ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Shriners Hospital for Children (Québec) Inc.

Montréal, QC

On-site survey dates: June 5, 2017 - June 8, 2017

Report issued: June 30, 2017

About the Accreditation Report

Shriners Hospital for Children (Québec) Inc. (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 June 2017. 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 Program Manager 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

Executive Summary

Shriners Hospital for Children (Québec) Inc. (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

Shriners Hospital for Children (Québec) Inc.'s accreditation decision is:

Accredited with Commendation (Report)

The organization has surpassed the fundamental requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: June 5, 2017 to June 8, 2017**

- **Location**

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

  1. Shriners Hospital for Children (Quebec) Inc.

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Ambulatory Care Services - Service Excellence Standards
  6. Biomedical Laboratory Services - Service Excellence Standards
  7. Diagnostic Imaging Services - Service Excellence Standards
  8. Perioperative Services and Invasive Procedures - Service Excellence Standards
  9. Point-of-Care Testing - Service Excellence Standards
  10. Rehabilitation Services - Service Excellence Standards
  11. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  12. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	36	1	2	39
Accessibility (Give me timely and equitable services)	44	0	2	46
Safety (Keep me safe)	436	2	46	484
Worklife (Take care of those who take care of me)	85	5	1	91
Client-centred Services (Partner with me and my family in our care)	163	3	5	171
Continuity (Coordinate my care across the continuum)	30	0	2	32
Appropriateness (Do the right thing to achieve the best results)	627	30	68	725
Efficiency (Make the best use of resources)	42	0	2	44
Total	**1463**	**41**	**128**	**1632**

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	44 (88.0%)	6 (12.0%)	0	35 (100.0%)	0 (0.0%)	1	79 (92.9%)	6 (7.1%)	1
Leadership	48 (96.0%)	2 (4.0%)	0	94 (97.9%)	2 (2.1%)	0	142 (97.3%)	4 (2.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0
Medication Management Standards	78 (100.0%)	0 (0.0%)	0	64 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	44 (100.0%)	0 (0.0%)	2	78 (100.0%)	0 (0.0%)	0	122 (100.0%)	0 (0.0%)	2
Biomedical Laboratory Services	64 (100.0%)	0 (0.0%)	7	98 (97.0%)	3 (3.0%)	4	162 (98.2%)	3 (1.8%)	11
Diagnostic Imaging Services	62 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	130 (100.0%)	0 (0.0%)	6
Perioperative Services and Invasive Procedures	111 (96.5%)	4 (3.5%)	0	103 (94.5%)	6 (5.5%)	0	214 (95.5%)	10 (4.5%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Point-of-Care Testing	36 (94.7%)	2 (5.3%)	0	40 (87.0%)	6 (13.0%)	2	76 (90.5%)	8 (9.5%)	2
Rehabilitation Services	42 (93.3%)	3 (6.7%)	0	75 (93.8%)	5 (6.3%)	0	117 (93.6%)	8 (6.4%)	0
Reprocessing of Reusable Medical Devices	86 (100.0%)	0 (0.0%)	2	40 (100.0%)	0 (0.0%)	0	126 (100.0%)	0 (0.0%)	2
Transfusion Services	25 (96.2%)	1 (3.8%)	49	15 (93.8%)	1 (6.3%)	53	40 (95.2%)	2 (4.8%)	102
Total	**680 (97.4%)**	18 (2.6%)	65	741 (97.0%)	23 (3.0%)	61	1421 (97.2%)	41 (2.8%)	126

* 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)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation 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 Shriners Hospital for Children plays a key role in treatment, care, and research to improve children's lives. The Shriners fraternity and network has built upon their history, from the Cedar Avenue Mount Royal site in 1925 to the new Glen site in Montreal in 2015. In addition to the beauty and comfort the building provides, there is a palpable sense of caring and healing throughout. The décor, with each floor themed to reflect different regions of Canada, is lovely and comforting to children who travel from across Canada and internationally to receive care at this world-class facility.

The Board of Governors is elected by their Shrine Temples from across the country to serve, and they do so with great passion and pride. Regulations contained in the "red book" provide rules and directions to the board to enact the headquarters/home office policies. As Masons and Shriners, the board members say they are "in it for the kids" and patients and families are sincerely grateful.

The hospital has an agreement with the Quebec government to provide specialized care and develop research. Many discoveries and innovations have evolved as a result of the efforts of the clinicians working at the hospital. The organization co-located with the McGill University Hospital Centre (MUHC) on the Glen campus, and is located next door to the Montreal Children's Hospital (MCH). Clinical studies and collaborations are strong within the partnership between McGill University and the Shriners Hospital for Children.

Community partners confirm that "this place in outstanding." While they would like to see more communication with the medical staff and more spaces for students, they describe the organization as caring, welcoming, partnering, kind, and awesome. The new building and strengthened partnerships have been made possible through the generous support of the community, that raised over $130 million for the hospital and pediatric musculoskeletal research chair.

There is tremendous dedication from the leadership of the Shriners Hospital for Children, as it is the only Shriners facility in Canada of the 22 facilities in the Shriners network. In October 2015, the organization moved into its new location with over twice as much space, private patient rooms, dedicated research space, and state-of-the-art clinical, teaching, and rehabilitation areas. The leadership is commended for developing contracts for services, such as pharmacy from the MCH and for preparing the staff, physicians, and patients for the move to the new site. As service volumes continue to increase (25 percent from 2015 to 2016 alone), the leadership will be challenged to meet the targets set out by the Shriners headquarters within a defined budget. Stewardship, one of the Shriners values, will be increasingly required to responsibly manage and maximize the benefit to patients.

The Shriners Hospital for Children has been described as a family, with many staff dedicating their entire careers to the organization. In 2016, 70 new staff were hired, bringing the total to 321 employees. To retain

staff, new initiatives such as stay interviews (in addition to exit interviews) are conducted by human resources. In light of the increased number of staff, the leadership realizes they need to communicate more often and in more ways. Town halls, print and e-newsletters, posters, and face-to-face opportunities are used to connect with staff and physicians.

The new hospital has significantly increased its size, space, and service volumes. The history and vision instilled by the Shriners of "transforming children's lives" is carried out by an interdisciplinary team of dedicated physicians, staff, and volunteers. It is impressive to note that the new model of care developed by The Shriners Hospital for Children – Canada has been adopted by all the Shriners Hospitals in the network. The FOCUSED (Family- and patient-focused care, Open communication, Collaborative, Understanding and compassionate, Safe and seamless, Expertise and education, Driven by research and best practices) approach to family-centred care is demonstrated by staff and physicians.

Education of the next generation of health care providers is part of the hospital's mission. The new hospital provides the multimedia technological learning environment that benefit clinicians with access to information with linkages, such as telemedicine and opportunities to practice using simulation.

As patients come to this specialized centre from across Canada, the décor of the various regions in the treatment and waiting spaces makes families feel at home. The natural light flows into the building and seems to make everyone feel better. Patients and families appreciate the sensitive and specialized care they receive. For those with complex, life-long conditions, one "go to" person to help coordinate their care, anticipate their needs, and provide the "big picture" holistic care is a wish. The Shriners Hospital for Children received the Guardian of Excellence Award for Patient Satisfaction from Press Ganey for 2015 – 2016 as a result of consistently exceeding 95 percent for overall patient satisfaction. Patients, parents, and grandparents indicated that even though the move to the new facility was both scary and exciting, the spirit of the Shriners is always there.

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		
1.3	The governing body approves, adopts, and follows the ethics framework used by the organization.	!
3.1	The ethics framework and evidence-informed criteria are used by the governing body to guide decision making.	!
7.9	The governing body oversees the development of the organization's talent management plan.	!
13.1	The governing body publicly discloses information about its governance processes, decision-making, and performance.	!
13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!
13.7	The governing body regularly reviews the contribution of individual members and provides feedback to them.	!

