ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

North York General Hospital

North York, ON

On-site survey dates: October 25, 2020 - October 29, 2020

Report issued: November 25, 2020

About the Accreditation Report

North York General Hospital (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 October 2020. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

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A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

North York General Hospital (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

North York General Hospital's accreditation decision is:

Accredited with Exemplary Standing

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

About the On-site Survey

- **On-site survey dates: October 25, 2020 to October 29, 2020**

- **Location**

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

  1. North York General Hospital

- **Standards**

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

  System-Wide Standards

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

  Service Excellence Standards

  5. Ambulatory Care Services - Service Excellence Standards
  6. Biomedical Laboratory Services - Service Excellence Standards
  7. Cancer Care - Service Excellence Standards
  8. Critical Care Services - Service Excellence Standards
  9. Diagnostic Imaging Services - Service Excellence Standards
  10. Emergency Department - Service Excellence Standards
  11. Inpatient Services - Service Excellence Standards
  12. Mental Health Services - Service Excellence Standards
  13. Obstetrics Services - Service Excellence Standards
  14. Perioperative Services and Invasive Procedures - Service Excellence Standards
  15. Point-of-Care Testing - Service Excellence Standards
  16. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  17. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool
  3. 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)	50	0	0	50
Accessibility (Give me timely and equitable services)	95	0	0	95
Safety (Keep me safe)	673	0	15	688
Worklife (Take care of those who take care of me)	133	0	0	133
Client-centred Services (Partner with me and my family in our care)	382	0	0	382
Continuity (Coordinate my care across the continuum)	82	0	0	82
Appropriateness (Do the right thing to achieve the best results)	1026	4	3	1033
Efficiency (Make the best use of resources)	66	0	0	66
Total	**2507**	**4**	**18**	**2529**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	95 (99.0%)	1 (1.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	29 (100.0%)	0 (0.0%)	2	69 (100.0%)	0 (0.0%)	2
Medication Management Standards	78 (100.0%)	0 (0.0%)	0	63 (98.4%)	1 (1.6%)	0	141 (99.3%)	1 (0.7%)	0
Ambulatory Care Services	45 (100.0%)	0 (0.0%)	2	76 (97.4%)	2 (2.6%)	0	121 (98.4%)	2 (1.6%)	2
Biomedical Laboratory Services **	72 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	177 (100.0%)	0 (0.0%)	0
Cancer Care	81 (100.0%)	0 (0.0%)	0	115 (100.0%)	0 (0.0%)	0	196 (100.0%)	0 (0.0%)	0
Critical Care Services	60 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	165 (100.0%)	0 (0.0%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Diagnostic Imaging Services	65 (100.0%)	0 (0.0%)	3	65 (100.0%)	0 (0.0%)	4	130 (100.0%)	0 (0.0%)	7
Emergency Department	72 (100.0%)	0 (0.0%)	0	107 (100.0%)	0 (0.0%)	0	179 (100.0%)	0 (0.0%)	0
Inpatient Services	60 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Perioperative Services and Invasive Procedures	115 (100.0%)	0 (0.0%)	0	109 (100.0%)	0 (0.0%)	0	224 (100.0%)	0 (0.0%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	47 (100.0%)	0 (0.0%)	1	85 (100.0%)	0 (0.0%)	1
Reprocessing of Reusable Medical Devices	84 (100.0%)	0 (0.0%)	4	40 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	4
Transfusion Services **	76 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Total	**1107 (100.0%)**	0 (0.0%)	11	1326 (99.7%)	4 (0.3%)	7	2433 (99.8%)	4 (0.2%)	18

* Does not includes ROP (Required Organizational Practices)
** Some criteria within this standards set were pre-rated based on the organization's accreditation through the Ontario Laboratory Accreditation Quality Management Program-Laboratory Services (QMP-LS).

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 (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics 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
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 (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Obstetrics 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
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	9 of 9	0 of 0
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
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
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 (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	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			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
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 (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	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.

North York General Hospital (NYGH) is commended on preparing for and participating in the Qmentum Accreditation program, especially during a global pandemic. Congratulations are extended to the organization for the work it has done to prepare for this survey visit.

NYGH has a strong connection with the community. These relationships have developed over the years and are a reflection of the fact that the organization is viewed as the community's hospital, and hospital sees its role as supporting the community.

NYGH primarily serves the north central Toronto and southern York region and serves a population of over 400,000. The hospital operates 403 acute beds, 32 Reactivation Beds and 192 long term beds with approximately 3,500 staff, 815 Physicians, and 900 Volunteers.

NYGH is to be congratulated for being ranked by Newsweek Magazine as being one of the top performing hospitals in Canada and the world. In addition, it is recognized as a leading community academic hospital while partnering with 36 different academic institutions, with many NYGH physicians having cross appointments with the University of Toronto. It is the top choice for many medical learners. The Hospital is the recipient of several awards and recognitions including Cancer Care Ontario award for top performing hospital for wait times, several ehealth awards, just to mention a few.

The Hospital is governed by a very strong volunteer Board of Directors (Board). The Board is well structured around governance accountabilities and provides the appropriate level of strategic guidance and direction to allow leadership to effectively manage the operation. Board members are extremely knowledgeable and use evidence-based governance strategies. Board functioning is very high-level, with a clear emphasis on quality, safety, risk mitigation, and fiscal stewardship. The board is commended for creating an effective recruitment process for new members.

The Board is involved in a number of key strategic initiatives, most notably the completion and rollout of a new five-year strategic plan for 2020-2025 "Thinking Beyond". Extensive Board, organization and community involvement led to the Plan as currently presented and it has served to very much redefine the focus of the organization. Plan oversite is comprehensive, with a clear balanced scorecard coming forward to ensure that the Board is tracking and, as needed providing course correction on NYGH priorities.

Inherent in this Plan is a recognition that the healthcare landscape is changing. As such, the Board is very mindful of the role it plays at the system level, with the commitment to the North York Toronto Health Partners (NYTHP), Ontario Health Team (OHT) as a very good example of this focus. Membership of the NYTHP includes 21 core partners, 130 primary care providers and 30 alliance members, all representing the full continuum of care, with the goal being to ensure seamless care for the North York Community.

Leadership is remarkably passionate about the organization, the care it provides, and the role it plays in the community and in the broader health care system. Significant efforts have been made to develop leaders throughout the organization, and exceptional tools are available to assist in this area, such as the Joy in Work Leadership development programs and the Workplace Mental Health Leadership program. It was noted that 60 staff have advanced in the organization during the last year. NYGH also offers a variety of workshops that focus on well-being as well as team building and coaching.

Over the last few years, NYGH has made eHealth an organizational priority and critical enabler of the corporate strategic plan. Strategic investments in health information technologies and meaningful clinician adoption of these technologies have improved the quality and safety of care delivered.

There are also many committees that work towards continually improving the organization. This includes the Workplace Safety committee and the Joint Occupational Health and Safety Committee, the Workplace Violence committee, Emergency Preparedness committee and the many working groups below these committees.

The organization's attention and focus on providing patient care through improved patient flow and patient experience are evident in the wide range of evidence-based and data-driven interventions. Constant and consistent communication channels is a hallmark of patient flow at NYGH. Electronic bed status reports, bed tracking, daily COVID dashboards and business intelligence aid in the management of beds in the Emergency Department (ED) and throughout the inpatient services. The team speaks of an all-in approach to surge and patient flow from the clinical teams to the human resources department. The success of flow in tight times is attributed to the whole hospital becoming focused and involved.

The Infection Prevention and Control (IPAC) team is to be commended for the leadership, and expertise that they have provided both within and outside of the hospital during the COVID pandemic. They have provided over 184 infection control practice training sessions to over 2000 staff. Weekly Infection Control Town Hall sessions led by the Medical Director during the peak periods of the pandemic were highly valued by the organization. Through the hub and spoke model, team members continue to share their knowledge and expertise to support 9 long term care homes, 13 retirement homes, 40 congregate settings and five shelters.

NYGH has a remarkably strong Patient and Family Advisor program and is to be commended for the leadership exhibited in this area. The Board certainly understands the important role of Patient and Family Advisors and the organization makes every effort to ensure they are involved in key decision-making processes.

The survey team visited most clinical areas of the organization and were impressed with the level of care provided throughout. Facility limitations and the resulting crowding in some areas were noted to a degree; however, efforts were made on a daily basis to ensure these challenges did not impact direct patient care. Staff were engaged, not only in care delivery in their immediate area, but also in the organization as a whole.

NYGH has successfully assimilated continuous quality improvement within the culture of the organization. which is commendable. Numerous qualities of care processes are noted throughout every aspect of the organization. Of particular note are the Quality Boards where hospital leaders meet weekly to share results with their teams, around key safety, quality and organizational metrics on a weekly basis.

Community partners are very satisfied with NYGH, and their comments reflect those of the staff and physicians. There is a general theme of collaboration, trust, and inclusiveness, where the partners look to the hospital a being innovative, nimble, and willing to help. There are formal and informal linkages and communication venues. The organization can be proud of the partnerships developed and the collaboration with community partners.

Commitments to processes such as Choosing Wisely Canada ensure the organization remains at the forefront of clinical delivery of services, and the relentless focus on quality and improvement will ensure the programs and services continue to follow best practice.

The organization is encouraged to continue of its impressive path to “Think Beyond”.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

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

It certainly has been a busy year of change for the Board of Directors of North York General Hospital (NYGH): responding to a global pandemic, strategically mapping out the Hospital's future, and preparing to recruit a new CEO. The interim CEO (CEO) has been with the Organization, in Senior Leadership roles, including the interim CEO role, for many years.

The Board of Directors (Board) have committed members that wish to advance services at the hospital. There is a strong relationship between the Board and the CEO. The CEO and management group report regularly to the Board. The Board understands its role as a governing body and in particular, is aware that oversight for patient safety, risk management, and quality improvement are fundamental roles of governance. The Board is proud of its efforts and that of the organization in driving quality for all decisions it takes.

The Board is commended for the focus it brings to “Good Governance.” Starting with the process employed to nominate and appoint skills- based members to the Board, through its orientation processes, learning opportunities and focus on governing versus managing, the Board very much sets a high bar. Board members describe a robust orientation that includes time with the CEO and senior staff in addition to materials regarding organizational information. More experienced board members support new board members, and the various voices and ideas are welcomed. Of note, since the last accreditation visit, there is a patient on the Board of Directors, and this is commendable.

The Board of Directors have a clear understanding of its roles and responsibilities and those of senior management. In completing its oversight role, the Board receives a comprehensive scorecard that includes a number of key metrics. The structure of the Board’s sub-committees ensure that the appropriate governance oversight is brought to key issues such as quality, finance, people, innovation, and risk. The Board is very aware of risks faced by the organization, including the current, challenging fiscal situation, resurgence of the Coronavirus, and understands its role in addressing this and similar issues moving forward.

There are processes in place to evaluate the governance structure and function. A process is in place to monitor performance of the CEO and the Chief of Staff performance. By-laws are reviewed periodically.

