ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Central Regional Integrated Health Authority

Grand Falls-Windsor, NL

On-site survey dates: September 30, 2019 - October 3, 2019

Report issued: October 25, 2019

About the Accreditation Report

Central Regional Integrated Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2019. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

Your Program Manager 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

Central Regional Integrated Health Authority (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

Central Regional Integrated Health Authority's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: September 30, 2019 to October 3, 2019**

  This on-site survey is part of a series of sequential surveys for this organization. Collectively, these are used to assess the full scope of the organization's services and programs.

- **Locations**

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

  1. Central Health Regional Office
  2. James Paton Memorial Regional Health Center

- **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. Leadership

- **Instruments**

  The organization administered:

  1. Governance Functioning Tool (2016)

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)	21	0	0	21
 Safety (Keep me safe)	31	0	0	31
 Worklife (Take care of those who take care of me)	44	0	0	44
 Client-centred Services (Partner with me and my family in our care)	16	0	0	16
 Continuity (Coordinate my care across the continuum)	2	0	0	2
 Appropriateness (Do the right thing to achieve the best results)	106	1	0	107
 Efficiency (Make the best use of resources)	21	0	0	21
Total	**241**	**1**	**0**	**242**

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	49 (98.0%)	1 (2.0%)	0	96 (100.0%)	0 (0.0%)	0	145 (99.3%)	1 (0.7%)	0
Total	**99 (99.0%)**	1 (1.0%)	0	132 (100.0%)	0 (0.0%)	0	231 (99.6%)	1 (0.4%)	0

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3

Summary of Surveyor Team Observations

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

Central Health is the second largest health region in the province providing services to over 177 communities. Recent challenges within the region have resulted in a robust strategic planning process being facilitated by new leadership. Chronic staff shortages including medical staff have presented significant challenges in recruitment and issuing of physician privileges. Much of the recent changes within the organization is being driven by a recent external review. Particularly, the organization has recognized the current challenges with physician credentials. In response it has developed solutions that will see changes that allow for greater input from Medical Staff and Board. There are several recommendations in the review which have been embraced by leadership and the Board. There are aggressive efforts by leadership to work on these recommendations. They are encouraged to continue with these efforts and develop an operational infrastructure and system that will prevent such future reviews from being unnecessary in the future.

A new CEO is in place providing leadership and support during this time of significant change. The leadership team works well together and endeavors to maintain a profile with staff in the various facilities. This is somewhat hampered by the location of administrative offices in a building separate from any health facilities. The leadership group is connected to external knowledge resources, staying current on all of the recent developments in health care across the country. There is a well developed Quality Plan in place and it is noted that the organization has adopted Lean methodology as the means to move its improvement initiatives forward. The organization has all of the elements of an integrated quality management system in place. The organization also has a well developed Patient Safety Plan in place and has done significant work on Peron and Family centered care and Patient Flow.

As part of this survey, a Community Partners Focus Group was established and met with a member of the survey team. Seven individuals representing a broad range of agencies and organizations were present. Representatives included: elected officials; representatives of the Alzheimer’s Society, Women’s Services, First Nations and others. There was evidence that these individuals feel passionate about their health services and appreciated the opportunity to have their voices heard. Many of the agencies represented indicated a good working relationship with the Authority.

References by the Community Partners were made to the recent completed review. Many of the recommendations that were made were welcomed, including open Board meetings and expansion of the role of the Community Advisory Committee’s. It was voiced that the Board and Senior Leadership should continue to take the recommendations seriously and continue to implement the changes suggested. Not withstanding the positive relationships, numerous opportunities for improvement were identified;

For women who may be reluctant to access services in a hospital setting, expanded outreach services would be desirable.

Communication professionals at the authority should look at the information that is circulated to ensure it is appropriate for the population served and not too wordy or geared towards a higher comprehension level than the intended audience.

In addition, not everyone has computers. As such, consideration should be given to utilizing more traditional forums for information sharing including churches, grocery stores and family resource centers.

Access to mental health services in Gander and specifically psychiatry was identified as an opportunity for improvement.