Surveyor comments on the priority process(es)

The Board of Governors of the Shriners Hospital for Children is composed of dedicated, experienced leaders who are passionate about their role in serving the Shriner community and “transforming children’s lives.” In addition to having responsibility for the hospital’s financial viability and stakeholder accountabilities, board members have taken on an increasingly greater roles in learning about oversight of the health sector and are interested in improving the board’s own governance functioning. The Board of Governors worked hard to prepare for the on-site survey and is commended for its efforts.

The Board of Governors has established the following committees, based on the direction provided by the Shriners headquarters in Tampa: research, performance improvement, public relations, plant and facilities, human resources, finance, and hospital management. The board chair has made some changes

to board committee membership based on a skills matrix and equitable representation. The Board of Governors abides by a code of ethics but does not have a formal ethics framework. The Board of Governors is encouraged to direct the leadership to develop a fulsome ethics framework that includes governance ethics in a health context, clinical ethics, and research ethics. This could be a "go to" reference for all levels of the organization from board to bedside.

Board members report undergoing some orientation to prepare them for their role and feel that they receive information with adequate time to prepare for board meetings and decision making. An orientation guide would be a helpful resource for new and current members alike. The Board of Governors receives information via email. Creating an electronic board portal for board materials would reduce printing and could potentially increase privacy and confidentiality of information.

The Board of Governors sets the tone for its commitment to the Shriners values of excellence, innovation, commitment, integrity, teamwork, stewardship, and respect. The Board of Governors receives presentations and regular reports to provide oversight for performance and accountability.

The Board of Governors evaluates itself using the Accreditation Canada Governance Functioning Tool. It is suggested that there be an evaluation of the board chair and that individual board member performance be reviewed, so as to continue to learn and improve board performance. As well, with public funding and support, opportunities for more public disclosure about governance processes and decision making and performance may be required. Tools such as the Guide to Good Governance or other courses and certifications could be used.

In describing their work for the Shriners Hospital for Children, governors describe a group that “all works together, wants to make an impact, is harmonious and gets along, and is part of something very special.”

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	
6.5 Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

The hospital is committed to meeting the needs of those it serves and works with its headquarters in Tampa as well as with the community and its stakeholders to support children and their families with highly specialized care. The Shriners Hospital for Children has a proud history of providing clinical care, academic research, and teaching. The strong alignment among the mission, vision, and values is lived out in the organization.

Community partners from a range of services and programs are very complimentary about the important role the hospital plays. They describe their relationship with the hospital as strong, with key contacts and linkages at all levels. Community partners see the organization as promoting innovation and feel they have opportunities to provide input into service and strategic planning, particularly prior to the move to the new building.

The mission, vision, and values have been strongholds for the organization for decades. Shriners hospitals throughout the U.S., Mexico, and Canada all aspire to these common cornerstones. The home office provides direction regarding community needs and strategic planning. Targets are established for expected volumes for care and importantly for the experience of care through a commitment to measuring patient satisfaction. The current strategic plan spans 2014–2019. An annual operating plan is established, as are departmental service plans with key objectives and timelines. The pillars include goals for quality and safety measures under the clinical, educational, and research pillar. Departmental dashboards are in place in some service areas. These are developed manually using Excel software. The organization is encouraged to pursue report generation options that are less labour intensive to create and that would allow service areas to pull data.

The Shriners Hospital for Children has been through significant change with the move to its new site. Each employee was invited to see the new site and town hall meetings are regularly held to increase communications. Kotter change theory was used to prepare staff prior to the move; however, since the move the approaches used have been more intuitive day-to-day fixes. The organization is finding it is developing capacity and readiness in new ways, such as cross-training individuals or having more than one individual with needed skill sets. Examples were shared of how “happily adapted” physicians are in

the new setting and how the Omnicell medication cabinets are making a positive impact as a result of planning and support from the home office in Tampa.

Staff and physicians indicate that having research co-located with clinical practice improves treatment and care. Children facing transition into adult facilities and care are helped with capacity building to be prepared and sustained wherever they go. Patients, staff, and physicians indicate feeling “blessed here at the Shriners.” Patients and families are the priority, and as such there is virtually no wait list for surgical procedures. Waits for outpatient care are monitored carefully, as sometimes circumstances such as unanticipated physician shortages mean increasing hours and being flexible to accommodate patients.

There are exciting discussions underway among the medical community to create more interdisciplinary clinics in multi-centres. The intent would be to create a musculoskeletal service with built-in outcomes and research. The organization is encouraged to document and plan these endeavours through project charters to capture communication, decisions, and progress. As well, having a common and formal process for change management is suggested.

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)

Strategic priorities are integrated with financial planning and take into consideration the direction in the award letter from the Shriners home office in Tampa. Targets are provided in the letter and there is an expectation that all efforts align with the Shriners mission. The Quebec government also contributes approximately 32 percent, not including research, to the hospital. Although the fiscal year differs between the Shriners home office (calendar year) and the Quebec government (April 1 – March 31), the hospital staff are able to manage and meet reporting expectations.

A calendar and process related to operating and capital budgets have been established. There are regular meetings among senior leadership and managers to determine cost pressures and ongoing monitoring of budgets. Managers receive training and support in variance analysis and budget monitoring. One of the benefits of the move to the new location was an opportunity to have new equipment to improve the care experience for patients.

Each month a variance report is reviewed by finance and department managers in this decentralized model. The operating room was described as “the heart of the hospital” and more complex implants and instruments are driving increased costs. A budget adjustment request can be made and is reviewed by senior managers and head office. One example of a budget adjustment is the increased need for utilities for the new site. Despite projections and estimates, the actual costs of heating/cooling and maintaining the site are higher than anticipated.

The hospital reports being underfunded as a result of the increased space, staff, and volume. The board receives monthly financial reports as well as in-person presentations at meetings. The board treasurer countersigns cheques for major expenditures. Front-line managers receive financial data, including details of expenditures.

The hospital is working through its funding challenges and current deficit by working with government and the Shriners head office. A financial audit was underway during the on-site survey.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
10.5 There is a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.	

Surveyor comments on the priority process(es)

The Shriners Hospital for Children has a history of caring for those who care for the patients. Many staff and physicians describe working at the hospital as “feeling like a family.” The expanded care team not only includes direct care providers but also those who support the work of the organization in its entirety such as volunteers, support staff, and administrative staff. Patients describe being well cared for and know that as it is a teaching hospital they may encounter student trainees as part of their care. Patients understand that they play an important role in helping to train the next generation of care providers.

When asked, staff report the strengths of the organization as “commitment to values, compassionate care, and experience of the staff and physicians.” A positive worklife has been fostered through numerous strategies, acknowledgements, and awards. There are preliminary plans to transform a storage area near the locker rooms into a multi-purpose room/staff wellness/fitness area.

The relationship with unions is reported as good. Approximately 25 percent of the staff are unionized. Staff retention is strong, with many staff working at the organization for over 20 years. Staff who have worked in other pediatric centres appreciate the benefits afforded them, such as manageable workloads, planned/elective procedures and clinics, and parking. There is a feeling of work-life balance and “extras that make the difference.” In addition to conducting exit interviews, stay interviews are planned by human resources, where they meet with staff with their first six months to gather feedback and support employees to stay. Staff and physicians report it is not hard to recruit to clinical positions at the hospital as the conditions are excellent. It is somewhat harder to recruit to administrative assistant positions as the salary scale does not compete with the public sector. A human resource talent management plan is suggested to help document and formalize what “is done but not known.”

While there is some variation in performance review completion, the hospital has initial plans to review its approach to performance reviews. Senior staff’s performance reviews are completed at a higher rate than clinical and support staff. The Shriners home office uses the electronic tool Hallogen; however, using this tool requires translation and building significant volumes of job descriptions. Leadership reports that staff are given regular, ongoing verbal feedback. The organization is encouraged to strengthen its commitment to completing performance reviews regularly.