Medical issues come to the Board through the Medical Advisory Committee with the Board understanding its roles and responsibilities regarding medical staff credentialing.

Feedback from community partners consistently described the organization and governing body as collaborative and as building positive relationships.

The Board has approved the ethics frameworks and provided examples of how it has used the framework to guide decision-making around around balancing the budget.

NYGH has a remarkably strong Patient and Family Advisor program and is to be commended for the leadership exhibited in this area. The Board certainly understands the important role of Patient and Family Advisors and the organization makes every effort to ensure they are involved in key decision making processes. A Patient story is presented to the Board by the Chief Nurse Executive at each Board meeting as a standing agenda item. Patient and family advisors are members of the Quality Committee of the Board. Patient feedback data is presented to the Quality Committee of the Board on a regular basis.

Ongoing Board Education was viewed as very positive, ranging from specific education sessions at meetings, to off-site Retreats, to tours of the organization – all serve to provide the Board with the tools necessary to effectively govern.

A key, recent milestone was the recently released Strategic Plan, 2020 – 2025, which refocused the organization. Extensive Board, organization and community involvement led to the Plan as currently presented and it has served to very much redefine the focus of the organization. Plan oversite is comprehensive, with a clear balanced scorecard coming forward to ensure that the Board is tracking and, as needed providing course correction on NYGH priorities. Inherent in this Plan is a recognition that the healthcare landscape is changing. As such, the Board is very mindful of the role it plays at the system level, with the commitment to the North York Toronto Health Partners, Ontario Health Team is a very good example of this focus.

Of note, The new strategic planning process including asking the stakeholders about the development of a mission statement. After several attempts, and a number of different versions of a mission statement, nothing really resonated with the staff. As NYGH wanted a statement that reflected "Who they were", it was decided to go with a statement that included both mission and vision statements, "Making a World of Difference" is the Hospital's purpose versus a mission and vision statements.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

Few organizations are as advanced as North York General Hospital (NYGH) in the area of planning and service design. The organization is commended for the focus it has placed on proactive strategic planning over the past few years. The refreshed Strategic Plan has re-energized the organization and is allowing it to truly focus on the organization and community's top priorities as it relates to health care across this region.

Strategic Plan 2020 to 2025 Thinking Beyond is noted with approval. The plan was developed with internal and external stakeholders, partners and the community to understand and identify health needs and directions. Focus groups, interviews, and surveys were conducted to inform the plan.

The strength of the organization's Patient and Family Adviser Program came to the fore as the plan evolved, ensuring that extensive input was provided while at the same time enhancing the visibility of this important program. Patient and Family Advisers were then in turn able to engage with other interested parties to help ensure the plan evolved in a way that maximized community input.

Staff and partners are well informed and knowledgeable about the plan and reference it in many conversations. As a result of the Plan, the organization has been able to develop a very focused 5-year strategy map which, in turn will allow for the development of in-year priorities that will advance the organization, similarly as to what occurred with the previous Strategic Planning process.

The values of Excellence, Respect, Integrity and Compassion, are visible throughout the organization. The refreshed of set of values included Collaboration as a 5th value. It is obvious that these values are more than simply pieces of paper as was demonstrated through the many interactions with staff, physicians and leaders.

Efforts to advance master planning across the organization are noted and NYGH is clearly defining future requirements from a development perspective. There was a Master Plan for further redevelopment (5, 10, 20 years) submitted to the MoHLTC approximately 16 months ago and planning for a new tower is

moving forward. Shorter term investments are ongoing, with emphasis being placed on addressing some of the immediate mental health and addiction space concerns. There is also an infrastructure renewal plan which includes transformer replacement, roof upgrades and boiler room upgrades to name but a few.

Communication between levels of the organization is open and transparent. There are opportunities and methods for staff, physicians, service providers and community to provide input into service planning. Strategies to engage hard to reach populations are in place.

As part of our eHealth efforts, NYGH introduced a Business Intelligence framework and technology platform to support organizational performance measurement and decision-making. This has supported planning and management needs.

NYGH in addition to providing a full suite of services through the organization itself, has a keen interest in driving appropriate partnerships across the region. The interest is based on doing what is right for the community and is not aimed at growing the hospital. A great example of this is the successful development and establishment of the North York Toronto Health Partners, Ontario Health Team. The organization's "Better Together" and "Thinking Beyond" leadership approach will go a long way towards this team's success.

Numerous examples were shared by community partners of how NYGH works collaboratively to treat the whole person, be open and transparent, leverage expertise and support marginalized populations. Community partners shared that NYGH demonstrates "finding a way forward" in a desire to provide care. The Hospital has a stellar reputation within and surrounding their catchment area, as relayed by the Community Partners.

The survey team was impressed with the depth and breadth of information received by the governing body, both at the Board and at the sub-committee level. This allows for strong governance oversight, as well as ongoing and regular scans as to continued applicability of strategies being pursued by the organization.

Challenges
Over the last 18 months, NYGH has implemented a corporate electronic policy management system and a coordinator to oversee the process. Corporate policies have been migrated to this platform with a plan to move all departmental policies on the platform as well.
However, several areas that were visited by the survey team had policies, procedures, plans etc. that were not consistent with NYGH's policy development and maintenance. In addition, policies were also found in hard copy and on-line with various version dates. It is recommended that the organization ensure that all policies are reviewed, updated and maintained.

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)

A very productive meeting focusing on the Resource Management systems of the organization was held, including finance leadership, front line clinical and support line directors and managers, senior leaders, physicians, and a patient and family advisor (PFA). North York General Hospital (NYGH) is commended for the integrity of its financial controls, both from an operating and a capital perspective. Review of documentation highlighted a robust process for setting annual plans and a clear commitment to full organizational engagement in fiscal planning. Annual process assumptions are confirmed by the board of directors and then rolled out to the organization in a structured manner.

The Hospital's three-year Financial Roadmap (the "Roadmap"), which forms the basis for the annual Hospital Annual Planning Submission (HAPS), provides a rolling, high level projection of revenues, expenses, capital investment levels, and cash flows over three years. It is reviewed and approved by the Audit and Finance Committee of the Board.

There are several criteria to be considered including the impact on risk, safety needs, replacement or new when setting a prioritized list of capital items. The list is finalized by a committee that reflect the various clinical leaders within the organization with final approval coming from the Board of Directors.

From an operational and capital financing perspective, the organization's resources are strained. Despite historically being able to balance its annual budget, pandemic-related costs, coupled with underfunded services and revenue loss is the realty that NYGH currently finds itself in. From the discussion, NYGH is very much focused on ensuring that it addresses its current financial situation. Robust financial metrics are available to those managing cost centres across the organization, and the leadership is continually looking for new approaches to deliver care through benchmarking and new relationships.

The North York General Foundation continues to be a key partner in the hospital's capital planning process. Through the Joint Planning and Priorities Committee ("JPPC") that oversees strategic capital priorities and as a member of the Equipment Capital Allocation Committee (ECAC), the foundation works closely with the SLT to align available dollars and future fundraising efforts with Hospital priorities

Clinical Service Teams meet monthly (Consultancy meetings) with resource consumption consistently addressed. Service volumes are regularly reviewed, as is case costing and benchmarking information. Financial Analysts and Decision Support are assigned directly to the teams providing a very appropriate and responsive resource to the Teams. Newer costing systems, such as Bundled Care, are well supported by the organization and are a way in which costs and outcomes can be better predicted and controlled.

As part of the eHealth efforts, NYGH introduced a Business Intelligence and technology platform to support organizational performance measurement and decision-making. This has enabled timelier, on-demand access to financial reports and balanced scorecards for hospital leadership and enhanced analytical capability to support planning and management needs.

The ability to generate information necessary for managers and directors to manage and lead their respective portfolios is noted with approval. The utilization of financial staff to act as controllers and conduits for each of the clinical programs is also favourably noted. This allows for better program engagement in the financial process and supports the fiscal education of the front-line managers and supervisors.

The relationship between the Board and its finance committee, the CEO and the financial management services has been very open and very supportive. This was confirmed in discussions with the Hospital Board. They feel that they have enough information to provide due diligence and yet do not cross the line into micromanagement

Likely many groups within the organization, the financial team is seen to be an active member of the corporate team and as such, a major support to the work of the clinical teams of the hospital. In other words, a team player.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

One of the most critical factors in providing high quality healthcare is having a motivated, appropriately skilled and experienced team that work collaboratively and share a common goal of improving health outcomes for the patient. North York General (NYGH) recognizes the importance of this strong foundation. This is evidenced in “People Come First in Everything We Do” being a strategic pillar in the 2020-2025 Thinking Beyond, Strategic Plan (Strategic Plan).

There is an energetic and dynamic team leading and supporting the human resources and organizational development portfolio functions at NYGH. The Board of Directors and leadership of NYGH help support a quality and healthy work life, and safe work environment through several strategies.

NYGH has a strong reputation as an employer of choice and ensures their values are incorporated into interview questions for potential employees. Many of those interviewed during the on-site survey had “grown up” at NYGH, working at the Hospital since graduating from their respective educational programs. Of note, we also met several staff who had left the organization for one reason or another, only to later return.

Employee files were well organized and in a standard format. Many staff confirmed that they have had regular performance reviews. Employee files are kept secure and up to date with employment-related documentation such as offer letters and employee information such position changes. Physician privileging and re-appointment processes are maintained.

Performance indicators such as overtime use, vacancy rates, and turnover rates are reviewed with unit/program leaders through consultancy meetings on a monthly basis. Hospital wide performance indicators are reviewed by the people services team on a monthly basis and reported to the Committee of the Board on a quarterly basis

The orientation of new staff has been described as very detailed and comprehensive. Commitment to ongoing education is commendable. There is an Education Development Fund, which includes Scholarship Awards, Education Grants and Professional Development sponsorships available to eligible staff.

There is a strong focus on developing leaders and professional development throughout the organization and at every level. Again, this is evidenced by the “Be an Exceptional Learning Community” strategic pillar in the new Strategic Plan.

There are numerous internal and external opportunities to attend education and training, such as the Joy in Work Leadership development programs and the Workplace Mental Health Leadership program. It was noted that 60 people were promoted within the organization during the last year. NYGH also offers a variety of workshops that focus on well-being as well as team building and coaching.

There are also many committees that work towards continually improving the organization. This includes the Workplace Safety committee, the Joint Occupational Health and Safety Committee, the Workplace Violence committee, and the Emergency Preparedness committee and the many working groups as sub-committees.

The organization also has a Standout Recognition program which includes an online peer to peer recognition process, as well as annual nominated awards: President Award, Team Award and Customer Service Excellence. In addition, there are "Everyone is a Leader", weekly awards and “In the Moment” appreciation recognition.

Workplace violence and harassment awareness is an area of focus and there is a policy and procedure addressing the prevention and management of workplace violence. There are numerous educational offerings for staff on workplace violence prevention. There is a mandatory online module, modules for the new behaviour assessment and visual triggers program as well as a module for non-violent crisis intervention. Internal trainers provide training on the prevention and management of aggressive behaviour. Prevention and Management of Aggressive Behaviour (PMAB) training is provided for areas that have demonstrated a higher need for crisis prevention and intervention techniques.

