ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Prepared for:

Frontenac Community Mental Health Services

Kingston, ON

On-site Survey Dates:

May 8, 2011 - May 11, 2011

May 25, 2011

Accredited by ISQua

Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Frontenac Community Mental Health Services.

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

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Frontenac Community Mental Health Services only. Accreditation Canada does not release the Report to any other parties.

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

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About the Accreditation Report

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

Legend

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

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

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

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

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

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Frontenac Community Mental Health Services

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

On-site survey dates	May 8 to 11, 2011
Report Issue Date:	May 25, 2011

Accreditation Decision	Accreditation with Condition (Report)

Locations

The following locations were visited during this survey visit:

1 Administration Services, Substance Abuse & Problem Gambling Services, Vocational Services
2 Clinical Services
3 Residential Services

Service areas

The following service areas were visited during this survey visit:

1 Addictions/Gambling
2 Community-Based Mental Health Services

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Frontenac Community Mental Health Services (FCMHS) has much to celebrate. The organization has witnessed significant growth and expansion. Change has been supported by a strong value base, a highly competent Board, strong and respected leadership and a competent, experienced and committed staff. The values of the organization were developed to reflect the lived experience of clients as well as best practice.

FCMHS is supported by a visionary Board, which values the development and protection of purposeful and highly supportive relationships both internal and external to the organization. This has contributed to the solid reputation that the organization holds in the community and with staff. The organization's partners report that the Board and leadership are consultative and solution focused. Many staff have made a long term commitment to the organization and fully embrace the philosophy of the organization.

The Board, leadership and staff have worked hard since their previous accreditation survey. In the last survey, two Required Organizational Practices (ROPs) were identified as not being met. FCMHS has been successful in meeting both these ROPs in this survey demonstrating a commitment to ongoing service delivery improvement as well as a commitment to staff and client safety. The strategic directions set by the Board identify an ongoing commitment to ensuring client safety in the provision and delivery of services.

A safe and healthy workplace is identified as a strategic goal. Strong oversight at the Board level as well as the development of comprehensive planning documents and programs support that direction. The human resource (HR) plan identifies a comprehensive training plan for all program areas as a key initiative, ensuring that staff feel competent in performing their roles and responsibilities. Supporting staff to attain certification in the Psychosocial Rehabilitation approach has as well, been identified as a key initiative. The development of the Professional Advisory Committee will provide support to staff as they respond to an increasingly complicated client group.

FCMHS is committed to the identification, prevention and management of risk. Oversight is a responsibility of the Board, leadership and staff at all levels in the organization. The development and implementation of the Risk Management Committee and cross representation across committees including the Joint Health and Safety Committee supports due diligence across all programs and at all levels in the organization. Occurrence reporting, staff incidents reports, prospective analysis, prevention maintenance reports, emergency drills and analysis, along with sound financial management reports and the continuous quality improvement plan support the Board and leadership in planning and moving forward to strengthen and to do it better wherever possible. The Risk Management Plan for 2010 and 2011 will support due diligence at the Board and leadership level.

The Board and leadership value staff and are committed to open communications and strong partnerships with staff as the organization moves forward. This is evidenced in the commitment to develop a coaching culture across the organization. A communication plan has been developed to guide the Board, leadership and staff in moving forward. The Board and leadership are equally committed to client input, as evidenced in the Client Advisory Committee and client participation in governance.

Frontenac Community Mental Health Services has demonstrated an ability to adapt and respond to changing environments. Success has been supported by effective consultative processes and consistent and effective oversight. In the immediate future FCMHS will face new challenges that will require a strategic change management plan. This plan will need to include a review of vision, mission and values; the identification of clear roles and responsibilities; good business plans; comprehensive service delivery agreements; and, ongoing oversight.

New challenges will include the expansion of services to support an increasingly highly complex client group as well as the first collective agreement for the organization. There are risks associated with the expansion. These include: availability of funding to support development of the clinical expertise required to manage and respond to clients with complex needs; availability of adequate housing and maintaining the current reputation of flexibility and responsiveness that the organization has in the community. A review of the values, mission and the current strategic plan would assist the organization to identify and plan for the impact of the expansion and a newly unionized environment.

