



ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:
Cambridge Memorial Hospital

Cambridge, ON

On-site Survey Dates:
November 30, 2008 - December 3, 2008

October 23, 2009



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AGRÉMENT CANADA

Accredited by ISQua

Final Accreditation Report

About this Report

This Report documents updated information and action taken by Cambridge Memorial Hospital to address areas for improvement identified in its Forecast Report issued in February 2009. It also shows the final accreditation decision.

The Report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the on-site survey and to prepare the Report. Any alteration of this Report compromises the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Cambridge Memorial Hospital 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 Qmentum Accreditation Program

Accreditation is a cornerstone of quality improvement and patient safety initiatives, enabling an organization to regularly and consistently assess and improve its services.

Accreditation Canada's Qmentum program offers a customized process aligned with organizational needs and priorities. Organizations complete self-assessment questionnaires, collect indicator and instrument data, and undergo an on-site survey during which peer surveyors assess their services against national standards of excellence. Qmentum also offers ongoing support from and liaison with Accreditation Specialists who work with each organization to address critical issues, assist with action planning, and monitor progress.

Accreditation results, and the accreditation decision, are documented as follows:

- ***On-Site Report:***
At the conclusion of the on-site survey, surveyors provide the organization with an On-site Report summarizing their findings. The organization reviews the results and starts working on areas identified for improvement.
- ***Forecast Report:***
Following the on-site survey, Accreditation Canada issues a Forecast Report, containing more detailed on-site survey findings, a summary of indicator and instrument data, and a forecast of the final accreditation decision.
- ***Final Report:***
The Final Report is issued six months after the Forecast Report. It shows updated data, based on action(s) the organization has taken to address areas identified for improvement in the Forecast Report, and the final accreditation decision.

The findings in these Reports guide the organization as it incorporates the principles of accreditation into its programs and improves the quality of care and services provided to clients and the community.

An important adjunct to the Accreditation Reports is the Quality Performance Roadmap, available to the organization through a designated online portal. The Roadmap allows organization teams to review accreditation requirements and results in detail, and develop action plans, submit evidence, and monitor improvements.

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Previous on-site survey dates Accreditation Decision	November 8 to 9, 1982 Accreditation
Previous on-site survey dates Accreditation Decision	November 11 to 12, 1979 Accreditation
Previous on-site survey dates Accreditation Decision	October 10 to 11, 1977 Accreditation
Previous on-site survey dates Accreditation Decision	December 12 to 13, 1974 Accreditation
Previous on-site survey dates Accreditation Decision	April 4 to 5, 1971 Accreditation
Previous on-site survey dates Accreditation Decision	July 7 to 8, 1968 Accreditation
Previous on-site survey dates Accreditation Decision	September 9 to 10, 1965 Accreditation
Previous on-site survey dates Accreditation Decision	August 8 to 9, 1964 Accreditation
Previous on-site survey dates Accreditation Decision	June 6 to 7, 1961 Accreditation
Previous on-site survey dates Accreditation Decision	November 11 to 12, 1958 Accreditation
Previous on-site survey dates Accreditation Decision	October 10 to 11, 1957 Accreditation
Previous on-site survey dates Accreditation Decision	February 2 to 3, 1956 Accreditation

Organization's Commentary

The organization has no comment at this time.

1 Results Overview

This section of the Report shows an overview of the organization's results, displayed according to three significant components of the accreditation program: quality dimensions, required organizational practices, and standards sections.

1.1 Overview by Quality Dimensions

Accreditation Canada standards and criteria can be categorized into eight quality dimensions.

The following table summarizes the percentage of criteria associated with each quality dimension that were met by the organization, as well as the national compliance rate from January 1 to December 31, 2008 for all Accreditation Canada organizations.

Quality Dimension	Organization compliance rate %		National compliance rate * %
	Forecast Results	Final Results	
Population Focus <ul style="list-style-type: none"> Working with communities to anticipate and meet needs 	83	84	91
Accessibility <ul style="list-style-type: none"> Providing timely and equitable services 	97	99	93
Safety <ul style="list-style-type: none"> Keeping people safe 	88	97	86
Worklife <ul style="list-style-type: none"> Supporting wellness in the work environment 	98	98	91
Client-centred Services <ul style="list-style-type: none"> Putting clients and families first 	97	99	92
Continuity of Services <ul style="list-style-type: none"> Experiencing coordinated and seamless services 	96	96	92
Effectiveness <ul style="list-style-type: none"> Doing the right thing to achieve the best possible results 	89	91	86
Efficiency <ul style="list-style-type: none"> Making the best use of resources 	94	95	91

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the criteria associated with each quality dimension.

