in the hallways and rooms. This can lead to potential infection control risks and safety overall. Teams are encouraged to continue to review the physical space and optimize the storage spaces.

Preventive maintenance records are maintained by the biomedical department and this ensures consistent tracking for all equipment.

Priority Process: Competency

There are appropriate interdisciplinary teams in the medicine services that were visited during the on-site survey at McGill University Health Centre (MUCH). Nurses in these environments are experienced and the orientation process encompasses general hospital orientation, extensive time on the unit with an experienced registered nurse (RN) and ongoing education for all staff members using a variety of mechanisms.

General nursing orientation covers a broad array of topics, with some emphasis on patient safety. Orientation objectives and skills checklists are used for the specific medical unit orientation. Nursing orientation includes an extensive unit-specific orientation with time for practice and review. All other staff members indicate that hospital orientation was appropriate for them to understand their roles and responsibilities to provide care safely. The teams are encouraged to continue to evaluate their functioning as they move towards new models of care in the future.

Performance reviews are not completed on a regular basis and this would provide consistent feedback to all team members. All staff members indicated that informal feedback on performance is provided by their supervisors

Infusion pump training occurs during orientation however, ongoing effective training on infusion pumps needs to take place.

Priority Process: Episode of Care

The medicine teams are knowledgeable and committed to excellence in patient-centred care. Staff members are proud of the care they deliver and work well in a diverse interdisciplinary team. Order sets and clinical pathways are well established on some medical units and should be rolled out wherever possible for this complex patient group. Clinical pathways have provided the Montreal Neurological Institute with indicator data and patient teaching materials to provide excellent patient care for specific neurological conditions. A variety of patient teaching materials exist on all units and the neurological resource centre for patients and families provides excellent information for all patients with neurological conditions.

Implementation of transforming care at the bedside (TCAB) has promoted the daily interdisciplinary rounds on all units. The white boards in patient rooms ensure active participation in care by both patients and their families. Patient needs, clinical status and barriers to discharge are continually assessed. A comprehensive electronic document is completed when Local Community Services Centres (CLSC) services are required.

Timely nursing assessments are completed within 24 hours of admission to units, every shift and as required. Assessments are comprehensive and cover all aspects of patient safety. Medical assessments are completed daily and allied health assessments are done as required. The discharge assessment is completed by the multidisciplinary team involved in care.

An ethical consultant is available at McGill University Health Centre (MUHC). Ethics consultation is used by the medicine teams. The interdisciplinary team could provide numerous examples of the support provided for specific case reviews on their units.

Medication reconciliation is formal in some medicine settings. The teams are encouraged to continue with implementation of medication reconciliation to all medical units. The pharmacy presence on the medical unit at Montreal General Hospital site ensures that medication reconciliation is completed with consistency for all patients during the hospital stay and at discharge.

Priority Process: Decision Support

It is noted that the organization is undergoing an extensive exercise to move towards the electronic health record. Some assessments are electronic as this transition continues to move forward.

There is documented evidence of the use of research-based and evidence-based clinical pathways to enhance care for patients with chronic conditions. The team is encouraged to continue the development of clinical pathways and orders for medical conditions as appropriate for medicine services. Some pathways are currently being revised and the team is encouraged to update pathways based on best practice.

Priority Process: Impact on Outcomes

The medical care teams have developed some clinical pathways based on the population being served. This provides opportunity for the team to benchmark best practices in medicine service areas.

The interdisciplinary team makes changes to care plans during daily discharge rounds and updates white boards during this discussion. This provides the team with updated information on all patients in the units. All team members are active participants in rounds especially related to patients with chronic conditions. All medicine units are encouraged to move forward with the transforming care at the bedside (TCAB) project. This will provide opportunity to post quality indicators that are meaningful to staff members and this is well engrained at the Montreal Institute.

Patient satisfaction is monitored in a variety of ways in the medical units. All teams were able to provide examples of changes made as a result of surveys conducted with patients. The teams are encouraged to share their patient satisfaction tools so that a more formal tool could be developed in the future. Patients expressed great satisfaction with the white boards in patient rooms that allowed them to actively participate in the care process.

The fall prevention/management strategy is well engrained into the practice settings. Fall assessments are completed on admission and re-assessments are done when required. There is evidence on all units that high-risk patients are identified and interventions are put into place. Two client identifiers are used prior to administration of medication or treatment.

Written information is available for patients with certain medical conditions. The team is encouraged to continue to develop comprehensive patient information pamphlets and evaluate their effectiveness over time.

3.2.16 Standards Set: Mental Health Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.2	The team's goals and objectives for its mental health services are measurable and specific.		
Priority Process: Competency			
4.10	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
7.6	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	7.6.1	There is a demonstrated, formal process to reconcile client medications upon admission.	**MAJOR**
	7.6.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
8.4	The team obtains the client's informed consent before providing services.		!
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
14.5	The team shares benchmark and best practice information against its partners and other organizations.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The mental health service reflects a highly functioning, collaborative and respectful inter-professional team. Different professions are well aware of the scope of practice of other members and this knowledge prevents duplication of effort and a comprehensive approach to care. More than one professional interviewed during the on-site survey stated that this was the best team he/she had ever worked on because of the consultation and respect afforded not only the members of the team but especially the patients they served. There is no clinical pharmacy support on the team. This population is often on multiple and powerful drugs that can result in significant side effects and metabolic complications and would benefit greatly from adding a clinical pharmacist to the team.