Training and education records are tracked electronically using the SHINE online system. Other education, such as university and courses external to the hospital are tracked in the employee files. Prior to the move to the new location a student was hired to standardize each employee file for ease of use, with defined sections such as letter of offer, education and experience, position changes, remuneration, performance evaluation, and certificates.

The span of control for managers is reasonable, and staff report having time to practice simulations to maintain their skills. Although a relatively small group, volunteers play a significant role and their dedication improves the experience for patients and visitors. The volunteers also receive orientation and training to fulfil their roles.

Credentialing for physicians includes both the headquarters in Tampa and the requirements of the laws of Quebec. There are clear expectations of what is required and what forms are to be completed to meet expectations. Online and in-person training is provided to ensure all hospital requirements are met. Physician appointments are for two years following reviews by the credentialing committee and board. It is felt that additional rigour is in place for credentialing and reappointments of physicians because of the requirements of the headquarters in Tampa.

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)

Quality is embedded in the patient quality and safety plan 2016-2018, and is embraced by staff. Quality and accreditation are notable drivers in the organization, with structures, tools, communications, and resources to support the work. Quality and safety improvement projects and initiatives are commendable; however, not everyone is aware of the projects and outcomes. Notable projects include improving discharge planning as a result of a lower score (88 percent) than the target Press Ganey score.

Patients and families were interviewed to learn about ways to improve the discharge experience from their perspective. The use of the white boards in patient rooms has been well-received by parents who write questions and communicate with their care team. These questions spark discussion during interdisciplinary bedside rounds, which take place once per week on Wednesday. There are tentative plans to hold these rounds twice per week, on Tuesday and Thursday.

The reporting structure for quality, patient safety, and risk management includes a number of underlying supporting concepts, such as the home office strategic plan, patient satisfaction, the accreditation and emergency measures plan, and reporting to the Patient Safety/Risk Management Committee and to Performance Improvement Committee of the board. There is a patient/family representative on the Patient Safety/Risk Management Committee. There is organizational support for quality, safety, and risk, with key roles and leadership to support the work. It is helpful to have administrative support for audits, which are completed regularly according to an annual calendar. There are plans to look at implementing patient safety huddles. Staff feel recognized for safety efforts through the tenth year of the employee safety recognition program.

In follow up to the patient safety culture surveys conducted over the past few years, the performance improvement department in collaboration with the Council of Nursing and Multidisciplinary Council developed and implemented a plan to promote a just culture with a learning environment to increase comfort with reporting incidents and accidents. The reporting forms are hard copy, with follow up and copies included. Staff reporting has increased and there is a ratio of approximately 3:1 of incidents to accidents.

The Shriners head office asks that incident/accident reports be resolved within 30 days. Physicians are able to describe their role in disclosure with patients and families, as is required by Quebec law. Emotional support is in place for families, staff, and physicians as needed.

Online policies and procedures are readily available to staff and are regularly reviewed and updated on a three-year cycle. Most recently, the safety brochures were reviewed and updated. The Shriners Hospital for Children is unique in Canada and therefore has traditionally had access to resources beyond typical government funding. It will be important to continue to be good stewards of resources and to use outcome and patient experience data to improve processes, garner efficiencies, and improve care.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.7	An ethics framework to support ethical practice is developed or adopted, and implemented with input from clients and families.	!
1.13	The ethics framework includes a process for reviewing the ethical implications of any research activity that the organization leads or participates in.	!

Surveyor comments on the priority process(es)

Ethics processes are separate for clinical and research. There is no overarching ethics framework. The organization is encouraged to develop a fulsome ethics framework to support the board and all staff, physicians, and volunteers in their work.

The Clinical Ethics Committee comprises staff from a range of departments and leadership positions. The committee is chaired by an expert clinical ethicist on contract to the hospital. The committee described its plans, with initial drafts of new ethics documentation, and indicated that input and feedback from parents and patients will be sought. Types of ethical dilemmas the organization faces include resource allocation and how to decide who gets funding for prosthetics. The committee also described the success of the ethics lunch education that includes principles of ethics and case scenarios and videos for learning.

There is a commitment to building capacity in ethics awareness and knowledge and the organization is encouraged to formalize the need for education. Ethics reviews for research are conducted by the Research Ethics Office (Institutional Review Board) in affiliation with McGill. This ensures the safeguards for scholarly and ethical conduct in research involving human participants are met. In addition, the Shriners Hospital Network also has a headquarters research office that oversees all research projects. The organization is proud of the many research projects underway within four programs and especially for receiving competitive funding from the Shriners and other national research grant funders.

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)

As the only Shriners Hospital in Canada, communication is particularly important both internally and externally. There has been a significant emphasis on the move and transition to the new site since October 2015. The changes included a staffing increase of more than 30 percent, which created more and new internal communication challenges. Staff report that communication in a physically smaller building was regular and frequent because “we would run into each other in the halls.” Now the organization is using additional strategies to connect with staff.

Communication strategies include town halls, screen monitors with information, hard copy and electronic newsletters, committee meetings, social media, poster boards, and face to face. The hope is to create a “homey feeling” in the new setting. Community partners and patients and families report good two-way communication with the organization and for that they are very grateful. Patients and families are more technically savvy and there are preliminary plans to try to have a safe presence on parent blogs.

Externally, the home office is beginning to use public service announcements. The plan is to have local patient and parent ambassadors support external communication for this site.

An electronic medical record (EMR) is in place and forms from the home office in Tampa are used to ensure security and privacy of information. Education sessions and open houses are held with the medical records department to share information with staff and physicians and answer questions. Fingerprints are used for Omnicell medication cabinet use and a smart card is used for security and for electronic records access. Access is limited to the clinical requirements of each employee.

Some policies are generated and mandated by the home office and others are developed locally. Patients over 14 years old and parents can consent to accessing and receiving a copy of their health records information.

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 new Shriners Hospital for Children is a state-of-the-art facility that enjoys the latest and most sophisticated infrastructure. The space is modern and well appointed, with attractive areas decorated in nature themes that are pleasant and inviting for the entire spectrum from children to adolescents.

Clinical areas are spacious, tidy, and uncluttered. Areas are well lit by natural light. There are outstanding areas such as the schoolroom, rehabilitation areas, and the cafeteria that make this an extraordinary place to work or receive care.

Signage in some areas, such as the ambulatory clinic area, is clear and effective. In other areas, such as emerging from the elevators onto a new floor, wayfinding is more challenging.

The physical plant is designed to facilitate patient flow, as evidenced by the co-positioning of the ambulatory and diagnostic imaging areas with connections at both ends. The operating suite is dedicated to perioperative services. The design follows the path of the patient, is thoughtful and functional, and has the capacity to expand services.

The organization incorporated many energy-saving design elements in the new physical plant, such as the building being positioned with a southwestern exposure that maximizes natural light in the building. Being adjacent to the subway enables staff and families to use public transportation, saving on fuel. Light sensors and a robust recycling program all help minimize the organization’s impact on the environment.

Infrastructure and mechanical controls for the heating, ventilation, and air conditioning (HVAC) system, water, and power supply are all centrally and electronically controlled. The systems are connected to electronic monitoring that alarms at the central control computer stations during office hours and to a maintenance person.

All systems have significant additional unused capacity that ensures supply is maintained and well controlled during service periods and system failures. High-risk areas such as gas pipelines, pressure connections, and regulators are checked annually. Back-up tanks are stored.

There are back-up systems to reduce the impact of utility failures. The organization has two back-up generators that have considerable unused capacity once engaged. The hot water supply has back-up from the adjacent Montreal Children's Hospital boiler. Routine back-up system checks occur on a regular basis.