While the organization has made an admirable effort in the identification of risk to client and staff safety, and while there are several planning documents in place that support services, there is a need to develop a consolidated and integrated client safety plan, which is readily accessible and easy to read.

Other initiatives that have been identified which will support the change process include the development and implementation of a professional development team and enhanced decision support via a revised score card.

Going forward the organization is well positioned to respond to the challenges and the risks that have been identified. The caution for the organization is to remain true to the values that have guided FCMHS historically and which have been identified by the clients, staff and its partners as the fundamental strength.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

The accreditation process has continued to be very valuable to our Agency in recognizing our strengths, identifying areas requiring further development, and enhancing our quality improvement continuum.

We recognize that efforts continue to be made improving the quality of the services we provide to the community. We also acknowledge that there are areas that require further improvement, and we will continue to make improvements in those identified areas as well as building on the areas we are already doing well.

We look forward to working with Accreditation Canada on our quality improvement journey.

Overview by Quality Dimension

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	40	2	0	42
Accessibility (Providing timely and equitable services)	19	0	1	20
Safety (Keeping people safe)	100	4	12	116
Worklife (Supporting wellness in the work environment)	55	0	0	55
Client-centred Services (Putting clients and families first)	52	5	1	58
Continuity of Services (Experiencing coordinated and seamless services)	14	2	0	16
Effectiveness (Doing the right thing to achieve the best possible results)	190	6	4	200
Efficiency (Making the best use of resources)	21	0	0	21
Total	**491**	**19**	**18**	**528**

Overview by Standard Section

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

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	89	2	0	91
Effective Organization	102	1	3	106
Customized Infection Prevention and Control	45	1	1	47
Customized Managing Medications	44	0	2	46
Community-Based Mental Health Services and Supports Standards	127	8	0	135
Substance Abuse and Problem Gambling Services	84	7	12	103
Total	**491**	**19**	**18**	**528**

Overview by Required Organizational Practices (ROPs)

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

Criteria	Required Organizational Practices
Community-Based Mental Health Services and Supports Standards 9.7	The team assesses and monitors individuals for risk of suicide.
Community-Based Mental Health Services and Supports Standards 17.7	The team informs and educates individuals and families in writing and verbally about the individual and family’s role in promoting safety.
Substance Abuse and Problem Gambling Services 15.4	The team informs and educates its clients and families in writing and verbally about the client and family’s role in promoting safety.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

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

Findings

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

Planning and Service Design

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

Surveyor Comments

Frontenac Community Mental Health Services has experienced extensive and progressive change. Change has been supported by a strong value base; a highly competent Board inclusive of clients; effective leadership; and, strong consultative processes. Today, FCMHS has both a solid reputation in the community and a spectrum of services to support the individuals, families and community partners that look to the organization for support. Ongoing consultation processes both internal and external to the organization support ongoing review and evidence based program expansion.

The organization has a mission statement, a vision and a statement of values developed with input from leadership, staff, clients and stakeholders. The extensive involvement of the Client Advisory Committee is noteworthy. The mission, vision and values are available on the website and across the organization.

FCMHS is guided by a visionary Board. Board oversight is supported by a highly diversified skill base, extensive and timely reporting processes and sound governance processes and policies. Score boards have been designed and implemented to measure the quality of services. Planning documents support communications and the monitoring of anticipated outcomes. Notable examples include: the strategic plan; the risk management plan; the client safety plan; the communication workplan; the information technology plan; and, the human resource (HR) plan. The governance body is focused on promoting quality services. The focus on quality is supported by: timely and comprehensive financial statements; client and staff safety reports; service delivery updates; occurrence reports; direct access to the input of clients with client representation on the Board; and, an engaged client advisory committee.

There is a strong commitment to and investment in leadership training.

The voice of staff is sought via consultation processes, surveys and staff meetings.

FCMHS has demonstrated the ability to adapt and respond to changing environments. Success has been supported by effective consultative processes and consistent and effective oversight. In the immediate future, the organization will face new challenges that will require a focused change management plan. Those challenges include the expansion of services to include a highly complex client group and the first collective agreement for the organization. The size of the proposed expansion along with the level of clinical complexity that the expansion will bring, together with the newly unionized environment will have both anticipated and unanticipated outcomes. There are risks associated with the expansion, which include: availability of funding to support the development of the clinical expertise required to manage and respond to clients with complex needs; gaining access to adequate housing; and, maintaining the current reputation of flexibility and responsiveness that the organization has in the community. A review of the current strategic plan would assist the organization to identify and then plan for the impact of the expansion and a newly unionized environment.