1.2 Overview by Required Organizational Practice (ROP)

Required Organizational Practices are essential practices that Accreditation Canada requires organizations to have in place to enhance patient and client safety and minimize risk.

This section shows two tables. The first summarizes the safety areas addressed by each ROP, and shows the organization's compliance status and the percentage of Accreditation Canada organizations nationally that met the ROP from January 1 to December 31, 2008.

To help organizations identify specific areas for action related to ROPs, the second table shows detailed requirements for unmet ROPs, and the standards sections in which they appear.

Following the on-site survey and receipt of the Forecast Report, organizations have opportunities to submit evidence of action taken to address areas identified for improvement. ROPs that continue to be rated unmet may be a result of the organization submitting incomplete or insufficient evidence, or because it has chosen to focus on other areas.

1.2a Overview by ROP Safety Areas

Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Culture			
Adopts client safety as a written, strategic priority or goal	Met	Met	76
Produces quarterly reports on client safety, including recommendations from adverse incidents	Met	Met	77
Has a reporting and follow-up system for sentinel events, adverse events, and near misses	Met	Met	88
Discloses adverse events to clients and families	Met	Met	82
Conducts one client safety-related prospective analysis per year	Unmet	Unmet	61
Communication			
Educates clients and families about their roles in promoting safety	Unmet	Met	63
Ensures effective information transfer at transition points	Met	Met	89

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Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Communication			
Uses verification processes and other checking systems for high-risk activities	Met	Met	87
Conducts medication reconciliation at admission	Unmet	Met	36
Conducts medication reconciliation at transfer	Unmet	Met	34
Uses two client identifiers before administering medications	Met	Met	84
Medication Use			
Stores concentrated electrolytes away from client service areas	Met	Met	87
Standardizes and limits number of medication concentrations	Met	Met	92
Provides training on infusion pumps	Met	Met	79
Worklife/Workforce			
Delivers client safety training and education at least annually	Met	Met	84
Develops and implements client safety plan	Met	Met	82
Defines roles, responsibilities, and accountabilities for client care and safety	Met	Met	61
Has a preventive maintenance program for medical devices, equipment, and technology	Met	Met	78
Infection Control			
Ensures policies and procedures meet infection control guidelines	Met	Met	93
Delivers hand hygiene education and training	Met	Met	96
Tracks and shares information on infection rates	Met	Met	67

Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Infection Control			
Monitors processes for reprocessing equipment	Met	Met	88
Administers the influenza vaccine	Met	Met	91
Administers the pneumococcal vaccine	Met	Met	86
Falls Prevention			
Implements a falls prevention strategy	Met	Met	56

1.2b Overview of Unmet ROPs by Standards Section and Criterion

The organization is required to submit, through the Organization Portal, evidence of the action it has taken to meet the following ROPs in each of the identified standards sections.

Unmet Required Organizational Practice	Standards section and criterion #
Culture	
The organization carries out one client safety-related prospective, analytical process per year (e.g. FMEA), and implements appropriate improvements or changes.	· Proactive and Supportive Organization 7.6

1.3 Overview by Standards Section

The following table shows the percentage of high priority criteria in the identified standards section with which the organization has complied.

Standards Section	Organization compliance rate %		National compliance rate * %
	Forecast Results	Final Results	
Governance	83	94	89
Proactive and Supportive Organization	91	97	86
Infection Prevention and Control	100	100	92
Managing Medications	84	96	92
Cancer Care & Oncology Services	85	100	83
Critical Care Services	92	100	80
Diagnostic Imaging Services	95	100	88
Emergency Department Services	88	97	79
Long Term Care	92	100	81
Medicine Services	80	100	72
Mental Health Services	79	92	78
Obstetrics/Perinatal Care Services	92	100	82
Operating Rooms	98	98	93
Surgical Care	76	100	84

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

2 Status of Unmet, High Priority Criteria (from Forecast Report)

This section lists the high priority criteria from each standards section that were rated unmet at the time of the Forecast Report, and their current status. This table excludes the ROP data that is displayed in the previous section.

Following the on-site survey and receipt of the Forecast Report, organizations have opportunities to submit evidence of action taken to address areas identified for improvement. Criteria that continue to be rated unmet may be a result of the organization submitting incomplete or insufficient evidence, or because it has chosen to focus on other areas.

