ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Ongwanada

Kingston, ON

On-site survey dates: December 4, 2016 - December 8, 2016

Report issued: March 2, 2017

About the Accreditation Report

Ongwanada (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 December 2016. 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

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,

Leslee Thompson
Chief Executive Officer

Table of Contents

Appendix B - Priority Processes 4p

Executive Summary

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

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

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

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

Accreditation Decision

Ongwanada's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: December 4, 2016 to December 8, 2016**

- **Locations**

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

  1. Balsam Grove Centre
  2. Ongwanada
  3. Ongwanada - Crescent Centre
  4. Ongwanada - Napanee

- **Standards**

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

  System-Wide Standards

  1. Governance
  2. Infection Prevention and Control Standards for Community-Based Organizations
  3. Leadership Standards for Small, Community-Based Organizations
  4. Medication Management Standards for Community-Based Organizations

  Service Excellence Standards

  5. Developmental Disabilities - Service Excellence Standards
  6. Diagnostic Imaging Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2011 - 2015)
  2. Canadian Patient Safety Culture Survey Tool
  3. Worklife Pulse

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	23	0	0	23
 Accessibility (Give me timely and equitable services)	13	0	1	14
 Safety (Keep me safe)	170	0	16	186
 Worklife (Take care of those who take care of me)	55	2	1	58
 Client-centred Services (Partner with me and my family in our care)	80	4	0	84
 Continuity of Services (Coordinate my care across the continuum)	13	0	0	13
 Appropriateness (Do the right thing to achieve the best results)	263	8	10	281
 Efficiency (Make the best use of resources)	25	1	0	26
Total	**642**	**15**	**28**	**685**

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	49 (98.0%)	1 (2.0%)	0	35 (97.2%)	1 (2.8%)	0	84 (97.7%)	2 (2.3%)	0
Leadership Standards for Small, Community-Based Organizations	40 (100.0%)	0 (0.0%)	0	69 (98.6%)	1 (1.4%)	0	109 (99.1%)	1 (0.9%)	0
Infection Prevention and Control Standards for Community-Based Organizations	27 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	0	73 (100.0%)	0 (0.0%)	0
Medication Management Standards for Community-Based Organizations	57 (100.0%)	0 (0.0%)	9	52 (100.0%)	0 (0.0%)	5	109 (100.0%)	0 (0.0%)	14
Developmental Disabilities	46 (86.8%)	7 (13.2%)	0	79 (94.0%)	5 (6.0%)	0	125 (91.2%)	12 (8.8%)	0

Diagnostic Imaging Services	56 (100.0%)	0 (0.0%)	11	68 (100.0%)	0 (0.0%)	1	124 (100.0%)	0 (0.0%)	12
Total	**275 (97.2%)**	8 (2.8%)	20	349 (98.0%)	7 (2.0%)	6	624 (97.7%)	15 (2.3%)	26

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership Standards for Small, Community-Based Organizations)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership Standards for Small, Community-Based Organizations)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership Standards for Small, Community-Based Organizations)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Medication reconciliation as a strategic priority (Leadership Standards for Small, Community-Based Organizations)	Met	4 of 4	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards for Community-Based Organizations)	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
High-alert medications (Medication Management Standards for Community-Based Organizations)	Met	5 of 5	3 of 3
Narcotics safety (Medication Management Standards for Community-Based Organizations)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Patient safety plan (Leadership Standards for Small, Community-Based Organizations)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership Standards for Small, Community-Based Organizations)	Met	1 of 1	0 of 0
Preventive maintenance program (Leadership Standards for Small, Community-Based Organizations)	Met	3 of 3	1 of 1
Workplace violence prevention (Leadership Standards for Small, Community-Based Organizations)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-hygiene compliance (Infection Prevention and Control Standards for Community-Based Organizations)	Met	1 of 1	2 of 2
Hand-hygiene education and training (Infection Prevention and Control Standards for Community-Based Organizations)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection rates (Infection Prevention and Control Standards for Community-Based Organizations)	Met	1 of 1	2 of 2
Reprocessing (Infection Prevention and Control Standards for Community-Based Organizations)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls prevention (Diagnostic Imaging Services)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

The organization has an excellent rapport with community partners, community support service organizations, and local businesses, and has a broad reach across the region through its network. Community partners applauded the organization’s leadership role in key community development initiatives.

There is a need for a talent management plan and more attention to be paid to succession planning and leadership development, including funding for all staff. A governance review would be beneficial as the strategic plan unfolds. The organization is encouraged to evaluate the efficiency and effectiveness of meetings.

Given the transformational nature of Vision 2020, a change management strategy will be integral to success. It is suggested the organization work to develop capacities among its leadership team to lead and engage staff in the execution of the strategic priorities.

It is also suggested that better communication to clients, families, and stakeholders about the success of quality improvement initiatives, initiated or completed, would be beneficial. This is a challenge as the learning curve around quality and client care is steep when care needs change.

The organization is commended for its excellent relationships with external talent sources such as schools, as well for its clearly defined human resources processes for recruitment, selection, onboarding, and orientation.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
7.8	The governing body has a succession plan for the CEO.	
7.9	The governing body oversees the development of the organization's talent management plan.	!

Surveyor comments on the priority process(es)

Following a review of the organization's informative web site and the documents provided, a meeting was held with the chair and six members of the 16-member Ongwanada board.