No Unmet Criteria for this Priority Process.

Resource Management

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

Surveyor Comments

Resource management at Frontenac Community Mental Health Services is supported by a highly competent and diligent Board. Resource management oversight is a function of the Executive Committee of the Board. The oversight functions of the Board are in turn supported by sound fiscal management and budget planning and monitoring processes, which are inclusive of all levels of management. Utilization reviews inform planning and the allocation of resources. There is a comprehensive asset management program.

Currently, FCMHS is experiencing resource management challenges, which are arising from ongoing collective bargaining processes and specifically, increased legal cost. Going forward, the organization anticipates and is planning for additional cost increases when the collective agreement is ratified.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

The organization is committed to the provision of quality services that are both effective and safe. The achievement of these strategic directions is supported by: availability of training and professional development; healthy workplace policies and programs; support for work life balance; performance review and ongoing consultation. Client and staff safety is supported in policy, with training and orientation as well as with team processes at the clinical level. The Risk Management Committee in consultation with the Joint Health and Safety Committee has completed risk assessments and developed action plans.

The organization is focused on the professional development of its leadership team members to enable them to be effective and responsive in addressing and supporting staff. This is critical, as staff are witnessing and having to respond to increased complexity in the client population. Going forward, the organization intends to develop a Professional Advisory Committee, which will be another level of support. professional development for staff a priority also, and includes program specific training as well as mandatory training on safety.

The Board is committed to ensuring that FCMHS is a safe and healthy place to work. Staff have received compassion fatigue training and going forward, the organization hopes to implement a train the trainer program to ensure maximum availability of the program across the organization.

The results of the Work Life Pulse tool have been analyzed and shared with staff to identify opportunities to expand and strengthen the organization's investment in a safe and healthy workplace. The investment in a healthy and safe workplace was evidenced in the supports being made available to staff. These include flexible work schedules, an employee assistance program, and mental health days. A wellness committee has been developed to ensure effective oversight.

The Board and leadership team is sensitive to the need to strengthen communications for ensuring the safe delivery of quality services. Staff are appreciative of efforts expended by leadership to strengthen communications. Staff have noted that leadership is more visible and consultative.

Performance evaluations are completed and position descriptions are updated.

Exit interviews are completed, which support the identification of opportunities to strengthen retention.

Going forward the Board and leadership are committed to building a learning culture. To that end, there is a strong investment in developing the coaching skills of the leadership team and ensuring that solutions are the focus of all issue related discussions.

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

Criteria	Location	Priority for Action
Sustainable Governance		
The governing body has membership policies that include term lengths and limits, meeting schedules and locations, and compensation.	5.3	
The governing body reviews the contribution of and provides feedback to individual members.	7.3	

Integrated Quality Management

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

Surveyor Comments

The Board and leadership of Frontenac Community Mental Health Services (FCMHS) is committed to the ongoing development and strengthening of its quality and risk management process. To that end, the Board has implemented a score card, which is populated and presented it for analysis at the Board on a quarterly bases. The score card has been designed to facilitate ongoing review of progress towards achievement of the strategic goals of the Board, and has been recently revised to ensure that the organization meets the performance expectations of the funder.

Quality and risk management is supported by the position of a Continuous Quality Improvement (CQI) Coordinator.

There is a Risk Management Committee whose purpose is to promote effective risk management across the organization. The committee reviews occurrence reports, identifies trends and develops action plans. The committee develops and provides summary reports to the Board. The membership on the committee supports a comprehensive integrated quality and risk management process. There is an annual risk identification survey process to update the risk management plan.

Client and staff satisfaction surveys contribute to the identification of program strengths and opportunities.

The FCMHS has identified continuous quality improvement as a strategic goal of the Board and leadership.

The Board and leadership are committed to ensuring that staff experience a safe and healthy workplace. The Strategic Communication Plan is evidence of that commitment, as is the work of the Risk Management Committee and the Joint Health and Safety Committee.