Governance		Organization compliance status (Final Report)	National compliance rate * %
4.6	The governing body selects a concise set of indicators to monitor whether the goals and objectives are being achieved.	Met	67
10.1	The governing body has a process or framework to regularly evaluate its performance.	Unmet	78
10.2	The evaluation includes an assessment of the governing body's own structure.	Unmet	82
10.4	The governing body has a formal mechanism to recognize its achievements.	Met	85
17.5	The governing body obtains feedback from clients, staff, service providers, key stakeholders, and the community.	Met	91
17.6	The governing body monitors performance against goals and objectives, identifies opportunities for improvement, and takes actions to address them.	Met	86
Proactive and Supportive Organization		Organization compliance status (Final Report)	National compliance rate * %
1.4	The organization works with its partners and the community to set priorities amongst competing service needs, as applicable.	Met	92
5.4	The organization has back-up or contingency plans and mechanisms to respond to crises or unanticipated challenges.	Met	93
9.2	The organization provides enough resources and training to support quality improvement activities and achieve the quality agenda.	Met	83
11.6	The organization is in a good financial position.	Met	91

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

Proactive and Supportive Organization		Organization compliance status (Final Report)	National compliance rate * %
16.3	The organization uses an integrated, risk management approach to identify, report, assess, and manage risks.	Unmet	81
Managing Medications		Organization compliance status (Final Report)	National compliance rate * %
7.6	The organization's emergency medications and supplies are consistently available, controlled, and secure in client care areas.	Met	96
8.5	The organization securely stores chemotherapy agents in an isolated area with adequate ventilation.	Met	88
10.7	Prescribing medical professionals use special precautions when communicating orders for sound-alike and look-alike drugs.	Met	84
10.11	The organization monitors compliance with its processes for prescribing medications.	Unmet	91
11.3	The pharmacy computer system performs dose range checks and warns providers about low and high doses for all high alert medications.	Unmet	81
11.4	Prescribing professionals follow a policy for weight-based dosing in pediatrics.	Met	92
12.5	The pharmacy staff prepares IV products in a segregated admixture area using a certified laminar flow hood.	Met	86
13.3	The pharmacy dispenses the most ready-to-administer form of the medication.	Met	95
13.6	The pharmacy sets and follows realistic criteria for dispensing emergency, urgent, and routine medications.	Unmet	95
16.2	Prior to the initial dose, and when the dosage is adjusted, the providers communicate with the clients and family about the recommended drug therapy and any potential drug reactions or interactions.	Met	91
16.4	During the education process, service providers actively seek to understand and respond to any client concerns about their medication.	Met	96
19.6	Wherever possible, service providers use manufacturers' pre-filled syringes for injectable products.	Met	93

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

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Cancer Care & Oncology Services		Organization compliance status (Final Report)	National compliance rate * %
11.2	The team has specific processes for preparing, using, and administering cytotoxic drug products.	Met	98
11.7	The team stores and disposes of medications safely and securely.	Met	94
Diagnostic Imaging Services		Organization compliance status (Final Report)	National compliance rate * %
1.2	The team regularly surveys referring physicians to collect information about the needs of referring medical professionals.	Met	69
4.5	The team has control of temperature and ventilation to ensure client and staff safety, accurate film processing, and proper equipment function.	Met	88
16.2	The team involves clients, families, and other organizations when evaluating its diagnostic imaging services.	Met	56
Emergency Department Services		Organization compliance status (Final Report)	National compliance rate * %
2.3	The team has strategies in place to effectively manage overcrowding and surges in the Emergency Department.	Met	83
6.3	The team quickly recognizes overcrowding in the Emergency Department and follows its policies to reduce overcrowding with clear supportive leadership.	Met	87
14.1	The team is trained to identify and manage risk in the Emergency Department.	Met	89
14.6	The team monitors the achievement of its goals and objectives.	Unmet	64
Medicine Services		Organization compliance status (Final Report)	National compliance rate * %
12.5	Following transition or discharge, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	Met	46