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)
The Board of trustees of this organization is reflective of the communities being served. They are an energetic, dedicated group of individuals committed to doing their part to facilitate the provision of quality care and services. The Board has been presented with many challenges and faces significant change within the health authority. They are commended for their support of the organizations leadership and the improvements being made. It is noted that there is a provincial process in place for the selection and appointment of Board Trustees. The existing Board provides input as to its needs and may even put forward names for consideration. The Board is encouraged to continue in its efforts to appoint Board members with the knowledge, skills and attributes necessary to fulfill their mandate. It is noteworthy that the Board does not have any significant, formal role in the granting of privileges for medical staff in the health region. It is noted with approval that changes to the process for the granting of privileges is currently being reviewed by the organization's leadership with a view to increasing the Board's role in this function.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization's leadership is currently undertaking its strategic planning process for 2020 - 2023. A thorough community needs assessment is being undertaken as well as a review of the organizations mission and values. There appears to be broad input from stakeholders including patient advisors. This is in keeping with Person and Family-Centered Care being the guiding principle of this planning cycle. There are planning templates in use for the organizations operational plans.
The active participation of the organizations Board of Trustees in the strategic planning process is noted.

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)

Central Health is a large authority spread across 43 sites. Mechanisms are in place to establish annual operating and capital budgets. Input is gathered from internal and external stakeholders. Budgets are established and approved by the governing body and ultimately the Ministry of Health. The current budget for Central Health is over 395 million with 3200 staff and physicians. Payroll is in excess of 230 million. All budgets are monitored, and variance analysis occurs on a regular basis. Variances are examined from a contributing factors perspective and staff and physicians are engaged for solutions. Central Health is in compliance with completion of annual audits and Ministry reporting requirements.

Like most health authorities in the country, the financial challenges are significant. With competing demands locally, including aging infrastructure and increasing demands for services, the challenges will continue into the future. It is recommended that the team develop a contingency plan to guide Central Health in the event of a larger financial crisis. A framework could be utilized, such that patient care is the last area to be impacted. Framework could incorporate revenue expansions, program efficiencies and utilization management considerations.

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)

Central Health has over 3,100 employees, geographically dispersed throughout a large region.

The HR Team has a good understanding of the demographics of its workforce and the impact on future recruitment. Over 90% of the workforce is unionized and attempts have been made to maintain and improve relationships with the Unions and this has translated into a reduced number of arbitrations.

The organization and Human Capital have adopted Patient Family Centered Care. Job descriptions now reference PFCC focus. Furthermore, selected management interviews now include participation from PFCC representatives which is commendable. The team is encouraged to continue to adopt new initiatives to engage patients and families in Human Capital processes.

A determined effort has been made to increase the number of volunteers throughout the region. To-date over 700 volunteers have been recruited and this is noteworthy.

As of September 1, 2019 a new EAP provider has been retained. This is good news for the organization. The Human Capital team is encouraged to monitor utilization. Furthermore, it is suggested that data generated from utilization help identify gaps and needs for future Human Capital planning priorities.

All employees of the authority have corporate email accounts which assists with communication and information dissemination. A new Learning Management System has recently been launched. With the new launch new modules offer the potential for expanded opportunities for continuing education.

A good system is in place to monitor workplace violence, utilizing PIERS. Examples provided were incidents that were reported and improvements made to reduce risk or exposure for staff.

Employee files are secured in two locations for the region. Tracers were completed on 15 personnel files, including speaking to three employees directly. Employees are content and indicated a positive worklife environment.

The team has identified a number of areas for improvement including employee engagement, succession planning, recruitment and retention, recognition, psychological health and safety and creating a respectful workplace. These are important priorities and the team is encouraged to formalize and develop specific plans for the priorities identified. The team also recognizes the challenges associated with performance reviews. An opportunity for improvement exists to ensure performance reviews are timely and consistently administered across the authority.