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 hospital has worked hard to establish emergency preparedness at the new and larger site, with more staff and more patients. An Emergency Management Coordinators Committee provides oversight and support for emergency preparedness. There is a written emergency preparedness plan in Compliance – 360, the electronic policy platform for Shriners.

The organization has a fire brigade comprising staff with specialized education to respond in case of fire. The fire alarm system is hardwired into the entire Glen site, so all organizations on the site can see the fire panel. The organization has coordinated with its site partners for disasters.

Examples were shared of learnings from potential and real disasters such as a telephone failure and a hydro failure. In these examples the emergency Cisco phones were used for communication and debriefing immediately following, and later when formal reviews were conducted.

Regular practice drills are conducted (most recently a bomb threat and active shooter) with the support of the Montreal police. More tabletop exercises are planned for fall and the organization is encouraged to ensure all codes are regularly tested. Fan-out lists and pre-set email lists of managers are available to security so communications are ready if needed in the case of an emergency.

For business continuity, a data key can be removed from unit computers and downtime procedures are in place for staff as back up. Utilities back-up is in place and food and water are stored for a short emergency back-up if required.

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)

Timely access to specialized orthopedic care to treat complex disorders is an essential mandate of the organization. The Shriners Hospital for Children treats pediatric patients not only from Quebec but also Canada wide and internationally. In most organizations the concept of flow stems from the emergency department into the organization, but as the organization does not have an emergency department the Required Organizational Practice for this priority process is not applicable. However the importance of streamlined flow processes in each of the departments, such as ambulatory clinics, rehabilitation, and the operating room and inpatient unit is essential in serving this specialized population in a timely fashion.

For many patients the ambulatory clinic is the first entry point into the organization. Significant bottlenecks that affect flow were reported by staff and observed during the on-site survey; these vary depending on the day of the week. Key issues noted by the teams are a lack of smoothing of clinics throughout the week, delays in timely access to diagnostic imaging during crowded clinics, and late start times. The ambulatory team is undertaking a project to investigate these issues. The team is encouraged to continue with this and present its findings to the leadership so the issues can be resolved.

Once patients have been assessed and appropriately triaged for surgical intervention they are placed on a wait list. The site meets the surgical provincial wait list targets for elective surgery with no waits greater than one year. Although there are wait time variabilities between the surgical groups, if a patient's condition deteriorates they are re-prioritized by their respective groups. All patients are entered into the provincial SIMASS system and monthly wait list data are reported back to the site. The chief of surgery is the final approval for the operating room schedule and is responsible for final allocation of surgical time. It is very rare that surgical cases are cancelled.

Since the move to the new site, the inpatient unit has developed a more collaborative approach to flow with the Montreal Children's Hospital (MCH). Historically the more acute surgical patients who required higher levels of care received all of their perioperative care at MCH. This is no longer the case. Once patients no longer require higher acute post-operative care in the MCH, they are transferred directly to the Shriners inpatient unit for the remainder of their stay. The surgical manager is fully integrated within the weekly Montreal Children Hospital bed round meetings and is very proactive in planning. This has allowed the seamless flow of patients between organizations.

As the inpatient unit often has unoccupied beds, it also supports the Montreal Children Hospital when it is at full capacity by accepting transfers of stable post-operative patients. This collaboration between organizations to support access to care is an excellent example of partnership and the inpatient manager is commended for her work in streamlining processes to facilitate this work. Although there are no formal

structures and roles at the Shriners Hospital for Children to globally look at access and flow for the entire site, as the organization grows and the demand for access increases, leadership is encouraged to explore setting up some standard site-wide embedded flow strategies to address the system-wide issues, so flow becomes part of the culture of the organization.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The medical device reprocessing department is co-located with the operating suite. The area is clean, well appointed, and organized, with easily maintained stainless steel surfaces. Access to the service area is appropriately restricted. Functionally, there is clear separation of clean from dirty activities. There is a one-way flow of medical equipment from dirty to clean across the range of reprocessing services.

Cleaning and reprocessing is managed internally except for specific equipment that is contracted to external providers. These contracts are monitored to ensure the quality of services provided. Flash sterilization is used for emergency situations only in the operating room. A report is made of each use and kept for five years.

The team has policies and procedures to guide its activities. The organization has an established process to manage recalls for equipment where there is a problem with sterilization. This process includes producing a written report and notifying the affected area. Reports are kept for five years.

The reprocessing team consists of three fully trained staff, with back-up from operating room nursing if required. Team members receive specialized training to support their roles. There is robust orientation process for new appointees.

The organization has preventive maintenance contracts for all equipment. The program is managed through the Total Maintenance System software that prompts service schedules for all equipment. A five-year plan has been developed to manage the replacement of equipment and devices.

The organization has established a standardized process to procure medical devices and equipment. Internally, after the clinical area carries out its committee process to identify required equipment, a request is sent to the procurement officer as part of a capital equipment planning process. A series of steps to identify suppliers, obtain quotations, and review and select equipment is completed before approval is sought from head office.

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:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Point-of-care Testing Services

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team is guided by the strategic direction provided by the parent body. Goals and objectives are developed by team members to enable them to operationalize the strategic plan.

The team has built partnerships with surrounding regional hospitals that refer patients for care. The medical team is shared with Montreal Children's Hospital (MCH).

The team co-designed services with significant input from patients and their families. This was particularly true at the time of the design of the new unit and, since the move into the new unit, on a regular basis using the Press Ganey satisfaction tool.

Feedback from patients indicates they are satisfied with the ease and efficiency of the registration process and the timeliness of the response to their calls. Concerns were identified in the areas of patient flow and timely access to services. Work is ongoing to streamline the clinical process so as to address wait times for service after registration.

Priority Process: Competency

The organization supports and delivers training and education for the team, and provides resources to support them with ongoing professional development.

Team members receive infusion pump training that is led and monitored by the clinical instructor. Documentation for this training is maintained and was provided for verification.

A robust orientation program has been implemented by Human Resources and at the team level.

The team has access to clinical ethics expertise.

Team member performance evaluations are done inconsistently by leaders.

Team members are recognized for their contributions in multiple ways.

Priority Process: Episode of Care

The ambulatory team plans services based on the organization's strategic direction. Clinic staff aim to schedule services taking into account the priority needs of patients, available diagnostic imaging resources, and clinician availability. Patients have provided feedback raising concerns about long delays after registration to be receive care. Analysis of the causes of these delays has identified uneven scheduling, late physician start, and wait times for diagnostic imaging as the reasons for these delays.

Working with the diagnostic imaging and medical team, the ambulatory team has undertaken a quality improvement initiative to address the identified causes for delays.

Medication reconciliation is completed for each patient receiving therapies that may expose them to potential risk. Reconciliation is documented on a standardized best possible medication history. Discrepancies are corrected and changes are documented prior to discharge.

The organization has implemented a robust falls prevention program and an awareness program called Buckle-up that enhances the steps taken by the program to minimize the risk for falls.

Two patient-specific identifiers are used to confirm that the correct patient receives the service or procedure.

Patient information is transferred in a standard process through a document referral system and transfer of discharge summaries to referring physicians.

Parents who were interviewed affirm that they are encouraged to actively engage in their child's care, and that the team provides them with easily understood and clear information about their child's condition and care.

Priority Process: Decision Support

Patient records are partially in a paper chart and partially in the EMR. Policies are implemented to maintain patient confidentiality.

Patient information is shared according to legislation and with the permission of the patient.

Staff receive training on the electronic medical record.

Priority Process: Impact on Outcomes

The team has implemented standard protocols and evidenced-based guidelines to guide service delivery. Staff review these processes on an as-needed basis.

The team has implemented safety processes to mitigate risks for patients, such as using two patient-specific identifiers and implementing a falls prevention program.

Adverse incidents and safety incidents are reported, tracked, and analyzed.

A disclosure policy has been implemented.