Patient safety training is extensive, including annual mandatory training for all staff, physicians, and volunteers on emergency preparedness, Code responses, Privacy, Security, WHMIS, IPAC, just to mention a few.

Talent management includes leadership development, continuous development, performance management, onboarding and off-boarding, recruitment, competencies, diversity and inclusion, succession planning and employee and physician engagement.

Opportunity for Improvement
There are several HR policies in the on-line "Policy Medical" platform where polices have not been updated according to policy development and maintenance (every 3 years).

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)

North York General Hospital (NYGH) is commended for its overall focus on Integrated Quality Management. A very dedicated team of professionals, a broader leadership and very committed staff and physicians are clearly focused on continually improving care and minimizing risk across the organization. A culture of quality improvement is embedded across the organization. All areas visited had a clear understanding and appreciation of the importance of quality improvement and had the tools to identify opportunities and advance them accordingly.

There is a well-developed and integrated quality management program with client safety a strategic priority. The quality, risk management, and patient safety teams are dynamic and attentive to any situation, incident or accident that can be used in review processes.

NYGH's Performance Monitoring system is strong. Key Performance Indicators have been developed for all operational strategies and initiatives. These are regularly reviewed and monitored by all key players.

The governing body receives regular reports on all indicators through the various sub-committees of the Board, with roll-up Reports shared with the full Board.

An integrated risk management approach to mitigate and manage risk is in place. There is a comprehensive, and integrated Enterprise Risk Management program and Framework in place that is reviewed regularly. It ties into the strategic goals of the organization, informs service and operational plans and identifies significant enterprise risks.

There is an emphasis on best practices; order sets and evidence-based guidelines have been adopted and the teams are commended for this important approach to ensure a standardized approach to patient care.

Leaders perform regular rounds with their teams and staff and leaders have acknowledged that this activity is making a significant difference to address quality, safety and risk issues. Staff and leaders have discussions about opportunities for quality improvement projects; several process improvements were discussed during the tracer that had been identified by staff during the round's activities. This is very popular and provides an excellent forum for communication and to address safety concerns of staff. This is a commendable strategy that engages staff and leaders in quality activities.

Quality Board Huddles occur weekly. Numerous quality improvement activities/initiatives were noted throughout the on-site survey.

A patient safety plan is developed. There is a documented and coordinated process to disclose patient safety incidents to clients and families. A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.

Staff are very committed to meeting the needs of patients and quality improvement. Patients feel the care they received is truly patient focused.

The hallmark of the organization's focus on quality improvement is the development of the annual quality improvement plan (QIP). While this is required to be submitted to Health Quality Ontario and can be somewhat prescriptive in nature, NYGH sees the process as way to annually re-calibrate its quality focus. The current QIP aligns with the priorities of Ontario Health (Quality) and NYGH's new strategic plan. It outlines the hospital's priorities aimed to increase quality of care and the patient experience.

A patient story is presented to the Board by the Chief Nurse Executive at each Board meeting as a standing agenda item. Patient and family advisors are members of the Quality Committee of the Board. Patient feedback data is presented to the Quality Committee of the Board on a regular basis. A director presents a patient story at each Quality Committee of the Board meeting.

Fundamental to the success of any quality program is engagement of patients and families. The organization is making a very real effort to partner with patients. Patient and Family Advisors (PFAs) have collaborated and engaged with staff across the hospital including committees, working groups, hiring panels, patient education reviews, and capital redevelopment projects, just to mention a few.

The overall structure of the quality program certainly reinforces accountability. With a Board Quality Committee providing governance oversite, there is a nice roll-up of information from program specific quality committees. All Committees incorporate a PFA, with this focus across the organization bringing immense value to NYGH.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The survey team had the opportunity to meet with members of the organization that provide ethics support both internally and externally to the organization. North York General (NYGH) retains the services of the Health Ethics Alliance (HEA) for ethics expertise. The HEA is a multi-partner ethics service providing clinical, organizational, and research ethics support to the members of the alliance. A very strong Research Ethics Board (REB) is also in place, ensuring that the organization can continue in its leadership role in this important area.

Materials shared relative to the REB were reviewed and the organization is commended for the leadership role it is playing in research. Large community hospitals play a key role within the clinical trials space and NYGH is committed to advancing in this area. The NYGH REB requires all members of the REB and all researchers to complete the Tri-Counsel Policies Statement (TCPS) tutorial with documentation of completion managed by the Research Ethics Office. Structures and processes in place are very much driven by ensuring the rights of the patients and families are foremost in any decisions. The organization is also commended for how they specifically engage clients in discussions around clinical trials and are congratulated for having an engaged and committed team in this area.

NYGH has used the I.D.E.A. clinical ethics framework for over 10 years within their organization. In support of organizational ethics, the Accountability for Reasonableness framework is used to assist in decision making. On review of the framework, it does provide the organization with a step-by-step, fair process to help guide healthcare providers, Leaders, and the Board of Directors in working through ethical issues. It has been used to guide decision-making from the bedside to the boardroom. Front line staff gave examples where they used the Framework to help them work through an ethical issue. The team also reported that Medical Assistance in Dying (MAID) has been used over 70 times in the past year and anticipate that this number will grow when amendments to the legislation are passed.

The ethics frameworks are provided to all new staff at orientation sessions. The framework is also reviewed with the Board of Directors, the Clinical Chiefs as well as frontline staff at regularly established rounds.

The HEA collects (non-identifiable) data on all aspects of its work: clinical, research, organizational ethics consultations, policy involvement, debriefing sessions, ethics education and academic contributions. The annual report is presented annually to the Board of Governors, Senior Team, Leadership Forum and is also posted to the Intranet.

Overall, staff are remarkably appreciative of the Ethics support provided.

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)

Surveyors met with representatives of the "Communications Team," including Health Records, Privacy, Information Services, Chief Information Security Officer, Professional Practice, Patient Family Advisor, Patient Relations, OHT representative, Planning, Analytics, Physicians, Clinical leaders, eHealth, and Communications. From the outset, the diversity of the team was noted however the focus was clear – ensuring the right information is available to all who need it in a timely and transparent manner.

Over the last several years, North York General Hospital (NYGH) has made eHealth an organizational priority. Strategic investments in health information technologies and meaningful clinician adoption of these technologies have improved the quality and safety delivered at NYGH.

It was clear that the organization's philosophy is to view everyone as communicators. They have the tools in place and the right communications philosophy to make this a reality and always ensure that the messaging utilized reflects the diverse population both working at and supported by NYGH.

There is a very clear and strong commitment to transparency within and outside the organization. The organization's website is comprehensive, with significant amounts of information available. Ongoing reviews of this occur, with additional information being made accessible on an ongoing basis.

An important corporate communication plan is in place to cover the major projects namely the introduction of the North York Toronto Health Partners OHT, Virtual Platforms, My Chart, new Strategic Plan, capital development plans. These showcase the activities of the clinical and research areas, to promote the patient and family focused care approach and commitment to safe patient care to both internal and external stakeholders. The team commented on how responsive the communication team was, faced with Covid-19 and adapting to the ever-changing messaging requirements.

The hospital has established a comprehensive privacy protection framework of physical, technical and administrative safeguards to protect personal health information. It includes privacy, data protection and record retention policies, mandatory annual privacy and security training and confidentiality agreements for staff (contract or permanent), physicians, volunteers and students. All researchers are required to complete “Privacy & Security Fundamentals for Researchers” training before submitting a research study proposal to the Research Ethics Board.

All major groups, from the governing body to clinicians, have the information they require to track activities and outcomes in a timely way and in a format that allows this to happen.

The team had a good discussion on the preparedness of NYGH to respond to Cyber threats. Lessons learned from neighboring GTA Hospitals has informed NYGH's Cyber Security Program. In addition to cyber security audits, policies and procedures, tabletop exercises, a "Ransomware Play Book" was developed with the assistance of consultant group.

The annual communications plan, approved by the Board of Governors, outlines key communication objectives including engagement of staff, physicians, volunteers and learners and enhancements to community engagement.

The Community Stakeholder's meeting confirmed that the organization is very open with its communication, with all feeling that they can access information required.

The team is congratulated on the HIMSS Davies Award and the successful rollout of the eCare project.

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)

Although from the exterior, NYGH looks like a relatively new hospital it is comprised of areas built in 1968 and in 2000. The building is well maintained and clean. With the North York General Foundation's generous help in fundraising the hospital has refreshed areas such as the chemo clinic and the new paediatric ward and clinics which are modern facelifts of older hospital units.

There was a Master Plan for further redevelopment submitted to the MoHLTC approximately 16 months ago and planning for a new tower is moving forward. There is also an infrastructure renewal plan which includes transformer replacement, roof upgrades and boiler room upgrades to name a few. Green initiatives have also been undertaken which include LED light replacement, recycling initiatives and a current waste audit to determine additional opportunities. The team is proud of being recognized through an award in the decrease of energy consumption.

There are redundant systems in place at NYGH to support service interruptions like power and water. The areas that house environmental services, engineering, materials management and shipping/receiving are well organized and although this is the oldest physical area, it is clean and well maintained.
Air flow management in the OR is contracted out to manage air audits and OR air flow compliance.

Security is a contracted service managed through the NYGH management team and security upgrades continue to be completed, the most recent in exterior door locking. The parking structure has external management but is maintained by the hospital for maintenance needs.

Overall, the team is proud of the work they do to support the clinical services in the provision of quality care and service.

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)

There is a very comprehensive and detailed emergency preparedness plan for the organization. There is an interdisciplinary Emergency Planning Committee comprised of 19 members including a Patient and Family Advisor. Although the committee is large, this new structure which was put in place approximately 18 months ago has allowed them to make changes and approvals to the emergency plan manuals in a more efficient and timely manner.

Debriefing post incident is a regular practice for the organization where input and feedback from staff and stakeholders are shared with the Emergency Planning Committee and used for making improvements to their emergency plans. Code Silver and Code Purple were added in response to recent events in the community. A standardized debriefing tool for communications has been developed as one of the outcomes from the analysis and debriefing of events. Recently, tool kits have been developed and can be found on every unit. The new tool kits include details on roles and responsibilities, as well as the conference bridge number that is dedicated to establishing the Command Centre within 10 minutes on during the day and within 20 minutes during the night.

The Emergency Management Team shared many examples of where they have implemented the Incident Management System successfully. Together with their GTA partners, NYGH participated in a large-scale simulation of a Code Orange in November 2019. On an annual basis, NYGH partners with the fire department to do an on-site mock Code Red to test the internal fire response systems including the activation of sprinkler system. Cyber security table-top exercises testing the IT systems have been done collaboratively at the federal, provincial and city level. In addition, there was a cyber attack approximately two months ago where a virus impacted the hospital servers. The organization is to be commended for their prompt response. Fortunately, the virus was quarantined to two servers and the hospital only lost 24 hours of data.