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

Medicine Services		Organization compliance status (Final Report)	National compliance rate * %
16.3	The team monitors the achievement of its goals and objectives.	Met	62
Mental Health Services		Organization compliance status (Final Report)	National compliance rate * %
16.3	The team monitors the achievement of its goals and objectives.	Unmet	73
16.4	The team compares its results with other similar interventions, programs, or organizations.	Met	65
16.5	The team uses the information it collects about performance to identify successes and opportunities for improvement, and makes improvements as needed.	Unmet	71
Operating Rooms		Organization compliance status (Final Report)	National compliance rate * %
14.4	The team sets goals and objectives for performance, and measures the achievement of these goals and objectives.	Unmet	63
Surgical Care		Organization compliance status (Final Report)	National compliance rate * %
10.1	The team is trained to identify, reduce, and manage risk.	Met	94
12.6	Following transition or discharge, the team contacts clients, families, or referral organizations/teams to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	Met	67
16.1	The team identifies and monitors process and outcome measures for surgical services.	Met	70
16.2	The team monitors clients' perspectives on surgical services.	Met	77
16.3	The team sets monitors the achievement of its goals and objectives.	Met	69

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

3 Performance Measures (Instruments and Indicators)

As part of the accreditation process, organizations collect performance measurement data. These measures consist of both instruments and indicators, and are valuable components of evaluation and quality improvement.

This section compares the organization’s performance measurement data with national data submitted by Accreditation Canada organizations. It can be used by the organization for benchmarking or other purposes.

3.1 Instrument Results

Instruments are questionnaires completed by a representative sample of board members, clients, staff, leadership, or other stakeholders.

Governance Functioning Tool

The Governance Functioning Tool is an opportunity for governing body members to assess their internal structures and processes, provide their perceptions and opinions, and identify areas for improvement.

The organization’s governing body members completed the Governance Functioning Tool between January 25 and May 15, 2008. This table compares the results to national results obtained from January 1 to December 31, 2008.

Number of survey respondents = 4 respondents

Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
1 We actively recruit, recommend and/or select new members based on needs for particular skills.	100	88	0	0	0	12
2 We have explicit criteria to recruit and select new members.	75	80	0	0	25	20
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	91	0	0	0	9
4 The composition of our governing body allows us to meet stakeholder and community needs.	100	95	0	0	0	5
5 The composition of our governing body reflects the diversity of the community served.	100	85	0	0	0	15
6 Clear written policies define term lengths and limits for individual members, as well as compensation (as applicable).	100	95	0	0	0	5

Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
7 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	67	91	0	0	33	9
8 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	93	0	0	0	7
9 We review our own structure, committee practices, scope of authority and bylaws regularly.	33	85	0	0	67	15
10 Our committees have clearly-defined roles and responsibilities.	75	96	0	0	25	4
11 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.	75	93	0	0	25	7
12 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	89	0	0	0	11
13 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	93	0	0	0	7
14 Our meetings are held frequently enough to make sure we make timely decisions.	75	96	0	0	25	4
15 Individual members carry out their roles and responsibilities in between meetings, including committee work (as applicable).	100	97	0	0	0	3
16 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	94	0	0	0	6
17 Our governance processes make sure that everyone participates in decision-making.	100	92	0	0	0	8
18 Individual members are actively involved in policy-making and strategic direction.	75	87	0	0	25	13
19 The composition of our governing body contributes to high governance and leadership performance.	100	92	0	0	0	8

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Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
20 Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	100	94	0	0	0	6
21 Ongoing education and professional development is encouraged.	67	90	0	0	33	10
22 Working relationships among individual members and committees are positive.	100	97	0	0	0	3
23 We have a process to set bylaws and corporate policies.	75	96	0	0	25	4
24 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	98	0	0	0	2
25 We formally evaluate our own performance on a regular basis.	33	72	0	0	67	28
26 We benchmark our performance against other similar organizations and/or national standards.	33	65	0	0	67	35
27 Contributions of individual members are reviewed regularly.	50	55	0	0	50	45
28 As a team, we regularly review how we function together and how our governance processes could be improved.	33	71	0	0	67	29
29 There is a process for improving individual effectiveness when non-performance is an issue.	0	54	0	0	100	46
30 We regularly identify areas for improvement and engage in our own quality improvement activities.	67	75	0	0	33	25
31 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.	100	80	0	0	0	20
32 As individual members, we receive adequate feedback about our contribution to the governing body.	50	61	0	0	50	39

Patient Safety Culture Survey

The Patient Safety Culture Tool asks staff to provide their perceptions about the culture of patient safety with the organization. It identifies areas of strength, areas for improvement, and mechanisms to monitor changes.

The organization's staff completed the Patient Safety Culture Tool between January 25 and April 30, 2008. This table compares the results to national results obtained from January 1 to December 31, 2008.