Going forward, the organization has identified continued investment in quality improvement and the management of risk. The development of the Required Organizational Practices (ROP) Compliance Chart, Strategic Communication Plan, revised Continuous Quality Improvement Plan and Risk Management Plan for 2010 and 2011 are evidence of a critically engaged Board and leadership team.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

The Board has demonstrated due diligence in ensuring that the values of the organization are honoured at all levels of the organization. Due diligence is demonstrated in the: posting of the values statement on the website; inclusion of clients as members of the governance team and in a strong investment in the promotion and protection of partnerships both internal and external to the organization.

Policies and processes clarify the role of staff working with individuals that have mental illness and all other clients of the organization. Staff are seen as advocates and ambassadors to the community and are expected to demonstrate to the community their respect for those they serve. The Board, leadership and staff have demonstrated a commitment to excellence in the delivery of services. This is supported by a strong belief in the importance of value based decisions, which reflect the organization's commitment to recovery as a primary direction.

Value informed and evidence based decision making is supported by a comprehensive ethics framework. The framework includes processes for reviewing the ethical implications of research.

No Unmet Criteria for this Priority Process.

Communication

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

Surveyor Comments

Frontenac Community Mental Health Services is supported by a visionary Board that values the development and protection of purposeful and highly supportive relationships both internal and external to the organization. The governing board is committed to strong oversight and quality services. The governing board and leadership are committed to transparency and a consensus based approach to change management and conflict resolution. This is reflected in and communicated in the vision, mission and values of the organization. The Board is diligent in ensuring that the Board, leadership and staff are respectful of the vision, mission and values, which support clients to achieve full and engaged membership in their community. To this end, strategic goals have been broadly communicated and made operational at all levels in the organization.

The Board and leadership are committed to supporting a culture that is open, transparent and highly responsive to emergent needs both internal and external to the organization. Partnerships and utilization of web based technology supports that direction. There is a commitment to the identification and implementation of technology and technical support capability, which will facilitate timely documentation and consultation. The Client Advisory Committee supports engagement of clients in the development of pertinent programs and services.

The FCMHS has acknowledged that the organization has work to do to ensure that staff and the community at large are fully aware of the operations of the organization. There is strong evidence of due diligence at the Board and leadership level to understanding the key issues and to addressing those issues. The Communication Plan, which was developed with the assistance of an external consultant, and supported by a work plan, is evidence of that commitment to moving forward and strengthening communications with both internal as well as external stakeholder.

The organization is valued in the community and by its clients. There is a proven record of highly effective partnerships and quality services, which reflect emergent needs.

No Unmet Criteria for this Priority Process.

Physical Environment

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

Surveyor Comments

The organization owns many properties around Kingston. There are maintenance staff available 24/7 to attend to the needs of these properties and their occupants. The failure mode effects analysis (FMEA) results concerning fire were implemented to ensure that all residents know the fire safety plan.

The site at 552 Princess St. is currently undergoing a renovation. Client, staff and visitor health needs are protected during this renovation. Preventive maintenance and safety is a priority for the residential properties.

The newly purpose built facility for affordable housing, which includes Independent Supportive Living at Lyon Street is an excellent example of use of environmentally positive, Leadership in Energy & Environmental Design (LEED) construction. The units are large, well equipped and secure.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

Oversight of the design, implementation and ongoing review of disaster and emergency preparedness plans rests with the Emergency Planning Committee. There is as well, cross appointments with the Risk Management Committee and the Joint Health and Safety Committee.

Drills are completed regularly and at all sites.

There is a pandemic plan in place, however, it is not integrated into the emergency and disaster plan.

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

Criteria	Location	Priority for Action
Effective Organization		
The plan identifies who is responsible for managing and coordinating responses to emergency situations during regular and off hours.	11.3	↑

Medical Devices and Equipment

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

Surveyor Comments

There is minimal equipment on site. Medical devices in use include stethoscopes, blood pressure cuffs and weigh scales.

No Unmet Criteria for this Priority Process.