NYGH has a Business Continuity Plan to support recovery efforts following a disaster. The plan contains the five most critical functions, namely HR, Power, Water, Medical Gases and Clinical Applications. The Plan outlines procedures to support the hospital to ensure these functions are maintained. In addition, Information Services and Facilities have developed comprehensive downtime procedures for the applications and systems they support.

Staff are required to complete an annual online training program that includes a review of all the codes which is found on the “My Learning Edge” platform. There is a code of the month training program. Staff safety is recognized as a high priority for the organization with a corporate Workplace Violence Prevention Committee and they are congratulated on achieving an 80% completion rate for staff training. An external partner, Strategy Risk, is used to provide nonviolent crisis prevention training according to the level of patient contact provided by staff. The staff acknowledged and appreciated the training and support they received to prepare themselves for handling all types of emergencies including the Covid-19 outbreak.

The organization’s prompt response to Covid-19 was evident when they initiated their Emergency Operations Committee in January 2020. All the programs ensured that their pandemic plans were up to date and teams refreshed their sections following the guideline changes made by the Ministry. The organization is commended for their leadership in their response to minimizing the spread of the virus and to sharing their knowledge and expertise with their community partners. As the organization is moving into Phase 2 of Covid-19, the team is mindful of the mental and physical toll on staff and physicians and the importance of ongoing support being available with a focus on their well-being.

Priority Process: People-Centred Care

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

North York General Hospital (NYGH) has truly embedded Person and Family Centered Care (PFCC) within the culture of their organization. This is no small endeavor. It is supported across the organization from the Board of Directors to frontline care providers. The new Strategic Plan 2020 to 2025 (Thinking Beyond) describes being a "Patient-Centered Care Innovator" as an enabler to the "People Come First in Everything We Do" pillar. This is at its core a person-centred organization.

The staff demonstrates a genuine understanding of People-Centred Care principles. Embedded in their practice is a real appreciation of the value in educating patients and families on their role in self-management, the importance of patients feeling comfortable asking questions, and the respect due each patient for having unique needs, preferences, perspectives, hopes, and fears.

Patients and staff spoke without exception of having worked together to create goals of care. Staff spoke of their commitment to meeting patients at this level in every care encounter not because they had to, but because it was the right thing to do.

There are currently 43 Patient and Family Advisors (PFAs) in the organization. The PFAs undergo an extensive orientation. There are ample opportunities for continuing education via workshops, talks, eLearning, conferences etc. They are not only included on over 80 committees, such as the Quality Committee of the Board and unit-based Quality Committees, but in addition, they have recently been assigned to a clinical team.

The PFAs are a significant influence in the delivery of patient and family centred care at NYGH. They are committed to making a difference to their community by providing important feedback and input into hospital processes and care delivery opportunities. The Partners reported that their influence at the hospital is real—they are not treated as simply a "token voice" of patients and families but rather—that they are providing meaningful influence that is making a difference. Many examples of the work in which they have been engaged was shared during the impressive meeting with PFAs. Some of these include hospital planning and operations during the pandemic, such as Virtual Care which recently helped co-design educational videos for patients receiving chemotherapy.

The Survey team consistently heard how the PFAs were part and parcel of the work that the clinical and administrative teams were doing. At the governance and executive levels, plans, policies etc. were asked to be sent for more patient input before they were approved. The PFAS reported that the language that is now being used by leaders and staff/physicians reflecting the influence of the partners work. However,

they acknowledge that there is still work to be done at the delivery of care level where the true partnerships of patient/family and care provider occurs. This will take more time and education to reinforce how to truly build effective frontline relationships so that patient and family centred care principles become embedded in care delivery models.

North York General has taken an important step in connecting patients to their health information with the launch of MyChart™. Providing free online access to health records 24/7, patients can now easily view test results, clinical reports, and other health information.

NYGH has expanded their ability to offer Virtual Care in collaboration with the Ontario Telemedicine Network (OTN). The move to adopting this technology proved invaluable as the Organization responded to the Covid-19 pandemic.

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)

Constant and consistent communication channels are the hallmark of patient flow at NYGH. Electronic bed status reports, bed tracking, daily Covid-19 dashboards and business intelligence aid in the management of beds in the Emergency Department (ED) and throughout inpatient services.

Additional to the usual staff such as physicians and allied health team members, the ED the team also includes GEM nursing, mental health crisis nursing and a dedicated medicine physician. The use of medicine physicians at the ED/inpatient interface allows the team to determine strategies to support ED admission aversion of patients using outpatient management, quick care and testing and community services.

The team speaks of an all-in approach to surge and patient flow from the clinical teams to the human resources department. The success of flow in tight times is attributed to the whole hospital becoming focused and involved.

The teams continue to work on barriers to flow. A pilot initiative with Bayshore Health for 20 ALC beds and a direct access project are focused on ALC waiting for long term care which remains one of the larger barriers to hospital flow.

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 MDRD is a centralized reprocessing service for all areas of the hospital. The endoscopy area is on another floor but governed by the MDRD management and staff team.

There is a direct link between the OR and the MDRD area and they have dedicated elevators for dirty and clean equipment moving between these areas. In the scoping area the scope cleaning room is adjacent to the scoping rooms with a clean and dirty side for reprocessing of scopes.

The engagement and pride in the MDRD team is palpable. The attention to detail in their reprocessing work is clear and the communication with associated services enhances both patient and employee safety. The procurement of equipment engages all staff in a transparent and fair manner.

The team has worked towards standardized trays and custom packs for procedures which are accepted by the whole peri-op team. There is an OR product standardization committee with a multi-disciplinary team for any new purchases. There is an opportunity to enhance safety and mitigate patient risk by implementing an electronic instrument tracking system and should be considered for a leading hospital such as NYGH.

Education and training are ongoing including for when new equipment is purchased and processed through the MDRD area. Equipment requiring repair is tagged for internal or external repair support. The biomedical team is a partner in the peri-op area and work towards resolution or replacement of purchased equipment.

Overall, the MDRD area is a strong, knowledgeable and an enthusiastic team supporting patient care at NYGH.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: 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		
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The teams at the Baruch Weisz and Orthopedic Fracture Clinic are the largest of the approximately ten clinics within Ambulatory Care Program. They have very clear goals and objectives that align with the strategic planning goals of the organization with plans to refresh these with the newly launched strategic plan. The clinics have well defined criteria for referrals.
The clinics show a commitment to involve clients and families in service delivery by trying to match demand and supply in their programs. This evidenced by staff members making appropriate changes to

the scheduling of appointments to accommodate timely response times and reduce wait times. There is a strong sense of teamwork and leadership support to deliver high quality care to their patients. Staff feel engaged and heard. Members of the team show pride and enthusiasm in what they do. The work space is clean and well organized.

Priority Process: Competency

In both clinics there is strong culture of an interdisciplinary team approach including unit secretary, nurses, educators, students, physiotherapists, orthopedic technicians, team attendants, residents, physicians, wound care nurse and nurse practitioners just to name a few. There is a positive and strong working relationship with Diagnostic Imaging, the Medical and Surgical Programs and Genetics. Both clinics demonstrated a commitment to collaboration, teamwork and highlight the importance of communication within and outside of the department in order to provide high quality care. The performance evaluations of staff are completed every two years. In addition to the orientation program for all new recruits, there is annual mandatory core curriculum mandatory training and this includes infusion pumps, codes, and Workplace Hazardous Material Information System (WHMIS).

Priority Process: Episode of Care

All clinic patients receive a complete assessment which includes risk for falls. Staff members are knowledgeable about the needs of their multicultural population of patients and have access to a translation line for patients presenting with different languages. The team completes a best possible medication history (BPMH) on all patients and medication reconciliation is carried out at admission, every clinic visit, transfer points and at discharge.

Priority Process: Decision Support

The team effectively shares patient information with other service providers with the appropriate completion of patient records and well documented assessment tools. A paper based charting system and documentation is being used. This means that if the patient is admitted to an inpatient unit, the record cannot be seen by the inpatient staff until after the paper based chart is scanned by health records. In addition, the paper based system makes data collection, tracking and the monitoring of indicators including wait times and “no shows” more challenging. The organization is encouraged to move the Ambulatory Clinic programs onto the electronic system.

Priority Process: Impact on Outcomes

The clinics have goals and objectives which are measurable and specific. While the goals and objectives are visibly posted, staff identified that a huddle board would be helpful to post the quality and safety indicators that the team is tracking as a source of information for discussions among the team.
All staff members are aware of the incident reporting system, SLIP, and appear to have no reluctance to report and, in fact, understand the importance of reporting.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

OLA rating

Priority Process: Diagnostic Services: Laboratory

The Laboratory Medicine Program has a well established quality management system. The program meets the Institute for Quality Management in Health Care (IQMH)standards, an international laboratory accreditation where they achieved 99% in 2019. They have both clinical and anatomical pathology with phlebotomy, specimen processing and laboratory information systems (LIS). Since their last Accreditation, they have undergone modernization of some of their LIS equipment. They have changed the platform for blood collection and are now using bar scanning handheld devices, and they also recently automated their core lab services. They are to be commended for rolling out the implementation during a very challenging time with COVID.

The staff and physicians are committed to quality and sustaining a strong quality management system. Staff and physicians are actively engaged in regular reviews and process improvement efforts focused on opportunities. There are currently 10 pathologists who monitor their corrected reports and any discrepancies. The pathologists are open to peer review and meet daily to discuss any cases that are complex or challenging.

In the core lab, a strength is their commitment to working collaboratively with their clinical stakeholders to improve turnaround times. Turnaround times are closely monitored in real time with color coding at their work station in the lab.

The Quality Management Committee meet every two months, with a number of subcommittees. The subcommittees are made up of interprofessional team members who meet at regular intervals also focused on quality within the divisions of the Lab Program.

The Transfusion Safety Program is congratulated for meeting national benchmark for "choosing blood wisely". Staff were proud of their collaborative team approach where they feel like they work like a family and their main goal is patient care and safety.

Standards Set: Cancer Care - 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.	
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 Cancer Service is a provincial leader and Cancer Care Ontario (CCO) award winner in care access and treatment, both medically and surgically. The team speaks of an integrative care model within the program and in partnership with community and hospital partners. There is a strong buy-in across the program for program planning and design for current and future patients supported by DI, genetics services, pathology, the Foundation and family physicians.

The program includes inpatient services with a strong palliative care approach, as well as clinics for breast and other care modalities including pain/symptom management.

Priority Process: Competency

Education and training for all clinical providers is a strong focus in the Cancer program. CCO initiatives include MCC tumour rounds, a focus on the need for certification for nursing providing chemo care, and standard training for regime and protocol use.

Priority Process: Episode of Care

There is a strong approach to teamwork on the unit and in the outpatient chemo clinic. Patients speak of being well-informed in their care and care plans and speak of the kindness of all health professionals in their care. The team is diverse with the hope that an addition of a benign hematologist could round out the team for patients not requiring cancer care but still requiring timely care.