An external review was completed of the organization that identified significant challenges for the organization. Numerous areas for improvement relate to human capital. Some of these include: performance reviews; span of control; succession planning; quality of worklife; hiring processes and visibility of health resource leaders.
There is evidence this team and the organization has embraced the Review and solutions have and continue to be developed to the challenges identified.
Notwithstanding the above progress, this team is encouraged to continue to move forward and utilize the recommendations from the report to consider further changes.
In addition, Human Resources is encouraged to utilize up to date data to help develop solutions. The new EAP provider and the Quality of Worklife surveys would be good sources for current information.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
16.1 An integrated quality improvement plan is developed and implemented.	!

Surveyor comments on the priority process(es)

The organization appears to be well established in its quality journey. Leadership and the organization's Board provide direction and strong support for its quality management activities. The "Quality Assurance and Performance Committee" (QAPC) and the "Quality Improvement Oversight Committee" (QIOC) are responsible for the approval and monitoring of the organization's Quality Plan. There are well articulated quality and integrated risk management plans in place that provide substance to the organizations approach for these activities. The Quality Plan appears to be aligned with organizations strategic planning activities. It is also noted that the organization has adopted Lean methodology for the implementation of its improvement activities. This is modified somewhat by the use of the PDSA cycle in the "model for improvement".

The organizations IQM system also receives active participation from the Board. There are scorecards for several functional areas within the organization providing specific outcome measures to evaluate performance. There is a comprehensive inventory of indicators currently in use by the organization. A high percentage of them are structure and process measures. While this is an accepted norm the organizations Quality Committee is encouraged to identify measurable outcomes for specific improvement activities even if there is no intention of measuring them in the near future.

It is also noted with approval that there is a strong link between the organization's Quality Plan and its Patient Safety Plan.

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 organization has an established "Regional Ethics Framework" that outlines its components and utilizes provincial supports. The Ethics Committee has a terms of reference and tries to meet every 2 months. The committee uses education as a key component of the regions strategy on addressing ethical dilemmas. There is an Ethics Consultation Service available for the province located in St Johns. The organization's ethics infrastructure is connected to a provincial network of all the health regions. Guidelines, policy and frameworks have been developed to support and move the ethics agenda forward. It is noted with approval that a Patient Adviser is a member of the Ethics Committee. The mandate of the committee also extends to research related ethics.

However, there does appear to be a disconnect between the functions of the Ethics Committee and the ability of front line staff review and discuss possible ethic dilemmas before they are forwarded to the Ethics Committee for possible consultation.

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)

A comprehensive program exists for communication with both internal and external stakeholders.

An active website, newsletters, intranet, social media and other mechanisms help to ensure information is readily available. Information available including: Annual Report, External Report and Progress with Recommendations are available for the public.

Since the External Review, the organization has made improvements to help ensure stakeholders are better informed. Senior management reports are now available to internal stakeholders and Board Chair reports are circulated internally and externally.
It is suggested the communication team actively evaluate the effectiveness of current processes utilized for dissemination of information. More specifically, whether current media utilized are achieving the objective of reaching the broadest targeted audience.

The authority has good processes in place to protect the privacy and confidentiality of client information. Policies are in place to allow clients access to information in their health record.

Information management systems at this time are a hybrid of electronic and paper in the region. Discussions are happening to upgrade the current Meditec system and broader expansion of an electronic record and this is supported.
Within the region from a health records perspective the team has indicated a priority is integration and standardization.

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)

Central Health has a good team of professionals providing direction to ensure the physical space meets applicable law, regulations and codes.

Mechanisms are in place for meaningful stakeholder input. At any given time, staff are supervising upgrades to the facility, purchasing new equipment and co-ordinating major/minor construction projects.

Back up systems are in place, primarily for electrical in the two major Acute care sites. As referenced, under Emergency Preparedness, the team is encouraged to develop contingency plans in the event of loss of water supply to facilities throughout the region.

The team has identified as a challenge the aging infrastructure and competing demands for limited resources. Given the size of the region and the number of facilities, the need for current information to guide decision-making will remain important.

The team is recognized for the leadership provided in engaging clients and family in their decision making. Examples were provided in which clients are active participants in construction projects (ie parking redesign). The team has actively sought this input and incorporated it into their processes which is commendable.