There are often anywhere from two to 18 patients waiting in the emergency department for admission to the mental health unit inpatient beds. It is not uncommon for patients to wait for as long as three days or more for admission to a bed. While in the emergency department, patients receive medication for their illness and nursing supervision. However, no comprehensive case management plan is established until the patient arrives in the unit.

When the two mental health units at the Royal Victoria and the Montreal General hospitals merged services at the Montreal General site, a new unit was renovated, with much better patient and clinic and office space was established. Part of that plan included the establishment of a short-stay unit which is quite common in other hospital-based mental health units. The establishment of a short-stay unit has been put on hold due to fiscal restraints. A four-bed short-stay unit would help to keep overall length of stay down in the emergency department but more importantly, it would allow patients to begin more focussed psychiatric care earlier.

Priority Process: Competency

In June 2012, the inpatient departments at Royal Victoria and Montreal General hospitals merged onto one site. The process has been quite a culture shift for those that previously provided care at the Allen facility. In addition to renovations of the mental health unit, equipment was updated and additional supplies were made available.

Although there is no educator on the unit, the clinical nurse specialist and the other nursing leaders provide comprehensive training to all appropriate staff members. There is training in infusion pumps, code blue cart, code white certifications, workplace violence prevention, least restraint policies and procedures, suicidal assessment and prevention, and levels of observation.

Forty percent of the nurses in the mental heath program are over the age of sixty. It is imperative that a proactive and intentional plan be put in place to facilitate succession planning. At any time, and with only a few months notice, a significant amount of wisdom and expertise could leave the organization.

Priority Process: Episode of Care

The team recently participated in transforming care at the bedside (TCAB) process, a lean management approach to patient care. The team has developed a much more efficient and patient-centred approach to assessing a new patient on the unit. Previously each profession be it social work, occupational therapy, nursing or medicine would individually interview the patient asking many of the same questions while looking for different aspects of the information obtained. It could take as much as five hours to complete. A minimum of three members of the professional team now participate jointly in the admission process of a patient thereby saving the patient ,who may be anxious or otherwise distressed, to give as much information at one time and eliminate repetitive questions. The team can then develop the plan of care quickly and efficiently.

There are only two points of intake to the mental health services and they are the emergency department and a centralized intake process. A mental health nurse will assess a patient that feels in need of services and identify the complexity of need and what level of service is required. Some patients may be referred to specialized out-patient programs or may be acute enough to be sent to emergency for an urgent medical mental health assessment. All patients that need care will receive it but according to the ministry's mandate, there is an effort to repatriate patients back to the community in which they live via the Local Community Services Centres (LCSCs) and to primary care providers where possible. In many cases, patients have been in the care of this team for many years, sometimes decades, and are understandably reluctant to go to a new team in the community in which they live.

There seems to be limited ability to access beds at other health care systems when the bed situation is critical. According to the team, there is a bed crisis across Montreal. Thus, the opportunity to redirect admissions to another organization in a state of overwhelming wait times is virtually impossible.

Since the amalgamation of the two units to Montreal General Hospital site, there is timelier access to medical and diagnostic services when required. The unit was renovated and although it still seems crowded, it is apparently a significantly better space than previously used.

The team has developed a number of informative pamphlets that help patients and families understand that the unit is a locked unit and why. They explain to patients that privileges are related to their mental health status and reflected in three specific levels of care.

Priority Process: Decision Support

In preparation for an electronic health record and since June 2013, all chart documents are being scanned into the Online Application and Classification Information System (OACIS). As a result, there is a hybrid chart. For any information prior to June, the hard copy chart must be accessed. This situation, although perhaps frustrating currently, will resolve itself over time. The greater benefit is that important aspects of the patient's care is available for viewing by professionals providing care in other departments or locations in the organization other than in the mental health in-patient or out-patient units.

Priority Process: Impact on Outcomes

Although there are no formal written specific-measurable-attainable-realistic (SMART) goals, the team is united in identifying the need for a short-stay unit to enhance patient care and patient flow from the emergency department. The out-patient team is in the process of moving the social workers' offices from an isolated part of the building and embedding them within the teams. This change will enable the support required when some patients become angry or agitated, which is currently lacking given that social work is isolated on the sixth floor. This is a proactive move to ensure the safest environment possible for staff and is commended.

The team has not had any access to benchmarking data to effectively compare efficiency of services. The team members expect this information to become available as they continue to work with quality improvement advisors to develop a dashboard. The team does use what little information it has or knows to make improvements such as improving patient satisfaction by streamlining the admission process. Patient satisfaction surveys seem to be conducted in various ways across the organization and teams may or may not be using valid and reliable tools.

3.2.17 Standards Set: Obstetrics Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
9.5 The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.	ROP
9.5.1 There is a demonstrated formal process to reconcile client medications upon admission.	**MAJOR**
12.3 The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	ROP
12.3.1 There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The obstetrics and perinatal services that were visited during the on-site survey were located at the Royal Victoria Hospital site. The team provides high risk and routine obstetrics care for its clients. The team regularly collects and evaluates information on its clients.

The planned McGill University Health Centre (MUHC) redevelopment will involve the relocation of these services from this site to the new Glenn site by 2015. In addition, the team has been given new targets for patient mix, including the expectation that they will increase their high acuity, high-risk population relative to the low-risk population served. As such, teams are engaged in advanced planning to reconfigure and transition services. The complexity of this transition requires that the team plan at the regional and local

levels to ensure that access to services is maintained for their clients. To this end, dialogue with the St Mary's and Jewish General teams are underway. Staff members have expressed concern, anxiety and uncertainty about the upcoming changes. In general, the staff members that were interviewed remain positive in their desire to engage and to understand these changes as they evolve.