The pharmacy service is a core team member and a resource for staff, physicians and patient/families. Patient family advisors (PFAs) are a strong resource in quality improvement initiatives. The program supports research and clinical trials and have primary investigators on the team. In addition, the program indicates that "the system works" with good co-operation and support from other hospital departments including DI.

The program is aware that cancer care is a rewarding yet stressful service and a new program is being rolled out in late November called "Wellness Wednesdays" to provide care for the care givers.

Priority Process: Decision Support

There is an electronic medical record in the inpatient care area and an electronic documentation tool for outpatient systemic chemo care. The staff like the electronic system and indicate, once learned, it is easy to use to document and organize patient care. The inpatient records allows for fall documentation, pressure ulcer monitoring and other ROP management with prompts and reminders.

The roll-out of bar scanning of lab draws and medications support safe patient care practices from ordering to completion of blood or medication administration.

There is a large focus on the use of data in this program to inform care focus and program direction. The team are leaders in CCO metrics!

Priority Process: Impact on Outcomes

Performance indicators from both CCO and within the program monitor success in care and flag opportunities for improvement. There are operations and quality/safety committee structures that support decision in care and potential change initiatives.

The team discusses ethical issues regularly and works with the ethical framework to support them in their

deliberations. The team regularly reviews patient outcomes and treatments to improve both individual care as well as that of the larger cancer patient population.

Priority Process: Medication Management

The pharmacy works in strong partnership with the cancer program. A newly designed satellite pharmacy in the chemo suite allows for easy access and good communication between team members in the administration of chemo therapies.

A drug utilization committee supports the program. There is support for self-administration of medications in the inpatient unit provided by the patient including medical cannabis. Medication reconciliation is electronically supported from admission to discharge.

Standards Set: Critical 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.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

Neonatal

NYGH has a 20 bed Level 2C Neonatal Intensive Care Unit. This is one of the largest NICU's in the Central LHIN. This program is well served with a knowledgeable professional caring group of staff. The team works collaboratively with SickKids Acute Care Service Transport Team and receives neonates requiring Level 2C care. Criticall is used to support necessary transfers for those neonates requiring a higher level of care. This program is supported with relevant allied health professionals.

Critical Care

The Critical Care Unit (CrCU) is a closed 21 bed unit that is Intensivists led. This Unit is combined with the Medical Program. The CrCU can surge to 24 beds. During Covid, 5 PACU beds were opened and converted to CrCU beds. Ventilators for the Central LHIN Region are housed at NYGH. Nurses, who use to be critical

care nurses and working elsewhere in the hospital, were recruited back to Critical Care to assist during the Covid pandemic.

There are 2 Enhanced Care Beds on the Medical Unit. Long term ventilated patients may be cared for in these beds and a quality initiative called Transitional Care Rounds ensures patients placed in these enhanced beds have access to the Critical Care resources for 48 hours post discharge from Critical Care.

This program is supported with strong leadership; Chief, Director, Manager, Educator and Coordinator. The Leadership team noted the CrCU program has a very cohesive, caring and collaborative team. A Patient Advisor works closely with the CrCU team and feels she is a true partner who is consulted and assists to make decisions e.g. condolence
cards, designing space, providing diaries to patients/families.

The leadership team focuses on recruitment and retention of the "right people". This team is strongly engaged in research, Choosing Wisely work and has developed a Brain Bundle. Medical Assistance in Dying and organ transplant procedures are assisted by the CrCU team.

Priority Process: Competency

NICU
This program has an Educator who is accessible to provide ongoing education and assess staff skill sets. This unit has an all RN staff and the staff to patient ration is dependant on the acuity and census of the unit.

This program is supported by an interprofessional team such as Occupational Therapists, Lactation Consultants, Dieticians, a Nutrition Technician, Social Work, Pharmacy and Respiratory Therapy, Paediatricians and Neonatologists. In speaking with patients, this connected group of professionals are meeting the needs of the young population they care for.

The position of Nutrition Technician was recently hired to prepare feeds in a controlled environment thus limiting the potential for cross contamination of fortifiers, powdered formulas and mixing equipment. This position enhance patient safety related to infant feeding.

Interdisciplinary rounds occur daily and include the parent(s). The team works towards discharge and provides parental education on "Miles to Discharge" which is an inclusive list of criteria or discharge. Follow up appointments and referrals are arranged prior to discharge.

Due to the diversity of the population this program serves, interpreters, staff who speak a foreign language and communicative tools are methods used by staff to enhance communication.

Critical Care Unit

This program is well supported with an allied health team. On a daily basis, the staff round on each patient. Allied team members felt their input and recommendations were valued and there was respect for each member of the team. Prior to Covid, family members participated in their loved ones rounds. During the rounds, the surveyor noted that concerns for the family members, children and siblings were part of the rounding discussions. The team is commended for their holistic model of caring for all members in a family unit.

Staff have scheduled performance reviews every two years. Staff who were orientating had intermittent reviews and discussions in regard to leanings and development within the program. It was noted that the attitude and personality of an individual is equally as important as the skill set and experience at NYGH. Staff noted you can teach someone but you cannot as easily change one's attitude. This may be the reason that there is career longevity of staff in the organization and the underlying cause for the cohesive, collaborative teams.

The Manager, Educator and Coordinator of this program are visible and provide daily support to the team.

Burn out and fatigue may become an issue for staff working in this area, particularly with the added stress of Covid-19. It is important for leadership to monitor staff to ensure their health remains intact.

Priority Process: Episode of Care

NICU
The scope of this unit includes stabilization and management of neonates post 30 weeks gestation or older, short term invasive and non-invasive ventilation, surfactant administration insertion and care of invasive lines, TPN, advance feeding protocols and care by parents.

Staff and physicians feel they have good equipment and enough equipment to provide necessary services to their patients. They understand the capital acquisition processes and noted they have opportunities to request new equipment.

A Neonatology Hospitalist Model is used to provide coverage to the NICU. The Paediatricians and the Neonatologist collaborate to provide coverage and back up support for oncall.

The program uses Donor milk and a new position of Nutrition Technicians was recently created to ensure the safe handling of breast milk, labelling and storage. A Lactation Consultant is available and there are a sufficient amount of breast pumps.

There are courtesy rooms(within NICU) available for parents to room in while their baby is in the NICU. Parents are appreciative of this rooming option. A room is also set up for parents who are preparing to take their baby home. The baby will join the parents in this room and the parent will care for the baby while the NYGH staff act as support -only if necessary.

Critical Care Unit

Critical Care Unit

The Critical Care Team has developed strong partnerships with their external partners. This benefits their patients and ensures accessibility to pertinent care e.g. pacemaker and ICD implantation, progressive weaning and vascular surgery.

A 24/7 Critical Care Response Team (CCRT) was rolled out in 2006 and is comprised of an interprofessional team (MD, RN, RT). The CCRT follows up with all patients post discharge from CrCU. The CrCU "de-intensifies" the patients in preparation for discharge from the Critical care unit by gradually removing oxygen, tubes, ECG leads etcetera. Also a pamphlet entitled "leaving the Critical Care Unit" is provided to patients and to assist in the transition.

Critical Care Nurses are in the process of training for hemodialysis. Several nurses have successfully taken the necessary training and this service is available to patients who require dialysis.

The program works closely with the Ethicist and ethics in-services are provided to staff. Staff were familiar with the ethical framework. Each profession at NYGH has a Professional Practice Lead and each clinical unit has a Nurse Practice Council.

The equipment is routinely checked by bio-med, vendor or staff who have expertise.

Priority Process: Decision Support

NICU and Critical Care Unit

Electronic documentation is used and is accessible at the bedside. Staff have taken a privacy course and understand the significance of privacy. There is a process for patients to access their charts.

Priority Process: Impact on Outcomes

NICU
A quality board is used to post quality measures. The monitoring of Cerebral Function Monitoring was introduces in September 2020.

An interprofessional team which included patient advisors recently developed a discharge check list called "Milestones to Discharge".

Patient safety incidents are discussed and used as learning opportunities. Work Place Violence education is mandatory for staff and Zero Tolerance Signage is posted on the unit.

Staff have used the ethics framework to work through palliative scenarios (as an example). They will include the ethicist where necessary to assist with the process. The NICU team also works with the

SickKids Palliative Care team, the hospitals Spiritual Care Services, social workers and child life specialist to assist with palliative and bereavement care. Staff noted NYGH has programs to assist staff in dealing with both palliative and bereavement.

Critical Care Unit

Member of this program are heavily involved in research which benefits the organization and the community at large.

There are several Quality Improvement initiative in progress. These QI
initiatives have been identified a areas for improvements within the department and are meaningful to the performance of staff. As with other programs in the organization with quality improvement initiatives, sustainability needs to be monitored.

Priority Process: Organ and Tissue Donation

The Trillium Gift of Life Network meets 3 to 4 times per year and with key stakeholders such as surgery, ICU, ED, CNE, PFA, Ethicist, and TGLN representative). This program receives monthly validation reports which include the missed opportunities for a donor.

In 2019 NYGH had 2 organ donors which led to 7 transplanted organs and tissue donors. The organization has an annual "be a donor month" activities. There are "Hidden Heroes" who work diligently to enhance the philosophy of organ and tissue donations.

NYGH policies for organ and tissue donations are based on TGLN's and modified to fit the practices and culture of NYGN. In 2019 NYGH received the TGNL Provincial Conversion Rate Award for exceeding the 63% conversion rate.

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

The Medical Imaging Department conducts over 200,000 exams/year on a 24/7 basis for a catchment of approximately 500,000 people. This is an all modality department including general imaging, CT, MRI, U/S, interventional radiology and nuclear medicine. There are approximately 20FTEs of physicians that are committed to teaching, research and peer learning/review. Besides a robust and engaged physician group there are technicians, nurses, reception, booking and other staff that support patient care in all modalities. The challenge of this and other hospital departments at NYGH will be the potential for an increase in retirements due to people re-assessing their life choices due to the pandemic.

The department have been recognized as pioneers with many new initiatives (e.g. breast cancer cryo-ablation). The ability to develop new diagnostics and treatments has catapulted them to the status of a leading edge service. Besides clinical diagnostics and treatment the department is invested in leveraging information technology and systems to enhance connectivity to improve the quality of care (e.g. embedding a clinical EMR into MRI).

Although the ED and early pregnancy clinic physicians conduct U/S testing in their departments the Medical Imaging Department sets the standards and quality assurance for this out-of-department testing. Out of department PICC line insertion in ICU is occurring and a program for insertion of PICCs in general inpatient wards is underway.

There is a well defined process for booking and registering patients in the department and a process for no shows and late patients to the testing area. In addition, there is an e-referral project for family physician referral.

Standards Set: Emergency Department - 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.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Emergency Department (ED) is one of the highest volume EDs in the province with over 100,000 visits per year. The team uses a predictive analysis approach to determine community trends that will impact future ED care. An increase in mental health and addition service patients has challenged the department to serve this vulnerable clients group and find supports both inside and outside the hospital. The COVID pandemic has also challenged their usual triage process by having to decant triaged patients to a COVID assessment area outside but adjacent to the ED if they have potential exposure and/or symptoms.