Number of survey respondents = 413 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
1 Patient safety decisions are made at the proper level by the most qualified people	10	11	12	14	78	75
2 Good communication now exists up the chain of command regarding patient safety issues	16	16	18	17	67	66
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	83	79	11	11	6	9
4 Senior management has a clear picture of the risks associated with patient care	26	20	21	24	53	56
5 My department takes the time to identify and assess risks to patients	6	8	9	11	85	81
6 My department does a good job of managing risks to ensure patient safety	3	6	10	10	87	84
7 Senior management provide a climate that promotes patient safety	13	13	23	20	64	67
8 Asking for help is a sign of incompetence	95	93	3	3	2	4
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	95	94	2	3	3	3
10 Telling others about my mistakes is embarrassing	57	67	13	12	29	21
11 I am less effective at work when I am fatigued	7	11	9	9	84	80
12 Senior management considers patient safety when program changes are discussed	14	13	32	30	53	57
13 Personal problems can adversely affect my performance	29	32	22	17	50	51

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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	
	Organization	National	Organization	National	Organization	National
14 I will suffer negative consequences if I report a patient safety problem	88	86	10	9	2	5
15 If people find out that I made a mistake, I will be disciplined	55	56	27	24	18	20
16 I am rewarded for taking quick action to identify a serious mistake	36	37	33	32	31	31
17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care	36	42	27	24	37	34
18 I have enough time to complete patient care tasks safely	34	30	23	20	43	50
19 Clinicians who make serious mistakes are usually punished	50	46	38	37	11	16
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	56	54	19	19	26	27
21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	38	34	25	20	37	46
22 I have made significant errors in my work that I attribute to my own fatigue	85	80	9	12	6	9
23 I believe that health care error constitutes a real and significant risk to the patients that we treat	14	14	15	15	71	71
24 I believe health care errors often go unreported	22	26	23	24	54	50
25 My organization effectively balances the need for patient safety and the need for productivity	18	20	40	27	42	53
26 I work in an environment where patient safety is high priority	7	10	15	13	77	77
27 I believe that most serious occurrences happen as a result of multiple small failures, and are not attributable to one individual's actions	14	14	23	24	63	62

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
28 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	31	26	26	23	43	52
29 My supervisor/manager seriously considers staff suggestions for improving patient safety	16	15	22	18	62	67
30 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	66	69	19	17	14	14
31 My supervisor/manager overlooks patient safety problems that happen over and over	70	74	19	14	12	11

B. These questions are about your perceptions of overall patient safety	% Good/ Excellent		% Acceptable		% Poor/ Failing	
	Organization	National	Organization	National	Organization	National
32 Please give your unit an overall grade on patient safety	60	66	36	30	4	5
33 Please give the organization an overall grade on patient safety	41	53	53	39	6	8

C. These questions are about what happens after a Major Event	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
34 Individuals involved in major events have a quick and easy way to capture/report what happened	11	9	21	21	67	71
35 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	20	12	17	19	63	69
36 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	8	11	31	32	61	56

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C. These questions are about what happens after a Major Event	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
37 Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	13	16	32	34	56	50
38 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	18	17	40	37	41	45
39 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	21	17	20	19	59	64
40 There is a pharmacist who is a full member of the patient care team on the unit (e.g. they participate in rounds and are accessible to people on the unit)	19	30	22	25	59	45

D. These questions ask about some of your own actions	% Seldom/ Never		% Occasionally		% Often/ Always	
	Organization	National	Organization	National	Organization	National
41 If I see someone engaging in unsafe care practice, I confront them	8	9	28	25	64	66
42 I take shortcuts which involve little or no risk to patient safety	73	77	25	17	2	6
43 I talk about patient safety issues with fellow workers	11	10	32	31	57	59
44 I engage in unsafe care practice in order to get the job done	96	95	3	3	1	2
45 I report the errors I make	1	3	6	9	93	89
46 I learn from errors made by my colleagues	1	3	12	15	87	82

3.2 *Indicator Results*

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

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Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care Associated Infection Rates - C. difficile					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days	Notes received from the Organization
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/01/2008 31/03/2008	0.18	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/04/2008 30/06/2008	0.72	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/07/2008 30/09/2008	0	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/10/2008 31/12/2008	0.15	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/01/2009 31/03/2009	0.74	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/04/2009 30/06/2009	0.23	