The team's goals are closely aligned with the strategic direction of the organization. The team regularly reviews its services, while ensuring that they remain closely aligned with the strategic direction of the organization.

As a quality initiative, the team's adoption of the new Centricity platform and establishment of the interface with the organization-wide Online Application and Classification Information System (OACIS) has improved documentation and transfer of information. The team continues to focus on patient safety initiatives including safety rounds and guidelines to prevent falls.

In all clinical areas there is a process of biannual performance appraisals. While this has begun, it is not well-established to date.

Priority Process: Competency

In the antenatal, birthing and post partum areas, there is a well-developed multidisciplinary team that provides coordinated obstetrics services. The team regularly evaluates its functioning on a regular basis. The team has completed the three modules of the managing obstetrical risk efficiently (MORE ob) program. Tracking of performance metrics indicates a decrease in length of stay and there is trending of adverse events.

A transition team is in place to lead planning for the new facility. This includes simulation exercises that will ensure a smooth transition with suitable processes to guide delivery of care.

In all areas of obstetrics service provision, performance appraisals are undertaken sporadically. The team leadership is encouraged to formalize this process to ensure that team members receive feedback on their performance at regular intervals. Performance evaluations are being performed annually for all medical staff, although there is an opportunity to expand the current evaluation to include a complete 360 feedback process.

Priority Process: Episode of Care

The team has adopted standardized processes and developed a structured approach to documenting. They have in place policies and procedures, guidelines and use pre-printed orders as a routine part of delivery of care.

Client risk is identified and processes to manage clinical escalation and risk are in place.

There is no demonstrated formal process to reconcile client medications on admission across the organization. This is done by the clinical team and documented in the patient chart in this clinical area. McGill University Health Centre (MUHC) is encouraged to finalize the plan to roll out the formal process for medication reconciliation at admission and transfer across the organization.

Medication carts with drawers were observed being left unlocked in the clinical postpartum area. In this clinical area, there is an opportunity to secure medication storage units to ensure restricted access.

Priority Process: Decision Support

The team uses guidelines and has a process to update these to ensure their currency and reflect current best practice and research. This process involves all members of the interdisciplinary team.

Priority Process: Impact on Outcomes

The team members delivering obstetrics services are informed on how to identify and reduce and manage patient and staff safety risk. Clients confirm that they receive education by way of written materials and staff instruction.

The team uses the information it collects about the quality of its services to identify opportunities for improvement, sharing the results with staff and their clients.

3.2.18 Standards Set: Organ and Tissue Donation Standards for Deceased Donors

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Organ and tissue donation is part of the organization's strategic priorities. Policies are clearly defined for both organ and tissue donation and are integrated in all the clinical areas.

Collaboration with the centralized organ procurement agency (Hema Quebec) is well established.

Priority Process: Competency

The medical director supervises the donation program. All necessary credentialing is in place for team members and is regularly reviewed. Education is provided for the team. Roles and responsibilities of the interdisciplinary team are clearly defined.

Priority Process: Episode of Care

Team documentation including complete documentation on donors is obtained. Patients interviewed during the on-site survey indicated that the inpatient area is old and dated, but clean and acceptable. They report that they receive excellent support from care givers in the team.

Priority Process: Decision Support

Accurate, up-to-date records are kept, identifiers are used and carefully documented and information is stored for the required period.
Patient flow is coordinated by dedicated staff members who are available around the clock.

The team follows guidelines established in team discussion, and practice is updated at regular intervals.

Priority Process: Impact on Outcomes

Verification processes are followed for high-risk interventions. Sentinel events and adverse events are carefully recorded and tracked.

Outcome measures are tracked and the organization benchmarks against external like programs.

Staff performance evaluations are done inconsistently and this represents an area for improvement. Medical staff members have an annual evaluation and it does not include 360 feedback, which is another potential area for improvement.

Priority Process: Organ and Tissue Donation

The donation team closely adheres to the organization's policy that guides this process. The team is supported by the central procurement agency. In the organization, clinical teams receive support from intensive care units.

3.2.19 Standards Set: Organ and Tissue Transplant Standards

Unmet Criteria			High Priority Criteria
Priority Process: Organ and Tissue Transplant			
12.1	The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.		ROP
	12.1.1	The organization has a written thromboprophylaxis policy or guideline.	**MAJOR**
	12.1.3	The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	**MINOR**
Priority Process: Clinical Leadership			
2.2	The transplant program has a sufficient number of team members to complete data reporting requirements.		
Priority Process: Competency			
4.4	The transplant team regularly evaluates its interdisciplinary team functioning and makes improvements as necessary.		
Priority Process: Decision Support			
18.1	The organization has process to select evidence-based guidelines for transplant services.		!
18.2	The transplant team follows the selected evidence-based guidelines.		
Priority Process: Impact on Outcomes			

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Organ and Tissue Transplant

Team members support patients during the entire organ transplant process. The team identifies and addresses ethics issues with the support of the ethics team.

Psychosocial evaluation and access to emotional support and counselling of the transplant patient by the social work team is limited to consultation services only, and the team has identified the a need for increased support in this area.

The team does not use a written thrombo-prophylaxis policy or guidelines for pre and post surgical care.

Team members of the multi- organ transplant solid program clinical area were interviewed and indicated that they do not have access to pre-printed orders or formal guidelines. Medical staff members write individual orders on patient charts as needed and these are guided by practice decisions made during team discussions.