There is a need to prioritize the Emergency Department for urgent redevelopment. Given the high volume of patients the areas that are used to support patients in a safe, comfortable environment are now cramped and congested. As the ED is used for both children and adults the challenge is to serve the needs of very different patients in the same space. Although the ED staff have tried to be creative in their space use it remains inadequate for quality care. In the short-run there is a need to review the ED space and adjacent spaces to look for opportunities for a smaller in-house redesign/redevelopment initiative to accommodate the patients and health provider teams while they wait for the larger redevelopment plan.

Priority Process: Competency

All requirements related to certifications, training and continuing education are met through on-line and in-person group and/or one-on-one assessment. In addition to yearly skills reviews and on-line testing, there is a focus on rapid infuser use, paediatric resuscitation and other skills not used on a regular basis. The hospital supports external certifications in both time and funding for staff which includes ACLS and PALS certification for example.

Performance reviews are approached with a self assessment and learning objectives approach and subsequent manager staff discussion and review.

Priority Process: Episode of Care

The ED care path from triage to admission with care transition or discharge and follow-up is throughly addressed in the ED. Ambulance off-load is efficient and the paramedic service speak highly of the ED care team.

With the COVID pandemic the department has implemented a quick triage for disposition into the department or to the external COVID screening tent followed by a more comprehensive triage in either area. Triage and ambulance offload documentation is supported through an electric charting tool.

There is a strong patient-family advisor presence with active roles in care design, new staff hires and physical plant redesign. The department seeks out funding opportunities through the MoHLTC and other sources to pilot new initiatives in care.

Priority Process: Decision Support

The ED has a mix of electronic (triage) and paper documentation with a roadmap for the implementation of an Emergency medical record for staff and physician documentation. The team uses evidence-based care guidelines/protocols and medical directives.The department uses data to direct their care models and new initiatives.

Given the large ED volume in a physical footprint for a much smaller number the department struggles to provide privacy and confidentiality in care. As the ED is the "front door" of the hospital there is a need to prioritize redevelopment to this area to meet the demands of the community now and in the future.

Priority Process: Impact on Outcomes

The ED team uses data to support their care in the achievement of the highest standards in care. The department is a leader in P4R and other metrics that are important to safe and efficient ED care.

Staff and physicians are well trained and aware of the inherent risks and safety concerns in the department. The staff speak of incident review and improvement strategies and safety reviews post events. With the increase in mental health and addiction presentations additional time has been spent in Code White review, de-escalation strategies and increased team communication.

Patients and families speak highly of the department of the care they receive despite an incredibly cramped environment.

Priority Process: Organ and Tissue Donation

There is a policy and procedure for organ and tissue donation. Patients are identified as potential donors which starts the process. Staff articulate that families are more aware of organ/tissue donation than in the past and are more receptive to considering this option.

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 Infection Prevention and Control team is well established and highly regarded at NYGH.

The team is praised for the leadership, and expertise that they have provided both within and outside of the hospital during the COVID-19 pandemic. They have provided over 184 infection control practice training sessions to over 2000 staff, developed a volunteers training package, and weekly Infection Control Town Hall sessions led by the Medical Director during the peak periods of the pandemic were all highly valued by the organization. Through the hub and spoke model, team members are sharing their knowledge and expertise to support 9 long term care homes, 13 retirement homes, 40 congregate settings and five shelters. The organization can be proud of the partnerships developed and the collaboration with community partners.

The Infection Prevention and Control committee is composed of a very collaborative interdisciplinary and interdepartmental team including Environmental services and Occupational Health. Together they ensure there is an integrated and comprehensive approach to infection prevention and control throughout the organization.

They provide 24/7/365 coverage and members deeply value the support within their team for support and back up. Team members are assigned to units and support one another in completing audits. Team members are committed to quality improvement initiatives such as "cleaning of mobile shared equipment".

A patient and family advisor has been added to the Infection Prevention and Control Committee and this is seen as a valued addition to the team.

The team has led a very successful "Hand Hygiene Hero" campaign. Hand hygiene audits are completed monthly by the units and posted on the intranet, ERIC.

The team has developed a comprehensive antimicrobial stewardship program to assist with surveillance activities and support appropriate practice and proactive management of patients with infectious diseases.They closely monitor and track admitted patients with C.diff. Pharmacists are part of the team

and assist in management of admitted patients. The program has successfully expanded from the Intensive Care Unit to the inpatient Medicine Program.

There is a strong relationship with the capital projects team beginning from the design stage through to the completion of a project, small or large.

The infection control team is strong, however, as we move into Wave 2, the organization is encouraged to monitor the support that the infection control team provides to staff members and leadership to encourage work-life balance and to manage fatigue and stress.

Standards Set: Inpatient Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Medicine program is a big part of NYGH occupying approximately 49% of inpatient beds. There is also numerous clinics to support outpatient care. There is a full compliment of 70 acute physicians including GIM, sub-specialities, and hospitalists. As well as a full compliment of nurses and allied health the patient family advisors play a key role within the program.

The Pediatric Unit is comprised of twelve beds and two short stay beds. Newborns and up to eighteen years of age are admitted to this unit. Eating disorder patients can be admitted up to 19 years of age. The short-term beds are designated for patients who require one to 4 hours of care. These beds support surgical short stay pediatrics cases, those needing a transfusion and the Emergency Department during surge situations. The team noted that there has been an increase in eating disorders during the Covid pandemic while there has been a decrease in respiratory infectious diseases due to social distancing.

In partnership with the Clinical Genetics team, NYGH provides comprehensive services to support Genetic Terminations up to 23 weeks and 6 days.

This program is supported by approximately 10 hospitalist Pediatricians, who also support the NICU, Pediatric Ambulatory Clinics and L&D programs. The Pediatricians enjoy the complexity and variety of services offered by their department. Medical Residence appreciate their experiences at this hospital site.

They noted their orientation is well organized and that they receive valuable education to support their learnings. A Medical Resident commented that for one hour each day a Pediatrician will provide a lecture on a relevant topic.

North York General Hospital sees a variety of patients in their Pediatric Ambulatory Clinic. Pediatricians and Subspecialist provide consultation and treatment services for a variety of diagnoses. There is an allergy clinic, bowel and bladder dysfunction clinic, dermatology clinic, gastroenterology, gynecology, neurology, respirology and rheumatology clinics.

A nurse is accessible in the clinic and she is able to follow up with patients between clinic visits or provide telephone advice when appropriate. Virtual visits have become popular in this clinic and consideration is being given to continue this practice post Covid.

The current Pediatric Clinic space is small and crowed. This clinic will be moving to a newly redeveloped space adjacent to the Pediatric Unit.

Priority Process: Competency

Staff and physician orientation occurs at the corporate, program and unit level. There is a robust education and training program as the program is diverse in its patient population. There is a mix of on-line learning modules, group huddle in-services and on-line resources which is supported by an program educator.

Staff performance is regularly evaluated with self-assessment, manager feedback and goal setting. Through orientation of new staff the manager meets regularly to review where they are in their learning curve and suggests areas for additional learning.

A Nurse Educator supports the Pediatric program. She ensures annual e-learnings are complete such as pump infusion education and mock codes. The staffing model is comprised of Registered Nurse and Registered Practical Nurse, who work to their full scope of practice. This program is also supported by allied healthcare providers such as Occupational Therapy, Physiotherapy and Respiratory Therapy. A Pharmacist works closely with the Pediatric unit and assists with BPMH and Medication Reconciliation processes.

Priority Process: Episode of Care

There is a standard process for gathering information about the patient upon admission and throughout the care journey. The use of patient care rounds, now held by MS teams technology, and standardized care provider handover allows the patient to feel confident in their care providers.

There is active discharge planning and the patient/families indicate they feel heard and are well informed of care options and the final plan. The entire provider team speaks highly of their colleagues on the units and their teamwork commitment.

A Child Life Specialist supports the pediatrics program and is recognized for her ability to support children and families/siblings with meaningful activities to help them cope with the challenges of illness, disabilities or death.

This department, which has secured access, also receives formed patients. Pediatric patients, who have overdosed, have access to Psychiatry and Social Work. Criticall is used to refer and transport critically ill children to SickKids. The Poison Control Center provides valuable support. The Ethical framework has been used to support ethical decision making and an Ethicist is accessible to this program. The parents or significant family members are involved in the care of the patient during hospitalization. It was noted by the Pediatric Team that prior to discharging a patient, clear and safe follow up plans are arranged and communicated to the patient and family.

The team feels they have enough equipment and noted that the Foundation provides great financial support to their program.

Pediatric patients who were interviewed by the surveyor stated that they “felt respected by the team” and found staff from all disciplines to be “friendly and welcoming”. Family members felt informed and were comfortable asking physicians and staff questions.

Priority Process: Decision Support

An electronic medical record supports all documentation from admission to discharge. As well, the record includes all treatments and tests along with risk assessments appropriate to the patient population. Documents from the Emergency Department are scanned in to complete the health record.

There is a good flow of information amongst the health provider team and with the patients/families. Patient/family meetings support care planning and transitions from the hospital for post acute care as required. There are strong community links that supports care in the community.

In the paediatric area, the staff use computers on wheels. The staff feel supported by the Decision Support team.

Priority Process: Impact on Outcomes

The team is directed by evidence-based guidelines, research and decision support data. The team uses the data to guide their practice. A new COVID dashboard was designed by clinicians with the decision support team. As the medicine patient population has a large seniors component safety is of utmost concern both in the program and in transition planning. Incidents are reviewed by the team to look for opportunities for care changes to better meet the needs of all patients in their care.

The Pediatric Team is extremely committed to quality initiatives and improving the lives of the children they serve. Data and outcome measures are used to make changes to practice.

The Pediatric team is pleased that in a two-week time period, the Pediatric Unit will be moving to a newly redeveloped space. The new space is bright, spacious and the privacy of the patient is respected. The tastefully family lounges and meeting spaces for pediatric patients are donned with washable furniture, Corian countertops and large whiteboards for children to use. The Pediatric Ambulatory Care Clinic will also be moving to an adjacent new space and is equally patient centered in its design.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
12.2 Medication storage areas are regularly cleaned and organized.	
Surveyor comments on the priority process(es)	
Priority Process: Medication Management	

The entry to the Pharmacy Department is locked with controlled access and monitored with cameras. There are four exits within the Pharmacy space. A Pharmacist is accessible 24/7.

A Medicine Safety Committee was recently formed and is comprised of an interdisciplinary team, including front line nursing staff, physicians and patient representative etcetera. This committee reports to the Pharmacy and Therapeutics committee who reports to Medical Advisory Committee.

The program uses their electronic medical record for Computer Provider Order Entry with over 900 evidence-based power plans (order sets).