Direct Service Provision

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

Findings

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

Community-Based Mental Health Services and Supports Standards

Clinical Leadership

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

Surveyor Comments

FCMHS has a strong history and a sense of pride in its delivery of mental health services in the region. A strength of the mental health services at FCMHS is the broad focus on recovery and the alignment with the overall organization's mission. Services are arranged along a continuum to prevent as much as possible a long wait time for Case Management and Assertive Community Treatment Team (ACTT) services. This is accomplished with a Coordinated Intake, Transitional Case Management, a Crisis Service and Mobile Crisis Team that is available 24/7 and relatively well resourced.

The dual diagnosis service is a key partner in the pressures and priorities table for the region. The addition of a newly purpose built "green" facility for these clients is an achievement and reflects good community relations.

A key strength is the involvement of the Executive Director in provincial and national highly visible groups for both mental health and addictions.

The addition of more culturally specific services might be welcomed.

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

Criteria	Location	Priority for Action
The organization has established processes and policies to meet the diverse needs of the community.	1.8	
The organization delivers, or partners with other organizations to deliver, mental health promotion sessions in the community.	3.3	
The organization participates in community events to raise awareness about mental health, mental illness, and concurrent disorders.	3.4	

Competency

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

Surveyor Comments

The implementation of workplace harassment policies and practices has been comprehensive. There is a commitment to professional development and training at all levels and the staff teams have utilized a "coaching" culture across the organization. This will assist with change processes going forward and will enable staff to become contributors to the changes in the workplace.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

There is a Client Bill of Rights that is used across the agency/organization. Staff provide this to clients in their information packages.

The Crisis Service and Mobile Crisis Team work effectively to bridge some of the system and capacity issues. This has resulted in better continuity of care for clients that are waiting for longer term services, ACTT, or Case Management.

The continuum of care that is offered is broad reaching. An opportunity for improvement would be to develop a bridging and/or step down level, for offering less intense services, so that clients may be supported as their needs change and they are working on recovery. This would increase the capacity of the more intensive services.

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

Criteria	Location	Priority for Action
The team assesses and monitors individuals for risk of suicide.	9.7	↑
The team assesses each individual for risk of suicide at regular intervals, or as needs change.	9.7.1	
The assessment is shared openly with everyone involved in the process, including the team, individual, family, and other service providers in a timely and easy-to-understand way.	9.8	
The team and individual and/or family jointly review the assessment on an ongoing basis.	9.9	

The team shares information with individuals and families about what to expect during a transition or at the end of service.	14.1

Decision Support

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

Surveyor Comments

The organization uses a combination of paper and electronic files. There is interest in moving more to an electronic file. The paper files are orderly, and are in individual binders with reference to where information resides in the electronic data system. The clinical record management system (CRMS) platform has recently been upgraded to provide staff with a mobile version. This is encrypted for privacy and permits the staff who work outside the office to provide input to the clinical record. This also assists the quality of service provided as timeliness is increased.

Staff meetings and team meetings frequently have evidence based practice as discussion items. The overall commitment to psychosocial rehabilitation and the use of national and international literature on evidence based practices is demonstrated by the involvement of the Executive Director at a national level and the contribution to research by members of the Board of Directors.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The organization has a strong process for the reporting and disclosure of adverse events both to individuals and to family members. This would be augmented by trending the data and using it for staff development and education.

A draft safety risk assessment tool has been developed to look at situational hazards, environmental hazards, and a safety assessment plan. This looks like an excellent tool that will have a great deal of utility once it is finalized, implemented and the results are used for education and problem solving.

A strengthening of the written information concerning the client and family role in promoting safety would add to the existing verbal efforts in this area.

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

Criteria	Location	Priority for Action
The team informs and educates individuals and families in writing and verbally about the individual and family's role in promoting safety.	17.7	
Written and verbal information is provided to individuals and families about their role in promoting safety.	17.7.1	
Staff uses written and verbal approaches to inform and educate individuals about their role in promoting safety.	17.7.2	
Individuals indicate that they have received written and verbal communication about their role in promoting safety.	17.7.3	

Customized Infection Prevention and Control

Infection Prevention and Control

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

Surveyor Comments

The organization has an Infection Prevention and Control (IPAC) Coordinator for residential and other services of the agency. Information dissemination seems very good, and is visible at all the sites that were visited by the surveyors. Coordination with the Victoria Order of Nurses (VON) and Public Health is helpful and utilized appropriately.