Priority Process: Clinical Leadership

The multi-organ transplant program for solid organs spans multiple clinical teams including the surgical, cardiac, nephrology and gastrointestinal/hepatology teams. The multidisciplinary team members include surgeons and physicians, clinical nurse specialists, team nursing leadership, nurse coordinators, nurses, clinical nutrition and pharmacy.

The Surgical Mission provides leadership and oversight for this team. This team has been identified by the clinical activities priority setting (CAPS) as a priority program.

Although the multidisciplinary team meets regularly, significant decisions about program direction occur outside of the influence of this team. This creates a challenge for implementation of new procedures and policies for the team, and is an opportunity for improvement for the team.

The team has identified during the interviews that there is a lack of resources in the area of mandatory data reporting. This is a limiting factor for effective functioning. Data reporting, although meeting requirements, adds a significant burden on the clinical team that lacks administrative support in this area.

Priority Process: Competency

The team does not review its performance at regular intervals. Although the multidisciplinary team meets regularly, significant decisions about program direction occur outside of the influence of this team. This creates a challenge for implementation of new procedures and policies for the team, and is an opportunity for improvement for the team.

Priority Process: Decision Support

Team members work hard to maintain accurate, up-to-date records and reporting despite their limited administrative support. Patients indicate that the team provides exemplary care and psycho social support for their needs during the transplant process.

The team has an opportunity to improve care with the adoption of written guidelines. Currently, medical staff members write individual orders on patient charts as needed and this is guided by practice decisions made during team discussions. Team members that were interviewed in the Multi Organ Transplant Solid Program clinical area indicated that they do not have access to, nor do they use written guidelines or pre-printed orders for pre/post surgical care.

Priority Process: Impact on Outcomes

The team members track and monitor performance, both internally and as a part of their mandatory reporting requirements. They benchmark with comparator programs and share results with team members. Formal evaluation of the team has begun to evaluate patient satisfaction. This work is underway in the live donor transplant program.

3.2.20 Standards Set: Organ Donation Standards for Living Donors

Unmet Criteria	High Priority Criteria
Priority Process: Organ Donation (Living)	
The organization has met all criteria for this priority process.	
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Organ Donation (Living)	
The living donor team adheres closely to the disclosure policy, which includes the key elements of information required. The informed consent process is established and there is a process for donor withdrawal. Ethical consultation is readily available to the team. Full documentation on the living donor is assembled by the team. The team commented that social work support is available primarily on a consultation basis, and indicate that increased resources in this area are required. The team provides long-term follow-up of their clients. The team provides ongoing medical care, counselling and psychosocial support.	
Priority Process: Clinical Leadership	
The living donation program team is predominantly a team of clinicians and it experiences shortages in administrative support.	
Priority Process: Competency	
The donor team is a multidisciplinary team of surgeons, physicians, clinical specialists and psychologists, social work on consultation, clinical nutrition and nursing. This team meets regularly. The team has an ethicist available for consultation. Education and performance evaluation for trainees is regularly performed.	

Priority Process: Decision Support

Patient flow is coordinated by the donor coordination nurses. Up-to-date records are maintained.

Priority Process: Impact on Outcomes

The living donation program has a process to define its guidelines for practice. There is an opportunity to develop written guidelines, protocols and pre-printed orders to standardize all aspects of care.

Regulatory requirements are met by the team.

3.2.21 Standards Set: Point-of-Care Testing

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
1.1	The organization has a policy that clearly defines reporting and contractual relationships and roles and responsibilities for POCT.	
1.4	The interdisciplinary committee review POCT quality control data on an annual basis and make improvements as needed. CSA Reference: Z22870:07, 5.6.6.	
3.1	The organization orients and trains all health care professionals delivering POCT on the standard operating procedures (SOPs) for POCT.	
3.2	Health care professionals delivering POCT receive ongoing training and development. CSA Reference: Z22870:07, 5.15.	
3.3	The organization evaluates the performance of health care professionals delivering POCT annually. CSA Reference: Z22870:07, 5.1.5.	
3.4	As part of their performance evaluation, health care professionals delivering POCT must routinely demonstrate their competence. CSA Reference: Z22870:07, 5.1.5.	
3.5	The organization documents performance evaluation results in the personnel files of health care professionals delivering POCT.	
4.4	The organization places the SOPs in areas where health care professionals delivering POCT can easily access them.	
4.5	The lab director or suitably qualified health care professional informs and verifies that health care professionals performing POCT are trained prior to implementing a new or revised SOP.	
5.1	The organization maintains an accurate and up to date inventory of all POCT equipment.	!
5.6	The organization removes all POCT equipment that are inappropriate, non compliant, deteriorated, and substandard.	!
5.9	When the organization uses different types of POCT equipment for the same procedure, the lab director or suitably qualified health care professional works with a central biomedical lab to verify that each type of equipment gives the same result in all cases.	!
6.3	The organization follows a documented process for testing all new POCT supplies, reagents and media.	!