The board members explained the governance and committee structure. They feel the governance model, which includes seven to eight committees, has been very successful and allows the board to function in a manner that serves it well. The board reported that its review of the governance standards suggests it is in compliance with all of Accreditation Canada's requirements for board functioning.

The board comprises 16 committed and experienced members who have served for many years. Some have been on the board in various positions for over 35 years. There was consensus among the members that they are the leaders of the organization and that the board benefits from the experience they bring.

There are many board committees, including client care, financial, audit, finance and property, research, medical advisory, and executive. Individuals who are not members of the board but who can bring expertise the board needs sit on committees. The board's Nominating Committee, active at present, is responsible for overseeing board membership. According to the CEO, it reviews vacant positions to identify an appropriate mix of necessary backgrounds, experience, and competencies.

The board is commended for the development of the present strategic plan, called Vision 2020. The plan lays out the organization's mission, values, and strategic priorities. As well, an operational plan that

includes critical success factors is available to all stakeholders and the community. A scorecard that will provide metrics to identify organizational performance is in development.

The board clearly understands its role in accountability and achievement of results. A continuous quality improvement program and a risk management process are in place and adherence is monitored. With the recent addition of e-CIMS the Board intends to have more data readily available and analyzed to enhance performance monitoring.

It is suggested the organization review the many indicators it uses (some of which are required by the Ministry of Community and Social Services).

There was a discussion about key system indicators that focus on quality. While the board tracks and reports many indicators, there does not appear to be an organizationally directed quality improvement program that starts at the strategic plan and cascades down to the services for their input. It is suggested this be developed.

A review of board minutes and reports to the board demonstrate that the board is well informed about how the organization is managed, the challenges that confront it, and the opportunities for improvement that exist in these times of fast-paced change. Board minutes and reports from the CEO suggest the board is fully informed of all issues that have to be addressed.

The board sees its responsibilities as selecting and evaluating the CEO, overseeing the strategic planning process, approving the organization's capital and operating budgets and providing overall financial oversight, and approving corporate policies and ensuring they are followed. The minutes and board discussions indicate the organization has a process to identify and manage risk and identify strategic opportunities. The board is commended for its innovative strategy to provide resources for the pharmacy to address medication errors with a new format for packaging.

There is a framework for ethical behaviour and a comprehensive communication plan.

The board meets every two months and receives all materials in adequate time to be conversant with the issues and agenda.

Philosophically the board has endorsed the philosophy of client- and family-centred care (which the organization refers to as person-centred care) and has dedicated resources to incorporating this methodology into service delivery and ongoing planning to engage clients and families in board planning.

The community partners focus group commended Ongwanada for its openness to being a leader in innovation and networking that will be key to assisting the sector. Ongwanada contributes provincially through the Community Networks of Specialized Care. It is commended for its many partnerships though which it supports people with disabilities, not the least of which is its work in developing key outcome metrics for clients and services.

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 Standards for Small, Community-Based Organizations	
1.5 Policies addressing the rights and responsibilities of clients/residents are developed and implemented with input from clients/residents and families.	

Surveyor comments on the priority process(es)

A discussion was held with the chief clinical and planning officer and the CEO to discuss planning and service design at Ongwanada. The recently developed strategic plan and the review of the mission, vision, and guiding principles were also discussed.

The team is commended for the inclusive nature of the process and its inclusion of all staff, clients and families, and stakeholders.

The organization reported on its recent efforts to ensure it supports clients and families through a person-centred approach, and to ensure the concept was understood and that strategies were created to implement the approach. The organization contracted an expert consultant to work with staff to review the philosophy and principles of person-centred care (known as client- and family-centred care [CFCC] in the accreditation standards).

Six staff members who completed the training became person-centred care planners and were part of the ongoing plan to ensure all staff, clients, and families know and practice the person-centred care approach.

The team understands that the focus of CFCC is to have clients and families engaged in determining their own support and care. According to the team and front-line staff, this is not a major shift from how support and care is envisioned and delivered at Ongwanada. The CFCC philosophy also requires that clients and families be involved in developing and monitoring organizational programs and policies. This is in the beginning stages. The organization has applied to the ministry for financial assistance to develop a Client Advisory Group to help implement person-centred care across the organization.

The team works closely with the ministry. Participants in the community partners focus group expressed their appreciation for the work done by the leadership of Ongwanada.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The review of this priority process included a discussion with the senior leadership responsible for resource management and a department team member.

The financial policies of the board, as reported by a KPMG audit, comply with generally accepted accounting principles. Ongwanada complies with the guidelines of its funder, the Ministry of Community and Social Services.

The chief finance and administrative officer reported that the annual budgeting process, beginning at the local service delivery level, is underpinned by consideration of the mission, vision, and strategic goals and objectives. All programs and services have input into budget preparation and submit budgets for their individual departments.

Monthly reports are provided to all services and accountability is managed.

Team commended for the efforts made by the chief finance and administrative officer to provide training for appropriate staff on the budgeting process and financial management.

Budget planning is a careful process of analyzing requirements in all areas of the organization. There are up-to-date policies and procedures to guide the activity, and set criteria are established and clearly communicated in the planning process. The team is sensitive to changing needs in the organization and focuses on service delivery areas that frequently need attention. Policies and procedures are in place to provide direction and compliance with resource management.

The impact of resource allocations is reviewed on a continual basis to ensure funds are achieving the intended results. Client and staff safety is also a significant factor in decision making.

Financial performance is monitored on a regular basis by the organization’s leaders and reported to the board. In fact, financial performance is monitored at all levels of the organization. There is an ongoing focus on how to address the use of resources in ways that match the needs of the organization and align with the strategic plan.