The team is also recognized for the excellent use of the Archibus software. This program in addition to being a good preventative maintenance program, assists with asset control and overall monitoring, scheduling of all repairs.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The authority has a good process in place for emergency preparedness. Efforts have been made to educate staff across the region which is large with a variety of different size organizations.
Good processes are in place to engage support from outside agencies. Plans have been developed throughout the region and education and training occurs regularly beginning with orientation for new hires.
Testing of plans occur on a regular basis. Results of test, debriefings are shared. In addition, opportunities for improvement are identified and acted upon. At this time, thirteen codes are utilized in the region.
Pandemic planning occurs with good co-operation with public health representatives. Staff work with other health authorities and provincial agencies to ensure good practices are shared. Business continuity has been taken into consideration with the development of plans.
The team has identified a number of areas for improvement, including broader dissemination of preparedness information, especially through the intranet which is encouraged. In addition, broader education and involvement of all staff has been identified as a priority.
An opportunity for improvement exists related to the provision of water to all sites with particular focus on the two acute care hospital sites. More specifically, Emergency plans should take into consideration the potential loss of water supply and the impact on services. Business continuity, especially for services like Dialysis should be considered in the event water supply is restricted or not available.

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)

The organization is congratulated on the significant strides it has made embedding person and family centered care into all of its functional areas. As a key strategic direction, a PFCC strategy has been developed as well as the implementation of a PFCC education plan, communication plan and advisor program. Specific PFCC guidelines policies and standards have been implemented in identified priority areas. The organization currently has 20 patient advisors in place with plans to increase this to 40 by March 2020. Patient Advisors have participated in the strategic planning process, interviewing process for the organizations VP of Medical Services, various management positions, reviewing renovation projects, policy review, reviewing plans to improve site parking and a standing member on the senior management team.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization's leadership is commended for its efforts in dealing with the challenges of flow and access. The organization's Flow and Access Plan outlines the strategies that are in place sourcing the organizations strategic plan and Accreditation Canada's ROP for Flow. The Client Flow Working Group is tasked with putting into action specific activities that will improve flow within the health care organizations in the region. The working group is a multi site, interdisciplinary team that comes together to work collaboratively on flow issues.

The working group evaluates its efforts on an ongoing basis utilizing flow indicators in a balanced scorecard. ALC and wait time data are just a few of the data sources being used. The organization also depends on CIHI data and the compliance thresholds they recommend. There are specific elements in the Flow and Access Plan that include, access to care, admission planning, bed management planning, discharge planning, ER utilization and connect to primary health care and the community. These elements have been developed used to facilitate client flow strategies include; Home First Integrated Network Team, Wait Time Management Framework and Appropriateness of Acute Care Resource Management Work Plan. Positive results have been seen in several facilities.

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)
See Physical Environment for comments.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: March 4, 2019 to March 5, 2019**
- **Number of responses: 10**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	10	30	60	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	20	20	60	N/A
3. Subcommittees need better defined roles and responsibilities.	67	11	22	N/A
4. As a governing body, we do not become directly involved in management issues.	0	0	100	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	10	90	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	10	10	80	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	10	90	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	30	10	60	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	10	20	70	N/A
11. Individual members ask for and listen to one another's ideas and input.	10	10	80	N/A
12. Our ongoing education and professional development is encouraged.	0	0	100	N/A
13. Working relationships among individual members are positive.	20	0	80	N/A
14. We have a process to set bylaws and corporate policies.	0	10	90	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	40	60	N/A
17. Contributions of individual members are reviewed regularly.	50	20	30	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	40	20	40	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	50	40	10	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	20	20	60	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	10	30	60	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	20	80	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	10	10	80	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	10	90	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	44	11	44	N/A
27. We lack explicit criteria to recruit and select new members.	44	33	22	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	33	11	56	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	10	30	60	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	11	11	78	N/A
31. We review our own structure, including size and subcommittee structure.	30	10	60	N/A
32. We have a process to elect or appoint our chair.	50	13	38	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	10	10	80	N/A
34. Quality of care	10	10	80	N/A

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 15 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
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.