The staff that are in the community have a good sense of precautions and tools for infection prevention and control. The HR department coordinates the data upon reporting from individual staff and/or managers concerning clients. The Infection Prevention and Control Coordinator is provided the appropriate information from staff and/or managers. This information is tracked by the IPAC Coordinator. The HR Department collects the Infection Prevention and Control Tracking Form. All cleaning products in the organization/agency and in the residential and vocational programs are "green" products.

Scent free signage is abundant across the agency and in residential sites. Hand hygiene and cough etiquette reminders are placed in the residential sites and the clinical and administrative offices.

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

Criteria	Location	Priority for Action
Information provided to clients and families is documented in the client health record.	2.3	

Customized Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

Medication management is handled well by the RN's and the ACTT staff. The staff report an excellent partnership with Hunt's Pharmacy specifically. The pharmacy delivers several times per week, manages the sharps and pre-packages the medications. Medications are stored in a variety of effective and safe ways. There is a process for client self administration of medications and some clients are using this process successfully. In the Residential Programs, there is good tracking of all medications whether they are self or staff administered.

The requirement for two client identifiers is frequently a challenge with long term serviced clients. The teams have developed processes for identification but these might be strengthened in some settings.

The RN's report only one medication error in their memory. This was handled appropriately, with good monitoring of the client, consultation with the pharmacy and the physician, disclosure to the client and family and internal reporting.

No Unmet Criteria for this Priority Process.

Substance Abuse and Problem Gambling Services

Clinical Leadership

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

Surveyor Comments

The addiction and problem gambling services are new to FCMHS, as until about eighteen months ago the services were provided by another, separate agency in Kingston. The transition has involved many changes to work related issues for staff, and location changes for staff and clients. This has resulted in a comprehensive change process for staff at the Options for Change and Problem Gambling Program as well as staff and leadership at FCMHS. They appreciate the proposed name change to Frontenac Community Mental Health and Addiction Services. The involvement of a manager from FCMHS to transition the programs was helpful for staff and clients.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Since the Options for Change Program joined FCMHS, staff reported more access to training, professional development activities, enhanced interdisciplinary support and expanded supervision.

In order to achieve Bill 168 compliance, there have been some changes in the physical site, and for the program staff related to evening hours. Integration with other services is helped by the proximity of the Vocational Program. Other efforts at integration with mental health services would enhance client services.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

A challenge for this team is the lack of other services in the Kingston area to meet the needs of clients and families. Although detoxification services are available, many other services are only available outside the Kingston area.

The service would be strengthened by a more comprehensive and standardized assessment. The client/family orientation booklet is developing and is a useful tool for the clients and their families.

There is a quality improvement initiative for follow up with clients that is implemented and will be providing good information for service quality and planning.

Although there is not a formal comprehensive treatment plan at this time, the team is working to develop a process and plan that is useful.

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

Criteria	Location	Priority for Action
The team follows defined criteria to gather information from other service providers when deciding whether to offer services to a client or family.	6.7	
The team assesses the client’s physical and psychosocial health.	7.2	
The team works with the client and family to identify service goals and expected results.	9.1	
The team develops an integrated and comprehensive service plan for clients and families.	9.2	
The team shares the client’s service plan in a timely way with the client’s service providers, in accordance with privacy legislation.	9.3	
The team follows the client’s service plan when delivering services.	9.4	

Decision Support

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

Surveyor Comments

The team has received and appreciated the opportunities for training and education on information systems. The team is current with best practice and utilize these where possible. The team is enthusiastic about moving toward more learning and is accepting change very positively.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The changes in the past eighteen months have been significant for this team. The team has seen changes in many aspects of their practice and is continually developing, growing and expanding its focus on quality. The staff are committed and enthusiastic in their client work.