There is an annual external audit to manage financial resources and meet legal requirements.

The organization meets all legal requirements for managing financial resources and reporting. Policies and procedures are in place for financial management. The organization’s strength in managing its human

and financial resources is grounded in good controls and processes that are established and supported by effective policies and procedures and a competent and committed board and staff.

Approval for infrastructure improvements is obtained through an infrastructure review process with the province.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The chief human resources and information officer and a key staff member from the department were spoken with during the review. Additional staff responded to questions related to quality of work life in the organization.

It appears this organization is well managed from a human capital perspective. Personnel files that were reviewed were compliant with good human resources practice for file management. The team appreciates the work of volunteers and students. The organization reports there are over 30 teaching agreements in place, enabling students in programs such as developmental service worker, nursing, psychology, occupational or physical therapy, behavioural sciences, and psychiatry to further their education in developmental disabilities through placements at Ongwanada.

The human resources plan aligns with the strategic objectives. It identifies strategic initiatives and plans of action that consist of ongoing strategies to ensure the right number of employees, at the right time, and at the right cost are performing the right functions to deliver person-centred care to the clients.

The organization is commended for its approach to human resources and the development of this plan, which is reviewed annually. It has all essential elements. While the background is not provided in the plan, it is understood that the plan was developed based on an analysis of the current environment, the emerging environment that includes the recently designed person-centred approach to care, the organization's structure, the labour relations environment, and staffing demographics and indicators. The plan provides the organization with a focused approach to recruitment and retention of qualified staff.

The chief human resources and information officer and staff reported that the organization dedicates resources to creating an environment that encourages staff to lead a healthy lifestyle and have a positive and well-balanced work life. An employee assistance program is available. There is flexibility for employees to organize their personal lives and family responsibilities while still enjoying a rewarding career.

Ongwanada endeavours to have a safe and healthy workplace for employees, reduce the incidence of work-related accidents and illnesses, and assist employees to return to work from work- and non-work-related illnesses and injuries. This is in keeping with human rights, occupational health and safety, and workplace safety legislation to return employees who are on disability or sick leave to work as soon as it is safe to do so.

The organization is commended for developing and implementing the attendance awareness program that has reduced sick leave and saved money.

The organization used the Worklife Pulse Tool to monitor the quality of its work life culture. An action plan addressed the findings of the survey.

For the most part, Ongwanada employees report being willing to express concerns without fear of repercussion, due to the open door policy and the organization's commitment to provide the highest standard of care to clients.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

From a discussion with the senior leadership responsible for continuous quality improvement (CQI) and the chief clinical and planning officer, quality improvement appears to be focused on ensuring there is a safe and appropriate service delivery model to care for clients and their caregivers.

Quality is well addressed across the organization and is a focus for staff, management, and the board. There is a good system of reporting adverse events, near misses, and sentinel events. There is a thorough analysis of adverse events and follow up at various levels in the organization, depending on the severity of the event. It includes a rigorous quality and risk improvement review, with appropriate documentation and root cause analysis at various levels. Adverse event information, including statistics and trending, is provided to the board in detailed quarterly reports. Ongwanada complies with Accreditation Canada's standards and Required Organizational Practices for disclosing adverse events to clients and their families as appropriate. Written documentation on this ROP was reviewed.

The team discussion and a document review that included board and committee meeting minutes indicated that the key components of the CQI program are an integrated risk management program, an annual risk management plan, and a client safety plan. The quarterly report provided to the board's Planning Committee addresses over thirty indicators. It is suggested the organization review its present strategy for selecting, monitoring, and reporting performance indicators to ensure there is alignment with the strategic plan as indicators are developed and implemented. Appropriate indicators, including those developed with client and family input, will enable the governing body to avoid overestimating the organization's quality performance, as can happen if indicators are not appropriate or developed to assess organizational performance. Indicators can be retired from the performance evaluation process when they are deemed to no longer be of value. Appropriate selection of key indicators will give the organization a more global view of its performance, especially if the indicators are aligned with the strategic directions and operational plan.

Staff in the field validated that there are CQI activities in each residence and program. Information about these activities is forwarded through the supervisor of each unit to the CQI committee.

Clients and families spoken with report knowing how to file a complaint with the organization or report a violation of their rights. Documentation on these processes is provided to clients and families.

Participants at the client and family engagement focus group stated that client and family dialogue is valued and is used by the organization to improve the quality of care.

The organization is commended for initiating a client experience survey and for the actions taken to follow up on the findings.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the last on-site survey, the organization has worked diligently to advance and embed an ethical decision-making framework, code of ethics, and policy to enhance its ability to fulfil its vision, mission, and strategic plan (Vision 2020).

The ethics coordinators provide support and education and act as resources to the person-centred care planners, service coordinators, planning teams, staff, clients, and families.

Ethics education is provided for staff at orientation. There is also an annual review of the ethics policy and full ethics education every five years. The board receives annual education from the chief clinical planning officer. Front-line staff use the IDEA clinical and organizational ethical decision-making framework to address and resolve ethical issues. Ethical issues that cannot be resolved are “moved up the line.” It is evident that staff understand the escalation process; however, they would benefit from additional education and reinforcement of the decision-making process framework and policy. Three high-profile issues have been escalated to the board and its committees. The ethics decision-making framework guide and access to a bioethicist have been useful and effective in helping the board and senior team address and resolve ethical issues.