6.4	The organization periodically verifies that POCT reagents currently being used are working properly, not expired or deteriorated and appropriate for use. CSA Reference: 22870:07, 5.3.2.	!
6.5	The organization promptly removes from storage inappropriate, expired, deteriorated and substandard POCT supplies, reagents, and media and discards them.	!
7.5	Immediately prior to performing the point-of-care test, the health care professional verifies that the POCT equipment is in proper working order by means of a quality control check.	
8.3	Before performing the point-of-care test, health care professionals properly label the request form and the samples in front of the client, with the same information (family name, given name, record number and Medicare number) so that they can maintain traceability between the client and the sample.	!
8.13	The organization follows written criteria for accepting or rejecting POCT samples.	!
9.11	The organization securely retains records of all POCT request forms and their corresponding results for the period consistent with provincial regulations or guidelines.	
10.2	The lab director or suitably qualified health care professional develops and maintains a POCT quality improvement manual.	
10.3	The lab director or suitably qualified health care professional communicates the quality improvement policies to health care professionals delivering POCT and verifies that they follow them.	
10.4	The organization regularly monitors a set of POCT quality indicators.	
10.5	The lab director or suitably qualified health care professional uses the indicator information to guide decision making and make timely improvements to POCT.	
10.6	Health professionals delivering POCT gather and record quality control data for each point-of-care test.	!
10.7	Health professionals delivering POCT record quality control data in a daily a log.	!
10.8	Health professionals delivering POCT regularly compare and correlate their quality control results with a central lab.	!
10.9	The organization participates in an external POCT quality control program. CSA Reference: Z22870:07, 5.6.	
10.10	The lab director or suitably qualified health care professional reviews the quality control data on a monthly basis and make improvements as needed.	

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

The organization has created a Point-of-Care Testing (POCT) committee that works in conjunction with an interdisciplinary professional team to oversee the delivery of POCT. There is a POCT coordinator that supervises all related activities.

The project named, Glucose Meter Implementation Project is organization-wide. This is a McGill University Health Centre (MUHC) initiative to replace the current existing blood glucose meters. With the exception of a few locations namely, radiology at Montreal General Hospital and Lachine Hospital, this project has rolled out across all sites. This model should serve as a gold standard for ensuring compliance with standards and regulations for new POCT implementations or changes to the existing process.

Several of the POCT assays in use across the organization are not controlled by the laboratory program. Quality control practices are not followed for all POCT, for example, urine strips. Pregnancy test kits are in use in radiology and seven parameter urine strips have not been approved for use. The organization will benefit from developing and implementing a training and competency program for all its POCT activities.

The organization is strongly encouraged to build on the work done to date by meeting with key stakeholders to develop an appropriate and comprehensive POCT program that will meet the needs of the patients and clinicians. It is important to determine which tests can be done in the laboratory and which ones should remain as point of care. The laboratory is encouraged to ensure that all POCT meets all regulations and standards before the tests are fully implemented. It will be necessary to make available adequate resources to implement this program properly.

3.2.22 Standards Set: Telehealth Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Simplifying telehealth is the vision of this team and it is certainly fitting with the Virtual Health and Social Services Centre (VHSSC). This is a jewel for the Réseau Universitaire Intégré de Santé (RUIS) McGill, where the approach is directly centred towards the health care professional, the patients and/or the family. This triad links directly to quality, accessibility in a timely manner and breaking down the barriers to health care services.

Covering a wide territory of 62 percent of the province of Quebec, this team of 20 plus members is definitely looking towards the future to further extend and share their expertise in many other specialties. Since the previous accreditation, the growth of this service has been constant, as presented in the annual report.

Leadership and management processes are important foundations where pillars such as governance with vision, mandate, legal affairs and financial reporting; management and support of current activities for policies and procedures, checklist, training processes and tools; project management for selection criteria, cost analysis and product evaluation; quality and risk management for indicators and performance and survey satisfaction and finally, promotion and communication for frequently asked question repertoire, pamphlets and so on.

The surveyor team members were fortunate to host a virtual session with partners from the Royal Victoria Hospital in Montreal, Le Centre de Santé Tulatavik in Ungava, Le Centre Hospitalier Innuulitsivik de la Baie d'Hudson and le Centre Hospitalier de Val d'Or. Discussions concluded that this service, although at first

there were concerns regarding the ability to offer quality health care service in a virtual setting, with the support of the Virtual Health and Social Services Centre (VHSSC), these issues do not appear to be present.

Priority Process: Competency

This team is made up of dedicated personnel from support, informatics, quality assurance and management and nursing and leadership. Roles are established and collaboration amongst team members is evident. Access to continued education is available.

New partnerships are supervised and receive a full and comprehensive training to enable technology use in an appropriate manner.

Specific policies and procedures are developed regarding this scope of practice, orientation and expectations. Fine-tuning issues with the use of this technology for example, lag time, is ongoing and successful in many cases.

There is dedicated Telehealth equipment and space at each of the sites. Infection control processes are documented and in place, and this was confirmed in discussion with external partners.

Priority Process: Episode of Care

Ethics issues have not yet presented however, members and partners are aware of the official process if the need should arise in the future.

Regular scheduled virtual clinics are in place. Clinical responses to an emergent need are evaluated case by case and on a daily basis.

Scheduling processes are well defined and available as an online requisition where specific information is required to address the client needs. These requests are then streamlined by a coordination team and the applicant will receive confirmation of the telehealth reservation.

Priority Process: Decision Support

Physical environment settings are deemed appropriate for health care providers. Processes of tele-consultations are explained to patients and consents are obtained directly on site.

Access to equipment and or data such as patient charts respect organization policies.

Priority Process: Impact on Outcomes

Objectives and goals are in alignment with the organization. Telehealth services are promoted across the organization and this is confirmed by the increase of activity volume.

Quality assurance indicators are collected and available in the comprehensive annual report. Results are shared with team members. A shared value is to always continue to improve the professional and patient experience.