North York General Hospital (NYGH) has a committed Pharmacy team. Pharmacists have been decentralized to the clinical areas so that each program has an assigned Pharmacist who is there to support processes and provide guidance/information to the staff and patients. Pharmacy staff assist with the collection of BPMH and medication reconciliation information which has improved the completion rates and is currently at 99%. Medication Reconciliation at discharge is at 84% and the Pharmacy team is continuing to audit and educate staff.

NYGH has a robust Antimicrobial Stewardship Program and an allergy assessment process. There has been an 30% improvement in the correct documentation of allergies since this project was introduced. This program received an award for this work from the Canadian Patient Safety Institute and are encouraged to submit their allergy work to Accreditation Canada as a leading practice. They also received an Institute for Safe Medication Practice (ISMP) for their Opioid reduction project which directly impacts patient safety and addiction issues. Over the past three month an audit showed that opioid pill distribution for Cholecystectomy patients was reduced by 2,214 pills

The Pharmacy Department has outgrown its physical space. The space is cramped with equipment and furniture, and staff work in close proximity to each other. Corrugated boxes are delivered directly from the loading docks into the Pharmacy space. The need to increase inventory due to Covid-19 has made this space even tighter for staff to work in. There is also a need to have ergonomic assessment for staff

working in this area as some staff are bending to pick items out a container. Some desks appear low and keyboards incorrectly positioned. There is also an identified need to replace cloth chairs with chairs that have washable fabric.

There are numerous safety measure put into the preparation and distribution of medication management. The entire Pharmacy team is commended for their commitment to Quality Initiatives, evidence based research and best practices.

The Pharmacy Department has updated the Cannabis Guideline to address legalization of recreational cannabis. There are processes in place for the self-administration of medications including cannabis.

Risk Management projects managed through the Pharmacy Quality Committee in partnership with PFA's include: minimizing multi-dose vials, discharged without a prescription, contaminated equipment returns to pharmacy and parental preparations after hours.

Standards Set: Mental Health 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 mental health program is well integrated within and outside the hospital and provides a wide range of comprehensive services across the continuum including a 24/7 crisis program, 29 bed adult inpatient unit, 15 bed geriatric inpatient unit, 6 bed child and adolescent inpatient unit, numerous ambulatory clinics and day programs located across four sites. The team is proud of the recent opening of the Phillips House and their other offsite locations including the Champagne site. These offsite locations offer mental health care out of the traditional hospital setting into a therapeutic environment that promotes a positive patient experience. Additionally, the Champagne site is advantageous for patients as it offers free parking, accessible by TTC and is located on one floor.

There are plans underway to establish a five bed mental health zone within the Emergency Department that is purpose designed to promote a safe, physical environment for patients with mental health conditions. It is expected that this zone will be ready in the year 2023.

The mental health leadership team is extremely pleased that the newly formed Ontario Health Team, North York Toronto Health Partners will be working together to build seamless models of care for mental health. Work is already underway focusing on building wrap around services for patients with mental health and addictions, reducing wait lists and a centralized intake system.

Priority Process: Competency

The inpatient and outpatient programs are composed of a very collaborative interdisciplinary team including peer navigators and the Participants Council. Together they ensure there is an integrated and comprehensive approach to high quality patient care.
The performance evaluations of staff are completed every two years. In addition to the corporate orientation program for all new recruits, team members are provided with specific training to ensure that they have the appropriate skill sets to meet the needs of the mental health adult and child population. Training includes an overview of the Pinel restraints, and a two day violence prevention program. There is annual mandatory core curriculum mandatory training and this includes infusion pumps, review of codes, and workplace hazardous management information system (WHMIS). Recently simulated violence prevention training has been implemented and well received in collaboration with Security that includes role playing and case studies.
Team members are very proud to work in the mental health program and shared that their expertise is sought after by other programs to manage Code White situations and geriatric patients with difficult and aggressive behaviours. Peer navigator is a role established in the department for those who have lived experiences and is highly valued by the team for facilitating discharges from the Emergency Department.

Priority Process: Episode of Care

There is a faxed detailed report sent from the crisis workers in the Emergency Department to the inpatient services at the time of admission. The patient is accompanied by security to the unit. As a safety measure, patients are assessed by two nurses and a detailed care plan for each patient is developed. Regular rounding by staff decreases patient anxiety and preempts the escalation of patient behaviours in the care environment. Patients are monitored for self harm and suicide risk. Staff all wear safety pendants, Vocera. There is also panic buttons located in various locations on the units as an added safety measure. Recently, there have been renovations of shower rooms and introduction of stringless patient gowns. While the bathroom doors swing both ways, the doors to the patient rooms do not. In addition, the doors have hinges which may also pose as a safety risk. It is recommended that a robust environmental risk assessment be undertaken of the inpatient units.

Priority Process: Decision Support

Following the COVID outbreak, the team is commended for finding creative ways to rapidly introduce virtual care. The day hospital program has reestablished patient volumes at about 60% (20 patients) of their normal capacity (35 patients). The adult eating disorders program was not interrupted by COVID and they successfully continue to offer virtual care three evenings/week. Through virtual care, they have been able to offer services to patients outside of the catchment area.
With the support of their decision support lead, the program regularly uses data to monitor and evaluate their services as a means of improving quality of care. The Ontario Perceptions of Care (OPOC) data is collected to measure patient satisfaction. The leadership team reviews the Common Data Set on a monthly basis and quarterly report is shared with police. In keeping with the Ontario Mental Health Reporting System, the data being collected through the Resident Assessment Instrument was reviewed in

detail by the team to ensure the information collected accurately reflect the level of care received by individuals receiving inpatient mental health care.

Priority Process: Impact on Outcomes

The mental health program is commended for its attention to quality outcomes. They have implemented a Quality Huddle Board, maintained by four staff together with the educator. They have established a Program Quality Committee as well as a Quality of Care Incident Review Committee with a core team of staff who identify trends and issues for making improvements to care. Case conferences are held with presentations made by psychiatrists. These are seen to be very useful and very educational.
The Participant Council, which is made up of individuals with lived experiences has been in place for over 25 years at NYGH. Members of the council are considered an integral member of the team. They have an office at the Champagne site, and have actively engaged in programming with patients including the Hearing Voices group, cognitive behavior treatment for patients with psychosis. Their input is highly valued and their feedback has led to numerous quality improvement including the introduction of patient identification arm bands and the surgical safety checklist in the outpatient Electroconvulsive Therapy program.

Based on patient and family feedback, in the absence of having restricted visitors during COVID , an evening program has been implemented by the recreation therapist.

Standards Set: Obstetrics 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 Maternal Newborn Program is the second largest single birthing unit in Ontario with approximately 5000 births per year. The Maternal Newborn team describes themselves as a collaborative team. Together they feel they identify and tackle issues to improve the quality of care and outcomes for the patient. Midwives and Family Practice Obstetrical Care providers feel connected and that they are valued and an important part of the team. NYGH received a Hospital Integration award for their inclusive work with Midwives.

Patient Advisors and volunteers are recognized for their input into the functions of the unit and for assistance with various programs such as the Cuddle program. They act as advocates for patients and have direct input into policy and practice development. This Maternal Newborn program provides a comprehensive patient-centered service for mother and child care.

Priority Process: Competency

The L&D is staffed with an all RN staff and the post-partum unit has a mix of RNs and RPN's.

Staff has access to e-learning modules and required learnings. Since Covid-19, educations sessions have occurred virtually using various forms of technology. The Maternal Newborn staff participate in the MORE OB program.

Performance appraisals are completed once every two years and staff find the feedback and input provided by the managers is valuable to their professional development.

New staff feel they have adequate orientation and are mentored by senior staff. Learning plans and feedback is used to assist with learning needs. Educators support this program and are visible and available to staff. Staff have direct access to education related to neonatal and obstetrical urgent/emergent cases and fetal health surveillance. A SIM lab is located on the unit and is accessible to all staff for hands on learning. Virtual learning is used and has become more popular since Covid-19. It is important to note that many of the staff have been working in the Maternal Newborn Program for numerous years and are committed to remaining on this unit. They noted that it is a great place to work.

Nursing staff have large skill sets and are capable of working in many areas of this program; L&D, C-section Operating Room as scrub or circulating nurse and Post Anaesthetic Care Unit. The staff are commended for their ongoing learnings and sustaining competencies in all of the Maternal Newborn service areas.

The team offers a comprehensive bereavement support program to patients and families. NYGH has a Perinatal Psychiatrist who supports the Late Loss Support Program and the Post-Partum Depression Support group. A bereavement kit is provided to the family following a stillbirth.

Priority Process: Episode of Care

The Maternal Newborn program is a Level11C Obstetrical and offers high risk delivery services for planned deliveries 30 weeks gestation and older. The team works collaboratively with Criticall when transferring or receiving Obstetrical patients and/or newborns.

There are 16 L&D rooms, 3 Operating Rooms (one has been turned into a Covid-19 OR), 3 recovery bays and 6 triage spaces. All Maternal Newborn activities are in close proximity to one another. The programs are supported by an interprofessional team such as Occupational Therapists, Lactation Consultants, Dieticians, a Nutrition Technician, Social Work, Pharmacy and Respiratory Therapy, Paediatricians, Neonatologists, Anaesthetists, Obstetricians/Gynaecologists, Maternal Fetal Medicine Specialist, Family Practice Obstetrical Care Providers and Midwives.

Due to the diversity of the population this program serves, interpreters, staff who speak a foreign language and communicative tools are methods used by staff to enhance communication.

There is a need from an Infection perspective to remove the wood items from L&D's and other patient care areas. It is recommended to consider a practice with staff on how to safely remove moms and babies from the unit or building should the need arise.

Patients were pleased with the care provided during and after the delivery of their baby. Patients were taught the self-adminstration of analgesics and documentation processes.

Skin to Skin is practiced immediately after the baby is born.

Priority Process: Decision Support

The Electronic Medical Record is optimal communication tool and used by staff to assist with the transfer of patient information. There are processes in place should a patient wish to review his/her chart.

All staff receive privacy education.

There is a disclosure policy and there is a process on disclosing information to a patient.

The staff were familiar with the downtime processes and where the hard copy forms were located.

Priority Process: Impact on Outcomes

The program is engaged in several Quality Improvement Initiatives. As an example, the management of Post-Partum Hemorrhage and the Management of Hypertensive Disorders in Pregnancy were identified as areas for improvement. All staff were included in the work of these Quality Initiatives and could speak to the tasks and outcomes associated with these.

For the Post-Partum Hemorrhage carts were created and are located in post-partum spaces and didactic education occurred. Audit and data analysis is occurring with results showing favourable results. As with all QI initiatives, it is important to monitor and sustain the progress that has been made.

Daily safety rounds occur.

Standards Set: Perioperative Services and Invasive Procedures - 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.	
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 Surgical Program is supported with a Program Director, Chief of Surgery, Chief of Anaesthesia, and several Clinical Team Managers. There are three Clinical Nurse Educators who support the Peri-operative areas and the Inpatient Units. There is an identified need for one more Clinical Educator. There is a Nurse Practitioner(NP) who supports the Acute Pain Services and another NP who supports the inpatient Orthopedic program.