The introduction of person-centred principles and the link to the ethics framework will be a critical success factor if the organization is to achieve its five-year strategic plan and annual operational goals. The organization is encouraged to consider the SMART metrics to measure effectiveness and impact on person-centred care and outcomes.

The organization participates in the Southeastern Ontario Regional Ethics Network (SOREN), a regional multidisciplinary, cross-sector ethics network. The forum provides opportunities for ethics education, knowledge transfer, learning exchange, and access to external resources.

Senior leadership has identified a challenge regarding defining “best interest” agency perspective versus that of substitute decision makers. Given the vulnerable population served and increased stakeholder awareness around medical assistance in dying, the board and senior management team may wish to develop an organizational position statement, policies, and education and communication plans.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Ongwanada is commended for the resources it dedicates to communication. The expertise and effort of this small department of two individuals have resulted in a comprehensive communication plan aligned with the strategic plan.

The communications interdisciplinary team is “on top of its game.”

An integrated communication plan is reviewed quarterly. It defines the key audiences, objectives, and innovative strategies to enhance Ongwanada as a “top of mind” agency.

The communications team considered current and evolving information needs (cell phones for leaders, managers, and supervisors) and hardware and software (Nucleus) that meet the communication needs of the organization in terms of reliability, security, and user friendliness.

Communication is seen as key to operating effectively and efficiently. The privacy officer ensures the organization meets applicable legislation for protecting the privacy and confidentiality of client information. Minor breaches of confidentiality have been reported and addressed.

The recently acquired information management system enables the organization to collect meaningful data and trend and share that data with everyone from the board to the front-line workers. It is suggested that the frequency of evaluating the quality and usefulness of data and information be evaluated as to its usefulness and relevance.

The Horizons newsletter, the electronic The Source, and other key communication tools are used to connect clients, families, staff, and stakeholders to each other, to the community, and to the organization. Underpinning all communication efforts is the idea that service to the clients, their families, and the staff who stay connected and informed to care for them is of the utmost importance.

The organization is commended for the resources available that allow staff to access information to enhance their knowledge of best practices.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The physical environment at all facilities and homes is supported and well maintained by an internal team and external contracted services to meet applicable laws, regulations, and codes. Work schedules (e.g., testing, preventive maintenance, inspections) and accountability are assigned, completed, and documented. The internal team has been cross-trained to provide operational knowledge sharing and continuity.

The organization works collaboratively with external partners (e.g., fire department, public health unit) to ensure the facilities are safe and secure for clients, families, and staff. Notably, the organization has addressed fire code retrofits by installing sprinkler systems in 20 of 25 residences over the past three years.

The organization continues to pursue energy conservation opportunities, including lighting retrofits, LED lighting, and low flush toilets. An annual property assessment is used to inform the annual and forward-looking capital budget planning process.

There is an organization work plan to address the requirements of the Accessibility for Ontarians with Disabilities Act. The plan is on schedule, with the focus for 2016 being to address accessibility issues in pharmacy, x-ray, and the parking lot.

A scent reduction policy has been implemented as per a previous on-site survey recommendation.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The current and comprehensive emergency preparedness plan is updated annually. The plan is coordinated with community agencies as appropriate. Elements of the plan are tested monthly, a tabletop emergency exercise is scheduled annually, and fire drills with evacuations occur monthly in the residential programs, one of which is observed and evaluated by officials from the fire department.

The organization is commended for developing an emergency preparedness team directed by a specialized part-time consultant.

There are emergency preparedness boxes in three locations to ensure that in the event of a disaster direction can be provided from locations other than the Portsmouth Centre. Relocation arrangements have been made for all programs to either the Portsmouth Centre or community locations should the Portsmouth location be involved in an emergency situation. Portable generators are available for several sites and are stored and maintained at Portsmouth which has a back-up generator.

Policies and procedures are in place to manage outbreaks in the programs. The team was unaware of any reported outbreaks in the past year.

The organization's commitment to safety is noted by its implementation of a mock disaster in the summer of 2016. The findings have been used to improve emergency preparedness practices in the organization.

A considered and thorough business continuity plan has been developed for each organizational department.

The organization is encouraged to explore how to increase the involvement of clients and families in the development and evaluation of its emergency preparedness practices. In addition, it is encouraged to provide clients and families with education related to emergency practices, and to enhance its debrief with clients and families following evacuation drills and other emergency activities.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a coordinated admissions and transfer process that includes Developmental Services Ontario (DSO) as well as its community partners where appropriate. Potential new clients are assessed for compatibility by the intake staff who are registered social workers. An internal Admissions Review and Discharge Committee determines eligibility for more specialized services such as community behavioural services and adult protective services. Eligibility and discharge criteria are outlined in policy. An appeal process is in place for clients who are determined ineligible for service.

On admission clients are provided with information about the organization, their role in safety, their rights, and the complaints process, among other topics.

Given the increased demand for services, the social workers have reviewed and revised their service delivery model to provide service to more complex clients and offer consultation support to clients with less urgent needs. Groups facilitated by the social workers deal with a variety of topics such as community safety and developing healthy relationships and are also used as a method to reach more individuals.

Social workers have recently begun facilitating monthly meetings with clients in each service to increase their engagement in the program and in the organization as a whole. A client advisory group is also in development.