3.2.23 Priority Process: Surgical Procedures

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

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
1.8	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
2.3	The team's orientation includes training on all infusion pumps.	ROP
2.3.1	There documented evidence of ongoing, effective training on infusion pumps.	**MAJOR**
2.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
3.6	The team posts, follows, and documents a regular and comprehensive cleaning schedule for the operating room and supporting areas.	!
4.2	The appropriate team member verifies that the client has given informed consent for the procedure and anesthesia as applicable.	!
6.8	The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure.	ROP
6.8.1	The team has agreed on a three-phase checklist to be used in the operating room.	**MAJOR**
6.8.2	The team uses the checklist for every surgical procedure in the operating room.	**MAJOR**
6.8.3	The team has developed a process for ongoing monitoring of compliance with the checklist.	**MAJOR**
6.8.4	The team evaluates the use of the checklist and shares results with staff and service providers.	**MINOR**
6.8.5	The team uses results of the evaluation to improve the implementation of and expand the use of the checklist.	**MINOR**
6.9	Immediately prior to the procedure, the team conducts a preoperative pause to confirm the client's identity and nature, site, and side of the procedure.	!
6.10	The team documents the preoperative pause.	!
7.5	All medications delivered to the sterile field are labelled and handled using aseptic technique.	!

12.8	The team uses flash sterilization in the operating room only in an emergency, and never for complete sets or implantable devices.	!
14.4	The team sets performance goals and objectives and measures their achievement.	
14.5	The team benchmarks or compares its results with other similar interventions, programs, or organizations.	
Standards Set: Surgical Care Services		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for its surgical care services are measurable and specific.	
2.3	The team identifies the resources needed to achieve its goals and objectives.	
3.1	The organization identifies an interdisciplinary team to deliver surgical care services.	
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.4	Staff and service providers receive ongoing, effective training on infusion pumps. 4.4.1 There is documented evidence of ongoing, effective training on infusion pumps.	ROP **MAJOR**
5.5	The team has a fair and objective process to recognize team members for their contributions.	
7.3	The team assesses the client's physical and psychosocial health.	
7.15	The anaesthetist conducts a pre-anaesthetic assessment prior to the commencement of the procedure.	!
8.3	The team obtains the client's informed consent before starting the procedure.	!
8.7	The team provides clients and families with access to emotional support and counselling.	
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations or teams to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	

14.5	The team shares benchmark and best practice information with its partners and other organizations.	
16.1	The team identifies and monitors process and outcome measures for its surgical care services.	
16.5	The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

At the Montreal Neurosurgical Hospital (MNH) staff members received instruction on infusion pumps but, as the same pumps have been used for many years, the nurses do not receive any ongoing training.

There has been resistance to the introduction of registered practical nurses (RPNs) to an environment which is traditionally all registered nurses (RNs).

At the Montreal Neurological Hospital (MNH) site, cleaning of the operating rooms between cases was done by patient care assistants. Terminal cleaning is done by housekeeping staff members that do not report to nursing leadership in the operating room (OR). The OR has requested that housekeeping provide them with a comprehensive cleaning schedule so they know what is cleaned and when it is cleaned. Coordination between the operating and housekeeping staff members is important to optimize patient care.

While the team in general coordinates services with other peri-operative services there are issues at the Montreal General Hospital (MGH) site, with surgeons being able to keep patients in the post-anesthetic care unit (PACU) for 24 hours for monitoring rather than admit them to the unit and have them discharged the next day. This puts pressure on nursing when emergency cases are brought to PACU in the off-hours.

The OR areas are in general not well designed for current technology, flow and infection control practices however, there is only a limited ability to redesign the current space. The new hospital at the Glen site will have state-of-the-art operating room facilities.

At the Montreal Neurological Hospital, the surgical safety checklist is well done by almost all physicians. There is one physician and one anesthesiologist that have been identified in audits as not being compliant with the policy and it is recommended that this be addressed with these physicians, with penalties considered for further non-compliance. The MGH site and Royal Victoria site need to implement all aspects of the surgical safety list.

It was observed that not all patients have a signed consent for surgery on the chart and not all patients have a history and physical examination submitted to the chart by the surgeon. As part of a legal record, it should be expected that every patient going to the operating room should have an admission note from the surgeon, documenting the relevant history and a signed consent that will become part of the permanent record.

If there is a policy that informed consent for blood transfusion must be obtained by a physician, the policy needs to be reinforced and audited.

The thoracic cancer program has done an amazing job of reducing wait-times for lung and oesophageal, and the work with the referring community hospitals to expedite care is impressive.

Staff members report good access to ethics and this was consistently across the organization.

While the service has identified the need for enhanced information systems, McGill University Health Centre is at a low adopter of information technology systems.

Patient flow at the MNH is impaired by inconsistent rounding by surgeons. Fellows cannot discharge patients without the permission of the staff surgeon and does not 'round' early in the day. Beds often do not become available until later in the day which makes bed management difficult. The surgical list is often changed without good communication to staff members with the result that patients sometimes wait in hospital for surgery or have to be re-booked. There is no mechanism to expedite the operative procedure for a patient whose surgery has been delayed because of an emergency.

The use of flash sterilization at the RVH site should be audited and compared to other MUHC hospitals. If it does appear to be an outlier, steps will need to be considered to reduce its use.

Multiple examples of physicians and residents not sanitizing their hands prior to and after patient contact were observed at the MNH, MGH and RVH sites. This was noted by the surveyor and witnessed by accompanying MUHC staff. Physicians and residents were seen to make multiple patient contacts without handwashing or sanitizing. Physicians must held accountable for compliance with organization policy on hand hygiene.

The Montreal Children's Hospital's operating room experiences numerous changes in the OR schedule causing frequently disruption and loss of efficiency. It is suggested that the team include in its goals and objectives a review of the booking practice to reduce the numbers of last minute cancellations and delays.