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

Criteria	Location	Priority for Action
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.4.1	

Performance Measure Results

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

Instrument Results

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

Governance Functioning Tool

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

Summary of Results

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
1	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	100	0	0	
2	We have explicit criteria to recruit and select new members.	88	0	13	
3	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	
4	The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5	Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	88	0	13	
7	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	88	0	13	

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
8	We review our own structure, including size and sub-committee structure.	100	0	0	
9	We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	88	0	13	
11	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	88	0	13	
12	Disagreements are viewed as a search for solutions rather than a "win/lose".	100	0	0	
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0	
16	Our governance processes make sure that everyone participates in decision-making.	100	0	0	
17	Individual members are actively involved in policy-making and strategic planning.	100	0	0	
18	The composition of our governing body contributes to high governance and leadership performance.	100	0	0	
19	Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	100	0	0	
20	Our ongoing education and professional development is encouraged.	88	0	13	
21	Working relationships among individual members and committees are positive.	100	0	0	
22	We have a process to set bylaws and corporate policies.	100	0	0	

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24	We formally evaluate our own performance on a regular basis.	88	0	13	
25	We benchmark our performance against other similar organizations and/or national standards.	63	0	38	△
26	Contributions of individual members are reviewed regularly.	50	0	50	×
27	As a team, we regularly review how we function together and how our governance processes could be improved.	88	0	13	
28	There is a process for improving individual effectiveness when non-performance is an issue.	50	0	50	×
29	We regularly identify areas for improvement and engage in our own quality improvement activities.	100	0	0	
30	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	75	0	25	
31	As individual members, we receive adequate feedback about our contribution to the governing body.	50	0	50	×
32	We have a process to elect or appoint our chair.	100	0	0	
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	88	0	13	

Patient Safety Culture Survey

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

Summary of Results

Number of survey respondents = 88 respondents

	A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
1	Patient safety decisions are made at the proper level by the most qualified people	12	12	77	
2	Good communication flow exists up the chain of command regarding patient safety issues	22	16	62	⚠
3	Reporting a patient safety problem will result in negative repercussions for the person reporting it	84	8	8	
4	Senior management has a clear picture of the risk associated with patient care	27	20	53	⚠
5	My unit takes the time to identify and assess risks to patients	5	6	90	
6	My unit does a good job managing risks to ensure patient safety	5	6	90	
7	Senior management provides a climate that promotes patient safety	10	20	70	⚠
8	Asking for help is a sign of incompetence	91	5	5	
9	If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	92	3	5	
10	I am sure that if I report an incident to our reporting system, it will not be used against me	20	16	64	⚠
11	I am less effective at work when I am fatigued	7	8	85	
12	Senior management considers patient safety when program changes are discussed	17	23	60	⚠
13	Personal problems can adversely affect my performance	21	25	54	⚠
14	I will suffer negative consequences if I report a patient safety problem	90	8	2	

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	A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
15	If I report a patient safety incident, I know that management will act on it	13	26	62	△
16	I am rewarded for taking quick action to identify a serious mistake	23	44	33	×
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	45	28	27	×
18	I have enough time to complete patient care tasks safely	13	16	71	△
19	I am not sure about the value of completing incident reports	71	14	15	△
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	76	12	12	
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	26	24	50	×
22	I have made significant errors in my work that I attribute to my own fatigue	91	8	1	
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	30	14	56	△
24	I believe health care errors often go unreported	37	33	30	×
25	My organization effectively balances the need for patient safety and the need for productivity	6	34	60	△
26	I work in an environment where patient safety is a high priority	4	19	78	
27	Staff are given feedback about changes put into place based on incident reports	31	22	48	×
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	13	15	72	△
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	17	21	62	△
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	11	11	79	

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A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	84	10	6	
32 My supervisor/manager overlooks patient safety problems that happen over and over	82	11	7	
33 On this unit, when an incident occurs, we think about it carefully	7	13	80	
34 On this unit, when people make mistakes, they ask others about how they could have prevented it	9	21	70	⚠
35 On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	7	9	84	
36 On this unit, when an incident occurs, we analyze it thoroughly	16	16	67	⚠
37 On this unit, it is difficult to discuss errors	69	17	14	⚠
38 On this unit, after an incident has occurred, we think long and hard about how to correct it	13	22	65	⚠

B. These questions are about your perceptions of overall patient safety	% Good/ Excellent	% Acceptable	% Poor/ Failing	Priority for Action
	Organization	Organization	Organization	
39 Please give your unit an overall grade on patient safety	70	28	1	⚠
40 Please give the organization an overall grade on patient safety	60	33	7	⚠

C. These questions are about what happens after a Major Event	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	5	23	72	⚠
42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	21	35	44	✖

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C. These questions are about what happens after a Major Event	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
43 Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	21	31	48	✖
44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	30	37	33	✖
45 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	20	22	58	⚠
46 Changes are made to reduce re-occurrence of major events	6	16	78	

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Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife, and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals.