As it strengthens its person-centred care practices, the organization is encouraged to have client and family input into the admissions policies and processes and related topics.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization complies with the Broader Public Sector Accountability Act and directives and has aligned the organizational supply chain procurement policy and code of ethics and practice (e.g., requests for quotation or proposal). End users and clients are involved in product/equipment evaluation and selection. Staff training and education is provided to ensure safe use of products and equipment (e.g., introduction of new equipment such as client lifts and slings). Mandatory training and education is facilitated by the scheduling office.

The organization continues to leverage group purchasing contracts (e.g., Health Pro to realize operational and capital expenditures for beds, nursing/medical/surgical products, the facility etc.).

Microsoft Dynamics GP has been implemented to manage capital assets. The inventory management system tracks organizational and client-owned assets, age, life cycle, preventive maintenance, etc. This has increased visibility, safety, and confidence and mitigated risk. It has also provided the capability to plan for capital and service.

The single instrument previously identified for sterilization is processed by Kingston General Hospital and a formalized contract has been implemented.

Provincial Infectious Diseases Advisory Committee (PIDAC) and public health infection control recommendations were used to develop the policy on cleaning and disinfecting re-useable medical devices. Ongwanada has implemented a purchased services agreement with Kingston General Hospital for decontamination and sterilization of client equipment devices that require high-level disinfection and/or sterilization. The policy outlines the procedures, quality measures, and documentation required.

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:

Infection Prevention and Control for Community-Based Organizations

- Infection Prevention and Control for Community-Based Organizations

Medication Management for Community-Based Organizations

- Medication Management for Community-Based Organizations

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Diagnostic Services: Imaging

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

Standards Set: Developmental Disabilities - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	

6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
4.1	Required credentials, training, and education are defined for all team members with input from clients and families.	!
4.7	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
8.16	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
9.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
12.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families, to ensure they reflect current research and best practice information.	!
14.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

Goals are developed with the client and family, if appropriate, on an annual basis. Progress is tracked and reported at the next annual meeting at which time goals are revised. The introduction of the position of person-centred planner is reported to have improved the goal setting process and made it more inclusive. The client determines who will participate in the meeting and everyone works together to celebrate the client's successes and identify future goals.

The interdisciplinary team consists of psychology, psychiatry, occupational therapy, physical therapy, nursing, social work, and front-line unregulated service providers, all of whom collaborate on the development and implementation of the client's service plan.

The organization seamlessly transitions youth to adult services when necessary.

While it is recognized that clients are free to organize their personal living environment, the organization is reminded to include input from clients and families in the design of new space.

As the organization moves forward with the introduction of its person-centred care model, it is encouraged to evaluate the impact of the model on its resources and its effectiveness in assisting clients and families to identify realistic and appropriate goals.

Priority Process: Competency

Staff report a strong focus on education and training. Staff competency is regularly evaluated by supervisors through observation of their performance as well as scheduled formal performance reviews.

Staff receive annual and emergency training in crisis prevention intervention.

Understanding that the implementation of the person-centred care framework is underway, the organization is encouraged to accelerate staff training about the expectations of person-centred care, to support the efforts of the person-centred care planners in facilitating the development of goals and service plans for clients.

The organization is also encouraged to offer training related to the abundance of ethical issues that present in services such as these, as well as the use of the ethical decision-making framework at the front line.

It is also suggested that, in anticipation of the successful completion of Vision 2020, the organization provide staff with the necessary training to provide care for an increasingly complex client population.

The introduction of the person-centred care framework offers the organization the opportunity to obtain feedback on its staff recruitment and training practices from clients and families.

Priority Process: Episode of Care

Staff commitment to clients is evident at all levels of the organization. A holistic approach to client care ensures all client needs are addressed. Partnerships and working relationships with other community organizations offer additional complementary services as appropriate.

A comprehensive interdisciplinary assessment on admission includes a falls risk assessment, a skin risk assessment, and assessments by all involved disciplines. Individualized care plans are developed in consultation with the client, family, and providers. Care plans include goals extending from skill development directed to more independent living to social and leisure goals related to improved quality of life. Goal achievement is reassessed annually and goals are revised at that time.

Staff are aware of issues related to consent and capacity and respect the clients' wishes to the degree possible.

The organization demonstrates zero tolerance of abuse. Clients and families are provided with information about their rights and are aware of the complaint process should they have concerns.

Transitions of care are well organized and clients and families are assisted through the process. Follow-up supports are provided where possible in the event that a client is discharged to another organization or facility. A three-month post-discharge evaluation is conducted.

The implementation of individual client programs is consistent across all locations where the client is involved. Behavioural programs are described in Behavioural Supports Ontario plans and require approval by the Client Intervention Review Committee. Although staff are trained in crisis prevention intervention, the service philosophy is least intrusive.

Emotional support for clients, families, and caregivers is available from various staff including social workers and the chaplain.

It is suggested the organization solicit contributions from front-line staff in the development of client care plans and regarding operational program issues. Staff reports suggest an occasional disconnect between decisions made at the leadership level and the ability to implement those decisions at the front line.

The organization is encouraged to involve clients and families in the development of relevant organizational processes.

Priority Process: Decision Support

The recent introduction of e-CIMS, the electronic health record, has been well received by staff. The value of real-time communication between staff and programs and the program’s ability to generate data and reports is recognized. The organization is in the process of transitioning from hard copy files to electronic files. Access to electronic files is limited and based on need to know.

Policies and procedures for storing, retaining, and destroying client files are in place. Staff demonstrate an understanding of issues related to privacy of and access to health information.

The organization is encouraged to include input from clients and families when developing or reviewing its health information policies.