Leadership and front lines staff noted that they were a collaborative team who worked together to provide the best care possible to the patients they served. They described themselves as a "community" in the hospital and external to the hospital. Prior to Covid, the Peri-Operative team would join together to attend baseball games, OR Xmas parties, Rally Walks or go to IKEA for an ice cream. It is evident that this staff work as a team and have a supportive peer approach.

The team is proud of patient flow and the initiatives they have put into place to ensure the elective and

emergent cases can proceed. An Access To Care Team was developed and the physician from this team will attend daily rounds to assist with discharges and discharge planning, and to assist with inpatient flow.

The Chief of Surgery creates the Operating Room Schedule well in advance, so that surgeons may schedule elective cases in a timely fashion. To date (not including the Covid period), no elective cases have been cancelled. There is sufficient staff in all areas of the peri-operative program and no rooms have closed due to staffing issues. There are plans in place to ramp up the OR's so that Wait time targets can be met.

There is an OR dedicated to WSIB cases. There are weekly times slots allotted in the OR schedule for emergent cases and for each specialty e.g. ortho, general, plastics.

Priority Process: Competency

The Surgical Program is supported with interprofessional teams comprised of Nurse Practitioners, Registered Nurses, Registered Practical Nurses, Occupational Therapists, Dietitians, OT and PT, Speech & Language Technicians, Anaesthetist Assistants, Respiratory Therapists. A Nurse Navigator supports the Orthopedic program and assists those patients who require help to prepare for hospitalization, discharge from the hospital post surgery and arranging followup appointments. During these Covid times, leadership has increased staffing levels to support the surgical teams.

Staff in this program reported that they receive just in time feedback. Performance appraisals are completed once every two years. Staff complete mandatory e-learning modules and noted more learning has been completed using virtual technology.

New staff are support with a preceptor during orientation. Various staff throughout the surgical program have received recognition awards and were proud to share this with the surveyor.

The Operating Room, PACU and Daysurgery rooms were spacious and appeared to be well organized. The halls on the inpatient unit was crowed and could be a safety risk to staff and patients/families.

In speaking with staff in the peri-operative areas and inpatient surgical units, staff are familiar with Employee Assistance Programs and Zero Tolerance policies. Staff Workplace violence occurs more often with patients who have been sedated or have other health issues.

All staff working in the Operating Room must have their OR course and the PACU staff must have ACLS and PACU courses. The Surgical Team is familiar with the Ethics framework and could provides examples cases where the framework supported the decisions.

The Physicians attend Departmental Rounds, Divisional Rounds, Anaesthetic Rounds and participate in research associated with the University of Toronto. They also have morbidity and mortality rounds and discuss difficult cases and outcomes.

Priority Process: Episode of Care

North York General Hospital (NYGH) is a large teaching hospital with close affiliation with the University of Toronto.

NYGH provides a comprehensive range of surgical services to the community such as; General Surgery, Plastic & Reconstructive Surgery, Gynecology, Ophthalmology, Vascular, Urology, Orthopedic, Pediatric Dental, Oral & Maxillo-facial Surgery, Cystoscopy, Endoscopy and Bronchoscopy. At the Consumer site, Cataract surgery, non-cataract surgery and cystoscopies are performed. This site opened in 2020 and was not visited during this survey.

Major Thoracic, Cardiac and Vascular surgeries are referred to local hospitals. There is a surgeon with privileges at NYGH who will perform some thoracic surgery at this site.

The Surgical Program participates in and has implemented numerous Quality Based Procedures and have 15 to date. To ensure resource efficiencies, standardization of instruments, drape packs and other supplies have occurred. Case costing was used and the program is meeting their efficiency targets. They have been able to obtain a Nurse Navigator with the revenue from the ongoing QBP work.

Bundle Care has been created for Knees, Hips and Shoulders. NYGH has a strong focus on gastro-intestinal surgery in the surgical and cancer programs. In 2019/20, 184 colorectal cases, the largest number in the Cental LHIN were performed at NYGH.

Due to Covid-19, the Wait Times for Hips & Knees, Cataracts has increased. Cancer case remain a priority and the wait times remain stable. The surgical program is working diligently to meet case volumes and wait time targets.

Surgical Safety checklist and surgical pauses are consistently used. There is a flash autoclave in the Operating Room and it does get used, however staff were familiar with the documenting process in the patients health record and the incident reporting that is required.

The Operating Room, PACU and Day Surgery rooms were spacious and appeared to be well organized. The hallways on the inpatient units were crowed and could be a safety risk to staff and patients/families.

Priority Process: Decision Support

The Surgical Program uses an electronic health record which is supported by the Decision Support team. The electronic chart is an excellent tool for internal communication between departments and staff.

Patients who are transported to a referral center often have a hard copy of their chart accompany them. A verbal Physician to Physician and Nurse to Nurse Transfer of Accountabilities occur between hospital sites.

A verbal transfer of information is given by the anaesthetist and nursing staff to the PACU nursing staff.

Staff are up to date on their privacy training.

Priority Process: Impact on Outcomes

The Surgical Program staff is dedicated and works diligently on QI initiatives. They are particularly proud of the two below QI initiatives.

1) The Surgical Program is supported by an in-depth regional anaesthetic program. They have increased their total blocked patients by more than 35% since inception of this program.

2) This program was also involved in the Opioid quality initiative in an effort to decrease opioid utilization postoperatively. The team is congratulated on the successes of both these initiatives.

The leaders and staff of this program are to be commended for their ongoing quality initiatives which align with the goals and objectives of the program and the strategic direction of the organization. It is important to monitor progress and sustainability in QI initiatives.

Priority Process: Medication Management

The Anaesthetists are required to sign out narcotics from the Automated Dispensing Cabinets and are accountable for the returning of discarded medication. Nurses will only sign out medications on the anaesthetists behalf during an emergency.

Medications are secure in the peri-operative areas. Solutions are appropriately stored. Crash carts are strategically located throughout the peri-operative area and in the Day Surgery /Endoscopy area. The Pharmacy Department provides a tray exchange for each anaesthetic machine and replenished the crash cart trays when used.

The medications placed on the sterile tables were labeled and double checked.

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

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

The organization has met all criteria for this priority process.

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

The laboratory team makes a concerted effort to continually improve laboratory result turnaround times with the goal of minimizing requests for, or need of extensive Point-of-Care Testing (POCT) services. This approach has proven effective as there is only three point of care services at North York General Hospital. There are effective systems in place to ensure education of users and access to devices. As well, there are processes in place to monitor integrity of quality control checks.

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Episode of Care
Transfusion Medicine services supports the conservation of blood products through regular monitoring and management of their blood products.
Priority Process: Transfusion Services
The lab has a well established procedures for the use of blood and blood by-products. There is a transfusion safety officer in place and their goal is to reduce transfusion reactions and are commended for meeting national benchmark for choosing blood wisely.

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.

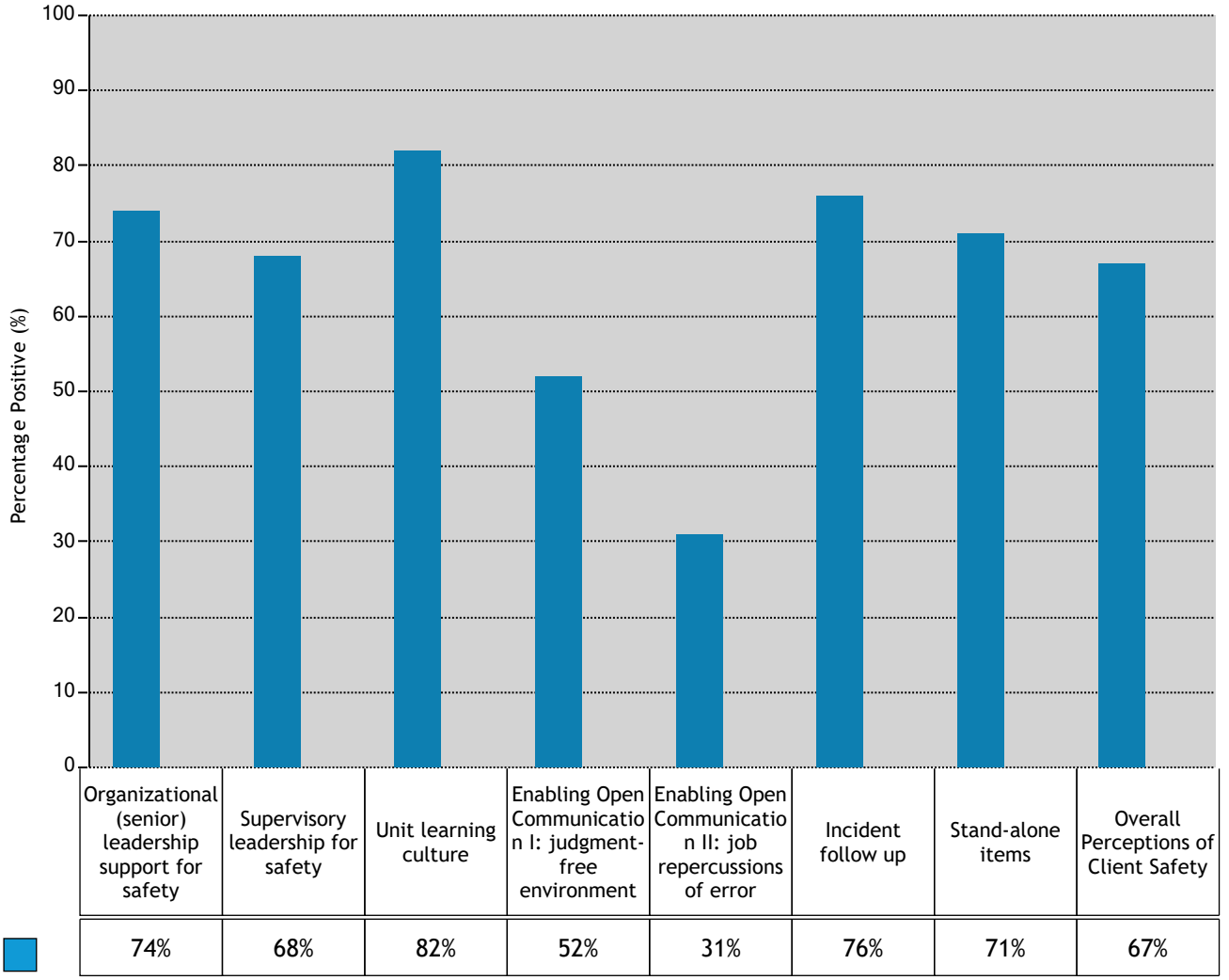
Canadian Patient Safety Culture Survey Tool

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: October 31, 2018 to December 5, 2018**
- **Minimum responses rate (based on the number of eligible employees): 329**
- **Number of responses: 477**

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
74%	68%	82%	52%	31%	76%	71%	67%

Legend

North York General Hospital

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.

The organization used an approved substitute tool for measuring the quality of worklife but did not provide Accreditation Canada with results.

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.

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