Performance metric data are tracked and used to identify quality improvement initiatives.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Laboratory		
11.3	The team updates its SOPs every two years or more often if required.	
16.4	The team uses water of the highest purity to prepare supplies, reagents, or media as required by its SOPs.	
17.3	The team regularly monitors the water supply to ensure it meets manufacturer's instructions and tests it whenever problems are encountered.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Laboratory

Human resources are one of the major assets of the laboratory. Staff are motivated and willing to learn. The laboratory director and laboratory manager are always available to support the staff.

The laboratory manager is a member of different interdisciplinary committees and the collaboration between the laboratory and the other departments is excellent.

The equipment is appropriate for the needs of the laboratory.

Many standard operating procedures (SOPs) are developed. The laboratory is encouraged to continue to develop missing SOPs and to review existing SOPs regularly.

Histology, cytology, pathology, and microbiology tests are sent to McGill University Health Centre (MUHC) as are most hematology and biochemistry tests.

The turn-around-time from MUHC is very good and the physicians are satisfied with the service received from MUHC.

Internal and external quality control is done for all tests analyzed in the laboratory. Reports for quality control are revised by the laboratory manager and director and corrective action is taken when needed.

The laboratory has expertise in molecular biology and histomorphometry. Due to the strong collaboration with MUHC labs, the volume of tests in hematology and biochemistry, and its expertise in molecular biology and histomorphometry, the organization is encouraged to evaluate different options to optimize its human and material resources.

The laboratory has a preventive maintenance contract with the manufacturers for most of the equipment.

The space is adequate for the activities of the laboratory, except for the anatomical pathology space.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	

The organization has met all criteria for this priority process.

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

Diagnostic imaging services are co-located in an area with the ambulatory clinics. This layout facilitates easy movement of patients between the two areas and allows providers in both areas to interact and consult about clinical care.

In this clinical area, patients have a pleasant and friendly theme-designed waiting area and a registration area that ensures privacy and patient confidentiality. The area has clear signage, with restricted areas clearly marked.

Services provided include x-rays and bone density studies for internal referrals only. Patients requiring other tests are referred to other facilities. Portable services are provided for patients in the operating room or those on the inpatient unit who are unable to go to the department.

The diagnostic imaging team monitors performance metrics including service volumes and wait times. The team regularly seeks feedback from its patients. One area that has been identified by patients as an issue is the wait time for procedures.

Members of the ambulatory and medical teams and the diagnostic imaging team itself have also identified access to imaging as a barrier to efficient patient flow. Contributing factors to the increased wait time experienced by patients have been identified as surges in demand that align with peak ambulatory flow periods and late clinic starts.

Working with the ambulatory team, the diagnostic imaging team has undertaken a project aimed at understanding access and flow issues. The project is in the data analysis phase. The team plans to develop and put forward recommendations that will be presented to the Quality Committee for these clinical areas. The organization's leadership is encouraged to address these recommendations as a priority once they are presented.

The team implements the organization's falls prevention strategy. Further patient evaluation for specific procedures that present additional related risks is carried out by the team. Two patient-specific identifiers are used to verify patient identities.

The organization is developing an electronic tool for performance evaluation. Team member performance is evaluated using a standardized tool, but completion of performance evaluation is inconsistent.

Quality improvement activities and learnings are shared with the organization, service providers, patients, and families informally.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Infection Prevention and Control

The team has access to an infectious disease subspecialist from Montreal Children's Hospital (MCH) who is part of the team.

The team uses a multifaceted approach to promote infection prevention and control, which includes town halls, lunches, and clinical group meetings; television streaming; bulletins; and hospital-based kiosks.

Staff receive training and certification for food handling. The organization has an annual external review of its food handling, cleaning, and hygiene policies and procedures.

The organization has developed policies and procedures that align with regulations, evidence-based best practices, and organizational priorities. These are developed using information gleaned through academic, public health, and hospital partners.

Patients and families are provided with educational materials about routine infection prevention and control practices and have access to hand-hygiene personal protective equipment resources where appropriate.

The organization has an established immunization policy. Staff are provided with vaccinations.

The organization follows the requirements for mandatory immunization and reporting that are based on provincial requirements. It is evaluating an electronic database that will allow tracking and prompt reminders where necessary.

The infection prevention and control (IPAC) team monitors compliance using direct audits and patient surveys. Results are shared within the organization and with the Board of Governors.

Infections are tracked and analyzed to identify outbreaks or trends. Recommendations to prevent recurrences are shared throughout the organization.

Since the relocation to the new site, the team continues to develop and modify protocols for the new site. It has played a key role in product testing, developed new routine housekeeping practices, and worked with training colleges to provide required infection control certification for all staff who will be hired in the new location.

The IPAC team was consulted in the planning, design, and construction for this new hospital. Since the move to the new facility, a new IPAC practitioner has been appointed who must take on the challenge of developing and modifying the program to integrate the needs of the new space and current standards into the program.

Part of the challenge for the new IPAC practitioner will be to ensure the organization's IPAC standards continue to meet provincial and national standards, a challenge that may require recommending early renovations to the new physical plant. One such challenge that has been noted within the organization are the hoppers that were installed in the dirty utility rooms. Current standards recommend the discontinuation of the use of open hoppers in dirty utility areas and recommend that they be closed off to mitigate their use. As the current dirty utility rooms are small, the removal of the hoppers may enable better use of the dirty utility space and create a better environment that meets a higher standard of infection control.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

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

The organization is situated on the campus adjacent to the Montreal Children's Hospital (MCH) and has a formal agreement between Montreal University Health Centre (MUCH) for contracted pharmaceutical services to ensure the provision of safe, continuous, and accessible quality pharmaceutical care for its patients. MUHC is solely responsible and provides all pharmacy services in accordance with Accreditation Canada standards, including all medication, related supplies, stocking, and transportation, with the Shriners Hospital for Children being invoiced for the services. Within the agreement the Shriners Hospital is responsible for appropriate facilities, storage, and security of all pharmaceuticals as well as Omnicells, which is a medication dispensing system and other dispensing systems throughout the site.

The agreement also includes the provision of professional pharmacist services including prescription validation, medication profile analysis, verification of dosing, preparation of sterile compounds, dispensing supervision, and clinical oversight and support to all staff at the Shriners Hospital for Children. The service is full time and includes on-call after hours service when the pharmacy is closed at the MCH/MUHC.

MCH/MUHC staff oversee medication and quality committees and standard audits, and are responsible for all policies and procedures as well as Omnicell configurations, stock lists, clinical follow up, integration within physician and nursing rounds, the creation and maintenance of the drug formulary, and in-services. A full-time pharmacy technician is responsible for daily top-ups, replenishing Omnicells, stock and narcotics, preparation and delivery of IVs including epidural, patient-controlled analgesia, antibiotics, and oral unit-dose medications. The pharmacy technician is the point person and liaison for pharmacy among the sites. The technician is a MUHC employee who is fully integrated and accepted as part of the Shriners Hospital for Children team, having daily interaction (Monday to Friday) with front-line and leadership staff and playing a key role in ensuring and planning for adequate stock that meets the needs of the patients.

Pharmacy staff are leading best practice and meet all standards for sterile preparation and air handling in the newly built MUHC site that supports both adult and paediatric pharmacy services. The adult and pediatric pharmacists are separate, with a dedicated computer and printer at the pediatric desk for the Shriners site. All services are standardized between the sites with full integration ensuring system safety

with the spread of computerized physician order entry and built-in alerts with the electronic medical record (EMR) at the Shriners Hospital for Children. The medication rooms meet best practices, with locking doors, identifier (ID) access, and cameras as well as fingerprint identifier Omnicells (medication dispensing system) for medication dispensing. Standardized audits and compliance reports are done with electronic reports being sent to clinical leaders. All medication errors are reported and reviewed at the clinical leadership committee. Staff are formally oriented on the Omnicell, the medication dispensing system, and on smart pumps online using the SHINE platform and hands-on in the clinical areas.