Priority Process: Impact on Outcomes

The organization has a well-documented process to report and evaluate client incidents. Root cause analyses are conducted where appropriate and the results inform practice change. Aggregate data from incident reports is trended and reviewed quarterly by leadership, staff, and the board. Corrective action is implemented where necessary.

Each program identifies quality improvement activities and performance metrics that it tracks, analyzes, and reports quarterly. These generally are in response to issues that have been identified in the program, and program changes are introduced where appropriate.

All quality initiatives are reviewed by the planning committee of the board and subsequently by the board. The client and family voice is present at both the planning committee and at the board and provides input into the quality initiatives identified and the metrics collected by the organization.

The organization's clinical practices are founded on best practices. With the introduction of person-centred care, the organization is encouraged to include input from clients and families on the selection and evaluation of best practices.

While the programs are recognized for identifying and tracking quality improvement metrics, the organization is encouraged to coordinate its quality improvement activities so the quality initiatives of individual programs support the overall organizational quality plan.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Competency

The coordinator of spiritual and religious care helps meet the spiritual and religious needs of clients and nurture their spiritual growth if they so wish. The coordinator is responsible for ecumenical and multifaith worship, spiritual counseling and support, ritual celebrations, integration of clients into community faith groups, and other administrative duties. As well, the coordinator supports the ethics team. Given space constraints, there is no designated chapel; however, the coordinator ensures appropriate space is available for spiritual practice.

The coordinator has taken a leadership role in planning and coordinating a number of annual events (e.g., Board of Governors' annual dinner, annual memorial service, community Christmas Eve dinner). Most notably, the coordinator has established a project called Circle of Friends which is a performing arts group focused on providing opportunities for those with disabilities to give back to their community through live presentations involving music and drama.

Priority Process: Diagnostic Services: Imaging

The Radiology Review Task Force is commended for developing and completing an action plan to address unmet criteria from the previous on-site survey. Notably, the team engaged the Kingston General Hospital diagnostic imaging (DI) leadership to advise and support several of its corrective actions (e.g., diagnostic reference levels).

The DI team has embraced a person-centred care approach in the design and delivery of diagnostic services, taking into account the special needs of the community served. This is validated by the clinical teams and clients in the community residences as well the results from the recent client and physician satisfaction surveys. The team continually strives to improve the client and family experience with a focus on quality improvement and safety.

Ongwanada provides funding for continuing education of the medical radiation technologists and leverages knowledge and best practice through the Ontario Association of Medical Radiation Sciences, Eastern Section.

The quality advisor and radiation protection officer provides medical leadership and oversight of the radiation safety protection program and is an advocate for ensuring the appropriateness of imaging requests (e.g., Choosing Wisely Canada, utilization management with referring physicians). The lead technologist has taken on an additional role and responsibility as the safety officer.

The leadership and DI team meet twice a year to review, discuss, and identify opportunities regarding financial, operational, and utilization data; quality assurance; quality, safety, and risk indicators and reports; and education.

Ongwanada is advancing its strategic plan Vision 2020 and the DI leadership will undertake an external operational review in January 2017 to identify strengths, issues, and opportunities for strategic alignment, program improvement, and sustainability.

The DI team is encouraged to pursue the opportunity with eHealth Ontario to connect with Hospital Diagnostic Imaging Repository Services or the Northern and Eastern Ontario Diagnostic Imaging Network. The latter initiative might be leveraged through a partnership with Kingston General Hospital and extended to include peer review.

Standards Set: Infection Prevention and Control Standards for Community-Based Organizations - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control for Community-Based Organizations	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control for Community-Based Organizations

The Ongwanada team is commended for its attention to infection control practices. There have been no outbreaks in the past year. The team vigilantly monitors vancomycin-resistant enterococci (VRE) and methicillin-resistant Staphylococcus aureus (MRSA), especially with clients being transferred to acute hospitals and repatriated. There have been no transmissions or colonization.

The team has a collaborative working relationship with public health, the Regional Infection Control Network, and PIDAC. Evidence-based practices are researched and used.

Handwashing education and training sessions are provided to staff, clients, and families. Handwashing audits are completed through observational audits (79 percent compliance rate) and results shared with staff. However, leadership has concerns with the current process and is considering supplementing observational audits with hygiene product use. Retrospective analysis using Swish product order data and utilization data is being considered as a proxy measure for hand hygiene. The team is working to refine this measure to determine validity and usefulness.

The staff influenza vaccine rate is approximately 30 percent. This would pose significant problems in the provision of client care should a pandemic occur. Tactics to increase the percentage of staff members who receive the influenza vaccine were discussed with the team. The majority of clients have received the influenza vaccine.

PIDAC and public health infection control recommendations were used to develop the policy on cleaning and disinfecting re-useable medical devices. Ongwanada has implemented a purchased services agreement with Kingston General Hospital for decontamination and sterilization of client equipment devices that require high-level disinfection and/or sterilization. The policy outlines the procedures, quality measures, and documentation required.

Infection prevention and control leadership has recently implemented Classmarker, an electronic education tool to deliver IPC education, testing, analysis, and reporting. Education is facilitated by scheduling service. Leadership has received positive feedback from staff and is considering expanding education modules to include annual Workplace Hazardous Materials Information System (WHMIS) and fire safety training.

Standards Set: Medication Management Standards for Community-Based Organizations - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management for Community-Based Organizations	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Medication Management for Community-Based Organizations

The organization has an on-site pharmacy that dispenses medications for all its residential clients and for those community clients who choose to use it. The pharmacy is also available to the staff and community at large.