It is recommended that MUHC quickly move to using all safety engineered needles and venous access devices. Blunt tipped needles should become the standard for drawing up all medications. Non-engineered needles should be used only for arterial lines. All physicians should be expected to comply with this policy.

Pharmacists are active participants in the critical care teams but have minimal presence on the surgical wards at MNH, MGH and RVH sites although telephone consultation is available 24 hours a day. Patient education on drugs is left to nursing as is the bulk of medication reconciliation and there is no antibiotic stewardship. The MUHC should consider the introduction of pharmacy to surgical programs.

It is recommended that pre-operative clinics have an anesthesia lead and be staffed primarily by anesthetists, with internal medicine available for consultations. It is not considered to be optimal care for anesthesia to be seeing patients for the first time outside the operating room, with the acuity of illness seen at MUHC. Discussing such issues as the risks of anesthesia, epidural or spinal anesthesia, difficult intubation, blocks and line insertion outside the operating room while lying on a stretcher, makes it very difficult to demonstrate informed consent has been obtained from a patient.

Section 4 Instrument Results

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

4.1 Governance Functioning Tool

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

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

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

- **Data collection period: January 18, 2013 to March 1, 2013**
- **Number of responses: 20**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	10	5	85	N/A
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	15	5	80	N/A
3 We have sub-committees that have clearly-defined roles and responsibilities.	10	0	90	N/A
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	5	5	90	N/A
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	5	15	80	N/A

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	15	10	75	N/A
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	5	95	N/A
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	5	5	90	N/A
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	5	5	90	N/A
10 Our governance processes make sure that everyone participates in decision-making.	5	20	75	N/A
11 Individual members are actively involved in policy-making and strategic planning.	15	10	75	N/A
12 The composition of our governing body contributes to high governance and leadership performance.	0	20	80	N/A
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	5	25	70	N/A
14 Our ongoing education and professional development is encouraged.	16	26	58	N/A
15 Working relationships among individual members and committees are positive.	5	10	85	N/A
16 We have a process to set bylaws and corporate policies.	0	10	90	N/A
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
18 We formally evaluate our own performance on a regular basis.	30	50	20	N/A
19 We benchmark our performance against other similar organizations and/or national standards.	20	45	35	N/A
20 Contributions of individual members are reviewed regularly.	42	37	21	N/A

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	32	21	47	N/A
22 There is a process for improving individual effectiveness when nonperformance is an issue.	39	50	11	N/A
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	25	35	40	N/A
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	12	24	65	N/A
25 As individual members, we receive adequate feedback about our contribution to the governing body.	32	32	37	N/A
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	5	15	80	N/A
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	10	35	55	N/A
28 As a governing body, we oversee the development of the organization's strategic plan.	10	20	70	N/A
29 As a governing body, we hear stories about clients that experienced harm during care.	25	35	40	N/A
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	10	30	60	N/A
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	14	14	71	N/A
32 We have explicit criteria to recruit and select new members.	13	33	53	N/A
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	13	19	69	N/A

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	5	10	85	N/A
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	5	0	95	N/A
36	We review our own structure, including size and sub-committee structure.	6	6	89	N/A
37	We have a process to elect or appoint our chair.	10	0	90	N/A

4.2 Patient Safety Culture Tool

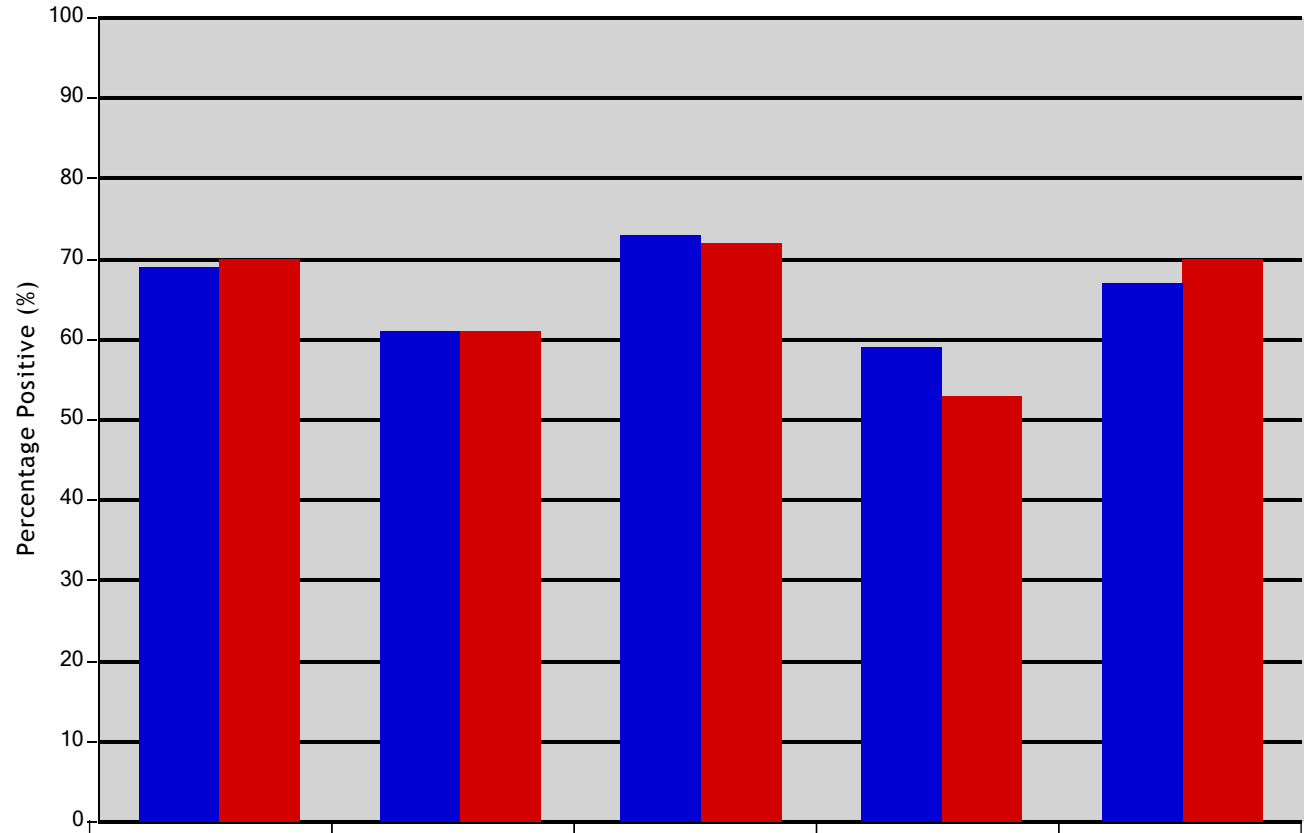
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