There is a clear understanding of responsibility and staff have embraced the new Omnicell, the medication dispensing system, and anesthetic cart technology in all areas since the building opened. All of the Required Organizational Practices are met in the Medication Standards.

The provision of pharmacy services is exemplary and seamless between the two organizations. An infection prevention and control-led antimicrobial stewardship program guides best practice. Current audits show some issues with compliance and leadership is encouraged to continue to work with staff to improve compliance. This should not be difficult as the leaders are aware of where gaps exist and which providers are non-compliant.

Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
8.2	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		
6.1	Required training and education are defined for all team members with input from clients and families.	!
6.6	Education and training are provided on the organization's ethical decision-making framework.	
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
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		
23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical leadership in the perioperative program works collaboratively with the teams and with department heads and anesthesia. The program follows a clear mandate and strategic direction. The organization's mission and vision are clearly displayed and all staff are engaged and fully embrace these in their daily practice.

The perioperative and inpatient managers have monthly staff meetings where they share data and information about quality, incidents, and operational issues. The programs are fully engaged in patient satisfaction and have recently been awarded a very prestigious Press Ganey award for the commitment to patient satisfaction.

The perioperative space has been designed with patient and family input. It is well laid out with a focus on patient safety and security. There is a strong focus on collaboration with patients and families, and those who were interviewed feel they receive the best care available and are included in all decision-making processes. Families are encouraged to room in and be present in all aspects of care if possible. Even in the operating room environment, if necessary or wanted families can escort their child to the induction suite and stay with them until they are induced.

The clinical leadership goes above and beyond daily for the teams and are well integrated into the daily activities of the units. This commitment to daily presence and support is commended.

Priority Process: Competency

All staff are appropriately credentialed. Mandatory training for staff is paid for and there is other readily available education and training. There are many sources of funding for ongoing education which are embraced by all staff. Education sessions are presented bi-monthly in the perioperative area and there is weekly and monthly education on the ward. Staff are also encouraged to attend Montreal Children's Hospital (MCH) grand rounds when staffing allows.

There is a strong culture of education, and access to simulation training is available and widely used. In the inpatient area, one of the empty rooms is set up for just-in-time low fidelity simulation sessions, and this is used on a regular basis. There are many educational supports, a site Clinical Nurse Specialist (CNS), as well as site educators who support all staff. All of the post-anesthesia care unit (PACU) staff are speciality trained and many have come from MCH. A fulsome orientation is in place for the perioperative and inpatient units.

Prior to the move staff were all current in emergency preparedness training; however, with the focus on the move and the new emergency preparedness processes that need to align with the MCH sites, the programs are behind in their unit-specific policies regarding disaster and pandemic planning. There are standard code polices for all other codes, and teams train regularly for code blue to maintain their competency. All current Required Organizational Practices are met in the perioperative area including the inpatient unit. Standardized smart pumps are used in all areas. A standardized handover tool is used for patients moving from the operating room to the PACU and from the PACU to the inpatient unit.

Performance evaluations are done on regular basis using a standard approach of self-evaluation. The organization is undertaking a new human resources initiative to further standardize performance management processes. The respective teams are collaborative in their care model and put patients and families first. The staff feel valued and recognized by the organization and at times feel overwhelmed by the organization's generosity towards them. The just culture of reporting is growing within the perioperative team and staff state they feel safe reporting issues or complaints.

Priority Process: Episode of Care

The perioperative program offers high-quality surgical services that meet all best practice standards.

Patient flow along the perioperative continuum is seamless, with a focus on collaboration with patients and families that meets their individual needs. During transitions in care, standardized verbal reports are used and signed off. Timely access to care was observed without impact to flow and operations.

Education and teaching are reinforced with the patients and families and messaging is consistent.

Full assessment and charting is done in all areas, and all Required Organizational Practices are followed. Use of a safe surgical checklist and consent were observed as were discussions between the most responsible physician and the patient and family both pre- and post-op. Standardized protocols are used with one-to-one nursing care. Patients in the perioperative environment are at risk for falls and strict adherence for side rails being up is followed.

Two patient-specific identifiers are used for all patients along their surgical journey. The operating room is set up functionally with easy access to all supplies. All operating room procedures are followed and meet best practice standards. In the inpatient area, the patients followed also met evidence based best practice with the highest standards of care. Discharge instructions were given to families with a full explanation of follow-up care that was needed.

Families who were interviewed felt supported and integrated in their care.

Priority Process: Decision Support

All patient data and information is captured on the EMR in the perioperative program. Staff are very adept with the system and with the exception of the handover tools and surgical safety checklist they are almost complete paper free. All data are captured in real time at the bedside or in the operating room. All staff are trained on the Shriners Hospitals for Children Information System (SCHIS) electronic medical record (EMR) and have education on legislation and privacy polices.

Each patient file has a photograph of the patient and only first names are used on display. This was developed with patient and family feedback as it helps the patients feel they are having a more personal experience.

Priority Process: Impact on Outcomes

Evidence-based guidelines are in place and used by the entire team In the perioperative environment.

There is strict adherence to standardized processes, protocols, and procedures to reduce unnecessary variation in care. The majority of providers (surgeons and anesthesiologist) work at both sites (Shriners, MCH) and the majority of policies have been adopted at both sites.

As a leader in research in the field there is a strict adherence to ethical policies and practice related to research. Safety was observed to be a top priority for the patients and the teams are fortunate to have resources to support high standards. Extensive data are collected, reported, and posted on the quality board. These data are updated monthly.

All incidents are filed and reported with quick turnaround times and investigations for any events that require follow-up. Currently, there are no surgical wait times greater than one year, with wait time variations depending on the surgical service. Cancellation rates are calculated monthly with variance tracking to determine the root cause of the delays; 21 percent of cancellations are due to human resources being unavailable, with the second leading cause being related to incomplete pre-op preparation. There is a plan to look at creating a more streamlined pre-admission process with medical oversight so these cancellations can be avoided.

The perioperative program, like other programs on the site, is in the early stages of robust patient and family participation and engagement in policy, protocol, and guideline review. The program is strongly encouraged to continue on this journey.

Priority Process: Medication Management

In the perioperative area, the latest Omnicell anesthetic carts are used to dispense all medications in the operating room in the new building.

Anesthesia team members state that they feel very comfortable with the new system and have no issues or concerns regarding rapid access to medications during times of crisis. The carts are locked and can only be opened with correct user identification in the operating room. Each cart is standardized in the operative suites, and medication delivery was observed to follow all best practice standards in sterility, aseptic technique, and labelling.

All medication administration observed was documented and there were double checks for high-alert medication and narcotics. There is an excellent working relationship with the Montreal Children's Hospital (MCH) pharmacy with full responsive support to the perioperative area at all times.

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

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.	
1.3	The lab director or suitably qualified health care professional works with an interdisciplinary professional committee to define the scope of services and oversee the delivery of POCT. CSA Reference: Z22870:07, 4.1.2.	
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.	
3.5	The organization documents performance evaluation results in the personnel files of health care professionals delivering POCT.	
4.6	The lab director or suitably qualified health care professional annually reviews and evaluates the effectiveness of the SOPs and adjusts the SOPs, training activities, or monitoring processes as necessary.	
5.8	The organization monitors and verifies that health care professionals delivering POCT use only the unique identification numbers assigned to them.	
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.	!
9.4	Health care professionals reporting POCT results follow a documented procedure for communicating and sharing results when they are outside of reference ranges for normal values.	!
Surveyor comments on the priority process(es)		
Priority Process: Point-of-care Testing Services		

The use of point-of-care testing (POCT) equipment is increasing around the world. If appropriately used, it presents many advantages to the physician and patient; however, if inappropriately used, it can have major patient safety implications. The POCT coordinator at the Shriners Hospital for Children is an energetic person who did huge work in this area.