Summary of Results

Number of survey respondents = 94 respondents

	How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
1	I am satisfied with communications in this organization.	32	24	44	✕
2	I am satisfied with communications in my work area.	14	16	70	△
3	I am satisfied with my supervisor.	15	11	74	△
4	I am satisfied with the amount of control I have over my job activities.	6	14	80	
5	I am clear about what is expected of me to do my job.	4	11	85	
6	I am satisfied with my involvement in decision making processes in this organization.	30	26	45	✕
7	I have enough time to do my job adequately.	15	18	67	△
8	I feel that I can trust this organization.	22	36	41	✕
9	This organization supports my learning and development.	9	26	66	△
10	My work environment is safe.	13	21	66	△
11	My job allows me to balance my work and family/personal life.	5	18	77	

	Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
		Organization	Organization	Organization	
12	In the past 12 months, would you say that most days at work were...	24	45	31	X

		% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
		Organization	Organization	Organization	
13	In general, would you say your health is...	47	43	11	X
14	In general, would you say your mental health is...	48	43	10	X
15	In general, would you say your physical health is...	47	41	12	X

		% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
		Organization	Organization	Organization	
16	How satisfied are you with your job?	89	9	2	

		% < 10	% 10 - 15	% > 15	Priority for Action
		Organization	Organization	Organization	
17	In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	78	16	6	
18	During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	86	9	5	

		% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
		Organization	Organization	Organization	
19	How often do you feel you can do your best quality work in your job?	3	20	77	

		% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
20	Overall, I am satisfied with this organization.	14	24	62	△
21	Working conditions in my area contribute to patient safety.	10	26	65	△

Appendix A – Accreditation Decision Guidelines

The key factor that Accreditation Canada uses to determine an accreditation decision is the degree to which client organizations comply with high-priority criteria and Required Organizational Practices (ROPs). *High-priority criteria* are criteria related to safety, ethics, risk, and quality improvement; *ROPs* are practices that must be in place to enhance client safety and minimize risk.

There are three possible accreditation decisions under Qmentum.

Accreditation	Accreditation with Condition (Report, Focused Visit, or both)	Non-accreditation
Issued when the client organization has:	*Issued when the client organization has:*	*Issued when the client organization has:*
Met 90 to 100% of high-priority criteria in each applicable set of standards AND	Met 71 to 89% of high-priority criteria in each applicable set of standards OR	Met 70% or less of high-priority criteria in one or more sets of applicable standards AND
Complied with all applicable ROPs AND	Failed to comply with one or more applicable ROPs OR	Failed to comply with one or more applicable ROPs AND
Submitted all required performance measure data	Failed to submit required performance measure data	Met 80% or less of the total criteria in all applicable sets of standards
*CSSS only: obtained 66.6% or more on all CQA indicator questionnaires	*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire	*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire

***CSSS (Centre de santé et de services sociaux)** clients in the joint Accreditation Canada/Conseil québécois d'agrément (CQA) program must also administer CQA's Client Satisfaction indicator questionnaire and the Employee Mobilization indicator questionnaire.

NOTES

Accreditation with Condition means the organization must meet conditions specified by Accreditation Canada to maintain its accredited status. The nature of the unmet criteria and ROPs determines the timelines for compliance (six or twelve months) and whether the organization must submit a report, undergo a focused visit, or both. If the conditions are not met within the timelines, Accreditation Canada may grant an extension of six months, based on surveyor input, proof of progress, and a plan to meet the criteria.

Failure to comply within the allotted time may result in accreditation being revoked, at the discretion of Accreditation Canada.

Non-accreditation: A non-accreditation organization may have its status reviewed six months after the on-site survey if it completes a focused visit within five months. The organization maintains its non-accredited status if the focused visit results are unsatisfactory.