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

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

- **Data collection period: October 10, 2012 to December 18, 2012**
- **Minimum responses rate (based on the number of eligible employees): 371**
- **Number of responses: 388**

Patient Safety Culture: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	69%	61%	73%	59%	67%
	70%	61%	72%	53%	70%

Legend

Centre universitaire de santé / McGill University Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2012 and agreed with the instrument items.

4.3 Worklife Pulse Tool

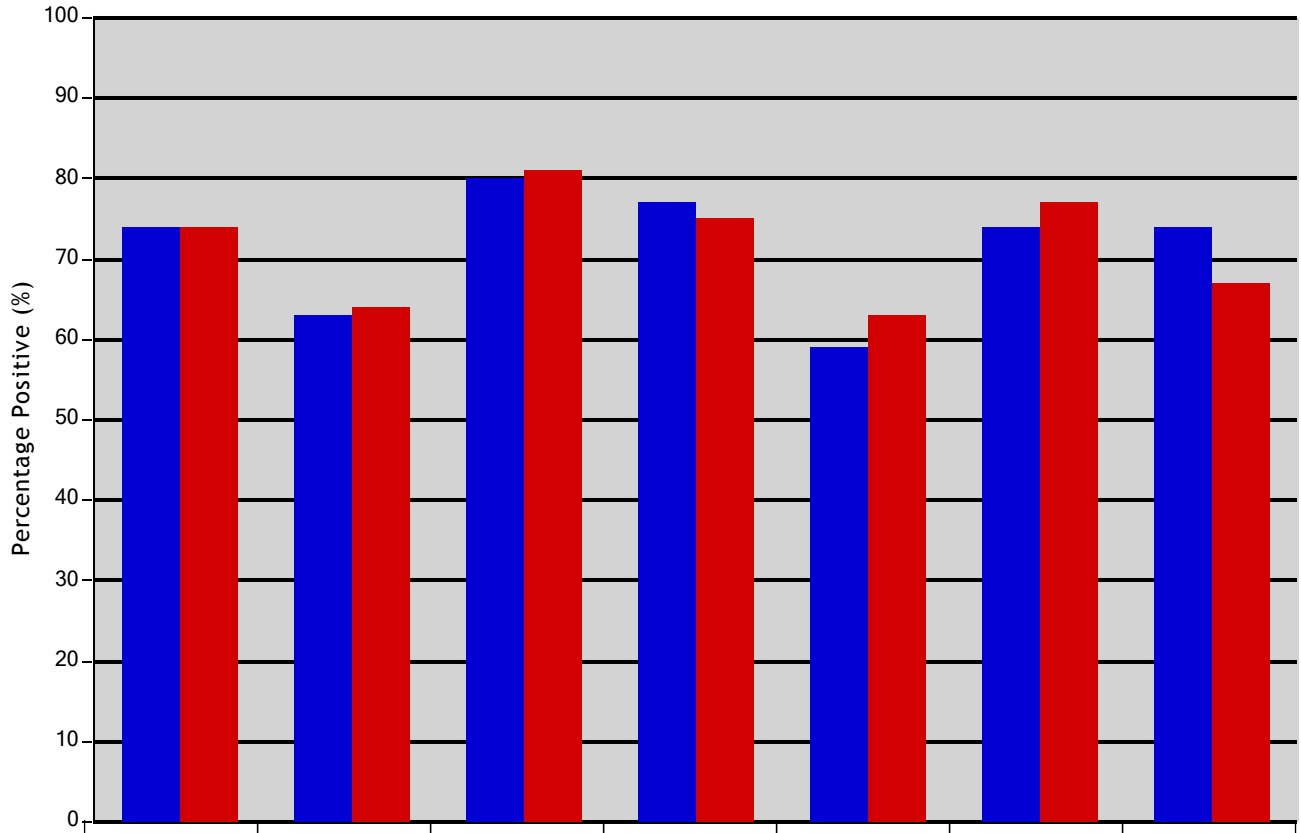
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: October 10, 2012 to December 18, 2012**
- **Minimum responses rate (based on the number of eligible employees): 371**
- **Number of responses: 482**

Worklife Pulse Tool: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	74%	63%	80%	77%	59%	74%	74%
	74%	64%	81%	75%	63%	77%	67%

Legend

Centre universitaire de santé / McGill University Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2012 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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