The users are aware of the involvement of the laboratory and their collaboration with the lab is excellent. Internal and external POCT quality controls are used. The results of quality control are monitored by the POCT coordinator and the laboratory manager and director. When a non-conformity is found immediate corrective action is taken.

It is important to maintain the quality of this program and the collaboration with the users. The organization is encouraged to re-activate an interdisciplinary POCT Committee under the leadership of the laboratory.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
5.2	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		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.6	Education and training are provided on the organization's ethical decision-making framework.	
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		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Rehabilitation is one of the flagship programs at the Shriners Hospital for Children. It is a well-established service that is delivered on site in the ambulatory and acute care environments. The rehabilitation team includes occupational and physical therapists, as well as a rehabilitation therapist who works with physical therapists, a patient care attendant whose primary role is to clean equipment and toys after each patient encounter, and administrative staff and a manager who oversee the program. There is also access to a social worker and child life specialist when needed.

The team is very nimble and adaptive. Rehabilitation staff assess and treat patients in almost any area of the organization where they are needed, such as the ward, ambulatory clinics, and preadmission clinic. If a patient who is seen in clinic requires physiotherapy, many times the rehabilitation team makes space that day and brings them to the gym for assessment and treatment.

The newly built rehabilitation space is spacious and very well thought out. It has dedicated occupational therapy and physiotherapy rooms. Patients and families helped plan this new space. Treatment can occur jointly with the teams or separately depending on the needs of the patients and families. Goals of care for all patients are clearly outlined and developed by the team, in partnership with the families. As many of the patients are very complex in nature such as osteogenesis imperfecta, cerebral palsy, or spinal anomalies, they are seen by the team and remain part of the program for years. As experts in the field, this team develops strong relationships and partnerships with the community and rehabilitation care providers which facilitates and enables excellence in caring for this unique population closer to home.

Although there is a very close inclusive partnership with the patients and families, input from patients and families with regard to job descriptions, roles and responsibilities, policy and protocol development, and determination of skill mix as per the focus on client- and family-centred care in the Accreditation Canada standards is still in the early stages of development and integration.

Priority Process: Competency

Team members are national experts in their field and all members maintain the highest level of credentials and qualifications. They are highly skilled in their area of expertise.

Staff who were interviewed state they have full access to ongoing education and training as well as professional development. Although there is a very low turnover of staff, all new staff receive a comprehensive orientation and training on all equipment prior to working in the area.

Performance evaluations are done on a regular basis by the manager and ad hoc as needed. Press Ganey satisfaction surveys are well established in the organization and results are shared with the team and with individuals when they are mentioned by name. Staff value this recognition as well as the many events hosted by the organization. This collaborative team values the safety awards and they nominate their peers on a regular basis. They are very proud of their work in the development of the Buckle up Campaign. They see themselves as safety leaders in the organization and take this role of prevention and safety to heart.

Priority Process: Episode of Care

Care and support in the rehabilitation program is provided by a strong, passionate, patient-focused, and interdisciplinary team. This is evident in the provision of care and the respectful and trusting environment established between patients and providers.

The program is nimble and adaptive and treats patients in whatever setting best suits their individual needs. All teams work collaboratively between the disciplines and the patient and family are the primary focus. The team attends patient rounds and is fully integrated in care planning along the continuum, with an emphasis on discharge and rehabilitation in the community.

All applicable Required Organizational Practices are followed, such as collecting Braden scores for preventing pressure ulcers and maintaining skin integrity, as well falls risk, two patient-specific identifiers, and standardized tools for handover.

Patients and families are true partners in care and are directly involved in all rehabilitation activities. Goal setting is done on an individual, case-by-case basis. Families note that they feel in charge of their care and feel like family with the team.

Priority Process: Decision Support

The SCHIS is the EMR and houses the complete patient chart. The EMR is up to date and easy to use, and there are many computers situated in the department so staff have easy access.

All encounters are documented online with patient files being updated regularly. Each patient has a picture on file that is updated when needed. There is a clear process for patients and families who wish to access their own records.

There are standardized tools and processes for all assessments, providing a high standard of documentation in terms of consistency and increasing the team's understanding of each patient. This integrated online process allows all providers to obtain a full picture of the patient’s specific needs, enabling a smoother flow for the patient along their care trajectory.

Priority Process: Impact on Outcomes

As leaders in the field, the rehabilitation team chooses evidence-informed guidelines for care and creates many new standards and evidence sets.

Research is well integrated in the program and many of the clinical staff also work part time in research. The team sees this as a major benefit that brings value to the program. As research is also one of the leading programs at the organization, rigorous standards are followed. There is also a newly appointed clinical ethicist who supports the teams and programs when needed.

Safety is a core value and a high priority for the team. It is embedded in all processes and each patient is assessed for risk. All staff are aware of how to report incidents and the culture of reporting is embedded into every day practice. When incidents occur the reporting, investigation, analysis, and quality improvement plan if needed are disseminated to the team in a timely fashion. The program embraces this just culture of safety and quality.

The program has many quality and performance improvement initiatives, and the teams use standardized tools to collect data which are reported on a regular basis. Due to the nature of program patients and families are well integrated into the quality program and the collection of data. The data and quality improvement initiatives are not displayed or shared in common areas. A suggestion would be to create a quality board for staff and patients that could be displayed in an open area, to further enable the culture of transparency and culture in the program.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Transfusion Services		
5.3	The team reviews and updates the SOPs every two years or more often if required.	
17.6	The team follows an SOP when transporting blood components and blood products within the organization.	!
Surveyor comments on the priority process(es)		
Priority Process: Transfusion Services		

There are no transfusion services or a blood bank at the hospital. Lab tests (cross matches, etc.) and blood products are delivered from the McGill Univeristy Health Centre (MUCH) directly to the unit (operating room or inpatient unit).

The laboratory is involved in training users and in the development of standard operating procedures (SOPs). Due to the relocation of the hospital, some of the SOPs need to be adjusted (e.g., transportation of blood products). The organization is encouraged to continue its efforts to develop and implement new SOPs that reflect the actual situation, and to review them regularly and modify them when needed.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: June 8, 2016 to June 24, 2016**
- **Number of responses: 17**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	2
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	3
3. Subcommittees need better defined roles and responsibilities.	24	24	53	72
4. As a governing body, we do not become directly involved in management issues.	35	35	29	10
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	6	6	88	2

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	1
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	6	94	2
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	6	94	2
9. Our governance processes need to better ensure that everyone participates in decision making.	18	29	53	64
10. The composition of our governing body contributes to strong governance and leadership performance.	0	12	88	3
11. Individual members ask for and listen to one another's ideas and input.	6	0	94	1
12. Our ongoing education and professional development is encouraged.	0	24	76	2
13. Working relationships among individual members are positive.	0	0	100	1
14. We have a process to set bylaws and corporate policies.	0	13	88	2
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	0
16. We benchmark our performance against other similar organizations and/or national standards.	12	12	76	10
17. Contributions of individual members are reviewed regularly.	12	29	59	13
18. As a team, we regularly review how we function together and how our governance processes could be improved.	6	35	59	7
19. There is a process for improving individual effectiveness when non-performance is an issue.	18	29	53	14
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	19	81	4

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	18	18	65	50
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	12	12	76	7
23. As a governing body, we oversee the development of the organization's strategic plan.	0	12	88	2
24. As a governing body, we hear stories about clients who experienced harm during care.	0	13	88	10
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	6	94	3
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	6	94	5
27. We lack explicit criteria to recruit and select new members.	76	12	12	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	6	94	3
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	18	82	2
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	6	94	3
31. We review our own structure, including size and subcommittee structure.	18	6	76	3
32. We have a process to elect or appoint our chair.	18	12	71	5

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

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	4

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
34. Quality of care	0	0	100	5