The organization is commended for its recent installation of a state-of-the-art medication dispensing system which is reported to have resulted in a notable decrease in medication errors, particularly those related to missed doses.

Medications are dispensed to the residential programs every two weeks and the medication administration records are updated monthly unless there is a substantive change in medication. Automatic stop orders are in place for narcotics and high-alert medications. Expired medications are disposed of by the pharmacy.

The pharmacist completes the best possible medication history for all clients, and medication reconciliation at all transitions of care.

While the pharmacist is on call to provide after hours support for unusual requests, partnerships have been developed with local pharmacies to provide this service during evenings and weekends.

There is a policy in place that complies with the Institute for Safe Medication Practices (ISMP) requirement for a Do Not Use list of dangerous abbreviations, symbols, doses, and routes.

The pharmacist and nurse provide a comprehensive medication administration training to new hires during their orientation and annually thereafter. Retraining is provided by the pharmacist as appropriate.

The Pharmacy and Therapeutics Committee, which is accountable to the Medical Advisory Committee, oversees and reviews all policies and practices related to medication administration.

While there is a policy in place outlining eligibility for and the practices associated with self-administration of medication, this is reported to have minimal use given the abilities of the client population.

Medication in the programs is stored in a secure location in locked cabinets. Staff appear to be well aware of the responsibilities associated with medication administration and adhere to the requirements outlined in policy when doing so.

Medication errors are reported and investigated as appropriate. All medication errors are reviewed by the pharmacist and remedial action is identified where necessary. Families are notified of errors in consideration of policy and the family's direction.

Instrument Results

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

Governance Functioning Tool (2011 - 2015)

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: August 25, 2015 to November 4, 2015**
- **Number of responses: 12**

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.	8	8	83	93
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	8	92	95
3	We have sub-committees that have clearly-defined roles and responsibilities.	8	8	83	97
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	17	83	95

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	8	92	92
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	95
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	8	92	96
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	8	92	94
10 Our governance processes make sure that everyone participates in decision-making.	0	17	83	94
11 Individual members are actively involved in policy-making and strategic planning.	8	17	75	89
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14 Our ongoing education and professional development is encouraged.	0	8	92	88
15 Working relationships among individual members and committees are positive.	0	0	100	97
16 We have a process to set bylaws and corporate policies.	8	0	92	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18 We formally evaluate our own performance on a regular basis.	8	8	83	82
19 We benchmark our performance against other similar organizations and/or national standards.	33	25	42	72

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20 Contributions of individual members are reviewed regularly.	25	42	33	64
21 As a team, we regularly review how we function together and how our governance processes could be improved.	25	25	50	81
22 There is a process for improving individual effectiveness when non-performance is an issue.	25	58	17	64
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	17	17	67	80
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	0	17	83	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	25	50	25	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	8	92	84
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	85
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	8	8	83	92
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	17	83	87
32 We have explicit criteria to recruit and select new members.	8	33	58	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	42	58	90

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	8	92	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	30	70	94
36 We review our own structure, including size and subcommittee structure.	8	17	75	89
37 We have a process to elect or appoint our chair.	0	8	92	95

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

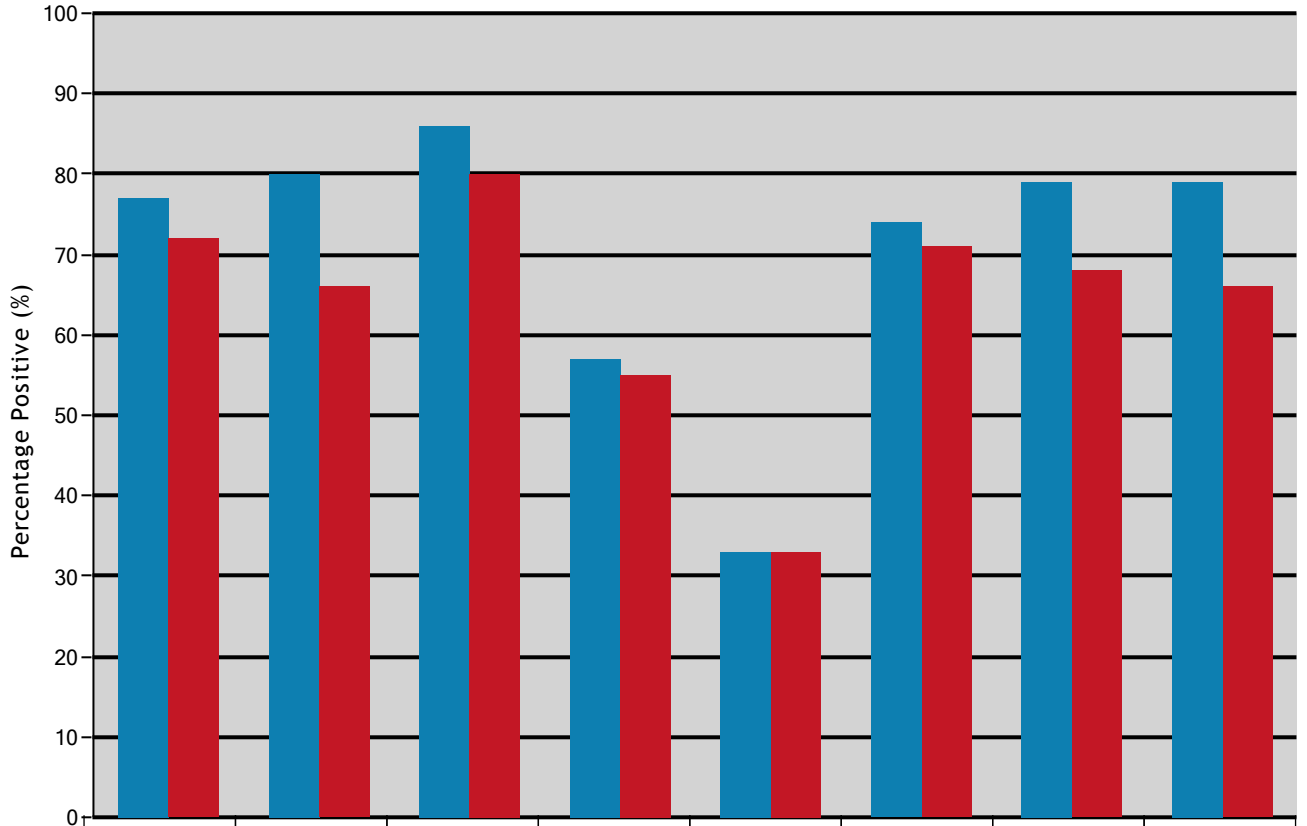
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: September 29, 2014 to November 20, 2014**
- **Minimum responses rate (based on the number of eligible employees): 177**
- **Number of responses: 191**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	77%	80%	86%	57%	33%	74%	79%	79%
	72%	66%	80%	55%	33%	71%	68%	66%