Threshold for Flags

RED: > 8/100

YELLOW: $\geq 6/100$ AND $< 8/100$

GREEN: $\leq 6/100$

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Health Care Associated Infection Rates - MRSA					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days	Notes received from the Organization
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/01/2008 31/03/2008	0.54	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/04/2008 30/06/2008	1	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/07/2008 30/09/2008	1.7	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/10/2008 31/12/2008	0.7	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/01/2009 31/03/2009	1	
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/04/2009 30/06/2009	0.5	

Threshold for Flags
 RED: > 8/1000
 YELLOW: >= 6/1000 AND < 8/1000
 GREEN: <= 6/1000

Surgical Site Infection

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Surgical Site Infection - Total Joint Arthroplasty					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics	Notes received from the Organization
RED	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/01/2008 31/03/2008	66	Total Hip Arthroplasty
RED	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/01/2008 31/03/2008	70	Total Knee Arthroplasty
RED	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/04/2008 30/06/2008	73	Total Knee Arthroplasty
YELLOW	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/04/2008 30/06/2008	84	Total Hip Arthroplasty
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/07/2008 30/09/2008	95	Total Hip Arthroplasty
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/07/2008 30/09/2008	96	Total Knee Arthroplasty

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Surgical Site Infection - Total Joint Arthroplasty					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics	Notes received from the Organization
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/10/2008 31/12/2008	92	Total Knees
YELLOW	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/10/2008 31/12/2008	84	Total Hips
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/01/2009 31/03/2009	100	Total Knees
GREEN	Cambridge Memorial Hospital (Infection Prevention and Control)	Infection Prevention and Control	01/01/2009 31/03/2009	94	Total Hip

Threshold for Flags
 RED: < 80/100
 YELLOW: >= 80/100 AND < 90/100
 GREEN: >= 90/100

4 Follow Up Required

The organization has earned Accreditation with Condition. The table in this section shows the follow-up required to comply with the specified condition (Report, Focused Visit, or both) and maintain the accreditation status.

Evidence of follow-up action taken by the organization to meet these requirements must be submitted by the specified dates, through the Organization Portal.

Report

Standards section and criterion #	Due Date
Proactive and Supportive Organization 7.6	April 2010
Managing Medications 11.3 13.6	October 2010

Closing Thoughts from the President and CEO

Congratulations on reaching this important milestone on your accreditation journey. We salute and celebrate your achievements, and look forward to continuing to work with you as accreditation increasingly strengthens and supports your quality improvement and patient safety initiatives.

Your ongoing efforts to incorporate Accreditation Canada standards and tools into your programs and services have been, and will continue to be, of great benefit to your organization, your staff, the people you serve, and your community. Please contact your Accreditation Specialist, or use the Organization Portal, if you have questions or require additional information in this process.

Thank you for your commitment and dedication to improving quality health care through accreditation.

Wendy Nicklin
President and CEO
Accreditation Canada

Appendix A - Accreditation Decision Guidelines

Under Qmentum, the two most important factors in determining an organization's accreditation status are the degree to which it meets high priority criteria and Required Organizational Practices (ROPs).

- High priority criteria: criteria focused on priorities such as safety, ethics, and quality improvement, and deemed sufficiently important by Accreditation Canada that not meeting them usually results in a request to the organization for further information and clarification.
- ROPs: practices focused predominately on patient safety, and deemed sufficiently important by Accreditation Canada that not meeting them results in a request to the organization for further information and clarification.

Based on the above, and after review of all findings, Accreditation Canada issues one of the following accreditation decisions.

- 1 **Accreditation** is awarded, with resurvey in three years, under the following circumstances:
 - (a) 10% or less of high priority criteria unmet per standard section
AND
 - (b) satisfactory compliance with all of the Required Organizational Practices.

- 2 **Accreditation with Condition (Report, Focused Visit, or both)*** is awarded under the following circumstances:
 - (a) more than 10% and less than 30% of high priority criteria unmet per standard section
OR
 - (b) unsatisfactory compliance with any one of the Required Organizational Practices.

*The specific condition and timelines are determined by Accreditation Canada based on the nature of the findings.

To maintain accreditation, organizations that earn Accreditation with Condition in their Final Report must comply with the requirements of the condition by the dates specified in the Final Report. If satisfactory follow up is not submitted by the specified dates, a one-time extension of six months may be granted, based on surveyor input and proof of progress. Failure to comply within the maximum allotted time may result in loss of accreditation, at Accreditation Canada's discretion.

- 3 **Non Accreditation** is issued under the following circumstance:
 - (a) more than 30% of high priority criteria unmet per standard section
OR
 - (b) Unsatisfactory compliance with all of the Required Organizational Practices.