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

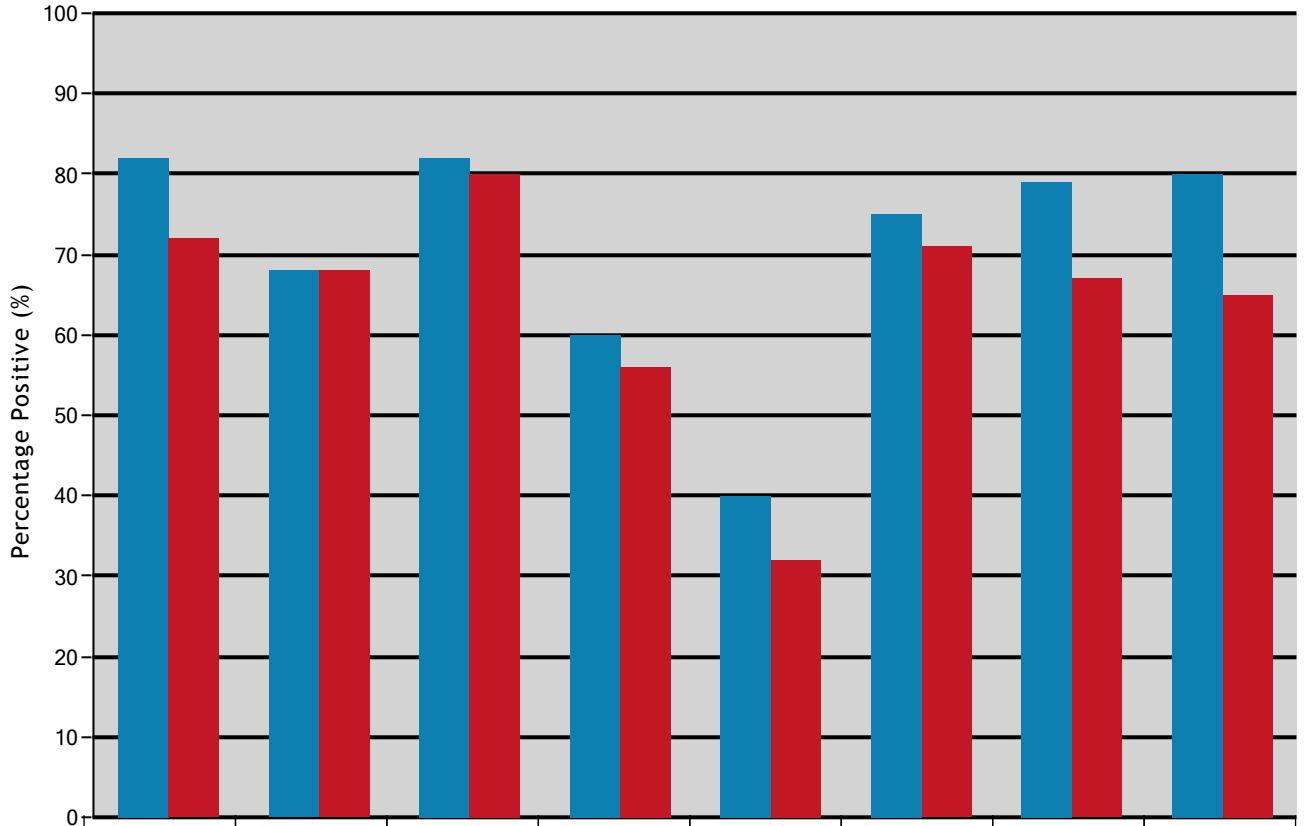
Canadian Patient Safety Culture Survey Tool

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: April 5, 2016 to May 14, 2016**
- **Minimum responses rate (based on the number of eligible employees): 111**
- **Number of responses: 141**

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
	82%	68%	82%	60%	40%	75%	79%	80%
	72%	68%	80%	56%	32%	71%	67%	65%

Legend

Shriners Hospital for Children (Québec) Inc.

* Canadian Average

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

Worklife Pulse

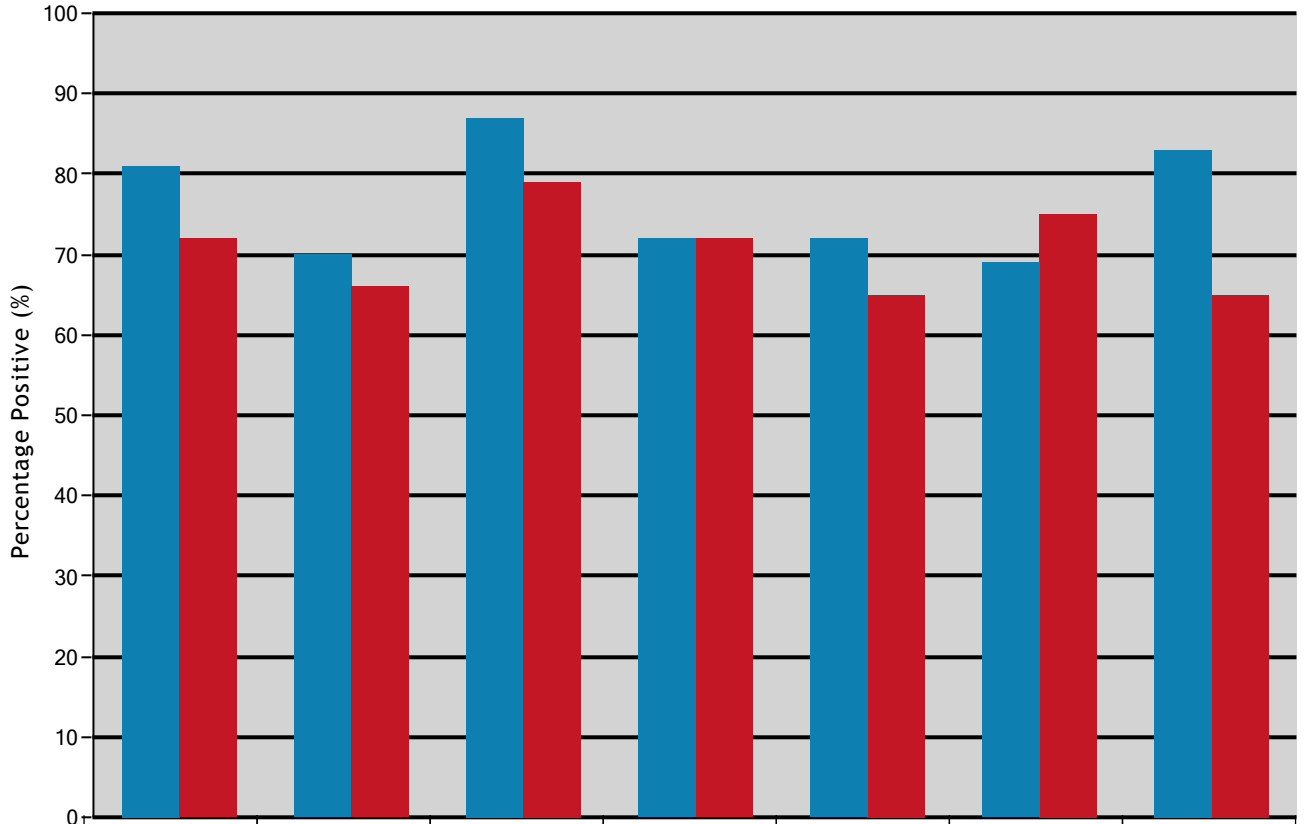
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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: April 1, 2016 to May 14, 2016**
- **Minimum responses rate (based on the number of eligible employees): 141**
- **Number of responses: 154**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	81%	70%	87%	72%	72%	69%	83%
	72%	66%	79%	72%	65%	75%	65%

Legend

Shriners Hospital for Children (Québec) Inc.

* Canadian Average

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

Client Experience Tool

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

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

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

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

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

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

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

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	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 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