Legend

Ongwanada

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

Worklife Pulse

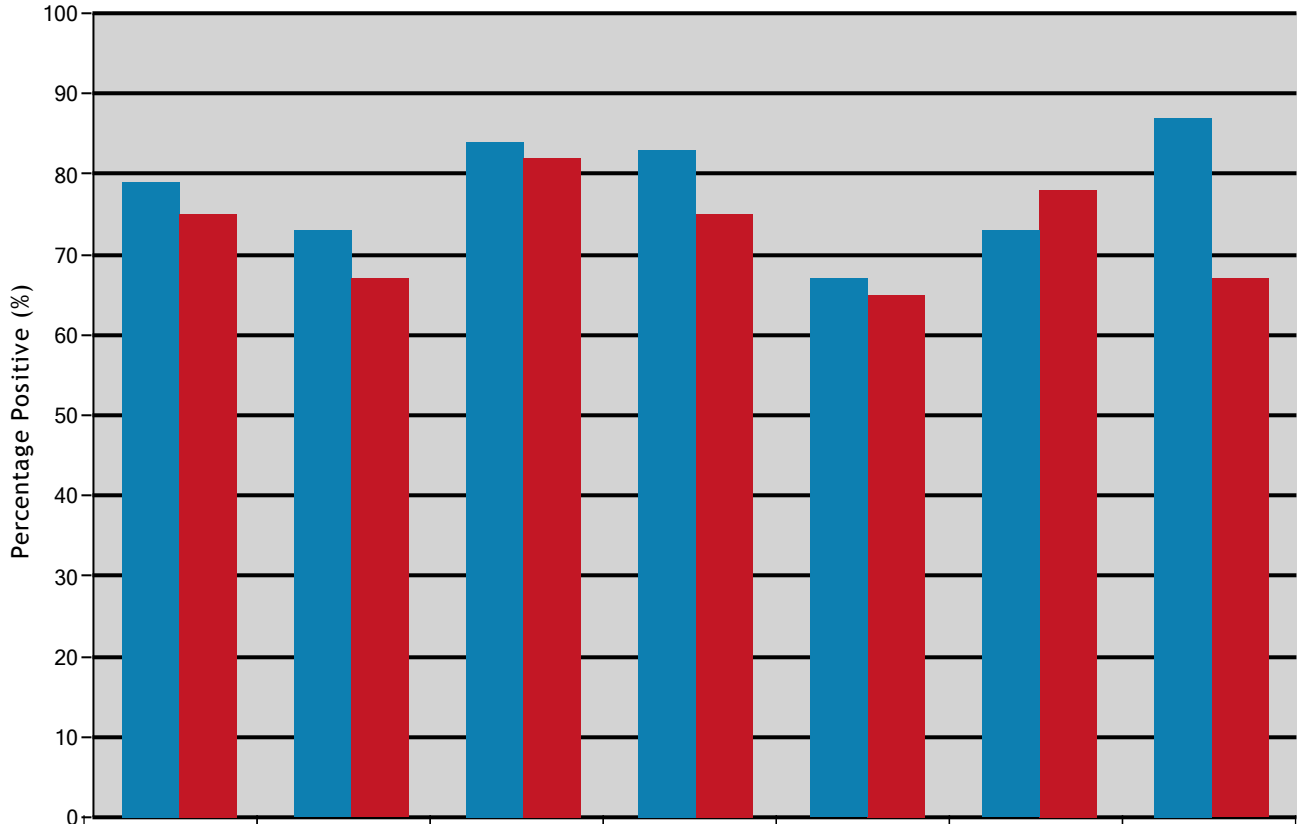
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: May 28, 2015 to September 5, 2015**
- **Minimum responses rate (based on the number of eligible employees): 191**
- **Number of responses: 193**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	79%	73%	84%	83%	67%	73%	87%
	75%	67%	82%	75%	65%	78%	67%

Legend

Ongwanada

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

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 making decisions about ethical dilemmas and problems.
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources.

Priority processes associated with population-specific standards

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

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

Priority processes associated with service excellence standards

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

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