



**ACCREDITATION CANADA**



*Driving Quality Health Services*

# Final Accreditation Report

Prepared for:  
**North Bay General Hospital**

North Bay, ON

**On-site Survey Dates:**  
November 23, 2008 - November 26, 2008

August 21, 2009



**ACCREDITATION CANADA  
AGRÉMENT CANADA**

Accredited by ISQua

# Final Accreditation Report

## About this Report

This Report documents updated information and action taken by North Bay General Hospital to address areas for improvement identified in its Forecast Report issued in December 2008. 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 North Bay General 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.

**Accreditation Summary**

**North Bay General Hospital**

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On-site survey dates	November 23 to 26, 2008
Forecast Report issued	December 24, 2008
Forecast of the accreditation decision	Accreditation with Condition

Final Report issued	July 28, 2009
Accreditation Decision	Accreditation with Condition (Report)

**Accreditation History**

Previous on-site survey dates	November 13 to 16, 2005
Accreditation Decision	Accreditation
Previous on-site survey dates	November 24 to 27, 2002
Accreditation Decision	Accreditation with Report
Previous on-site survey dates	November 28 to December 2, 1999
Accreditation Decision	Accreditation with Report
Previous on-site survey dates	February 4 to 5, 1993
Accreditation Decision	Accreditation
Previous on-site survey dates	July 31 to August 1, 1990
Accreditation Decision	Accreditation
Previous on-site survey dates	September 21 to 22, 1987
Accreditation Decision	Accreditation
Previous on-site survey dates	October 11 to 12, 1984
Accreditation Decision	Accreditation

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Previous on-site survey dates Accreditation Decision	June 6 to 7, 1981 Accreditation
Previous on-site survey dates Accreditation Decision	June 6 to 7, 1978 Accreditation
Previous on-site survey dates Accreditation Decision	June 6 to 7, 1975 Accreditation
Previous on-site survey dates Accreditation Decision	August 8 to 9, 1972 Accreditation
Previous on-site survey dates Accreditation Decision	September 9 to 10, 1969 Accreditation
Previous on-site survey dates Accreditation Decision	July 7 to 8, 1966 Accreditation
Previous on-site survey dates Accreditation Decision	April 4 to 5, 1963 Accreditation
Previous on-site survey dates Accreditation Decision	June 6 to 7, 1960 Accreditation
Previous on-site survey dates Accreditation Decision	June 6 to 7, 1959 Accreditation
Previous on-site survey dates Accreditation Decision	April 4 to 5, 1958 Accreditation
Previous on-site survey dates Accreditation Decision	November 11 to 12, 1955 Accreditation
Previous on-site survey dates Accreditation Decision	October 10 to 11, 1954 Accreditation
Previous on-site survey dates Accreditation Decision	January 1, 1951 to January 2, 1952 Accreditation

## Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

### Self-Assessment:

The new self-assessment facilitated increased participation of all staff in the accreditation process. This feedback served as the basis upon which action plans were developed across the organization to address identified gaps related to compliance with the accreditation standards. An area of concern was the use of the Patient Safety Culture survey results in the roadmaps despite a low response to that survey and Work life Pulse survey. These results were clearly well below the identified number that is required to legitimize these surveys.

### Survey Visit:

The new survey process clearly demonstrated and promoted front-line staff participation. Staff members consistently reported that they found that the survey process recognized their contributions within the organization and was a valuable experience in which to participate. Many staff felt that this was a more realistic approach to accreditation and were engaged in the process. Given the transition to the new hospital and today's reality, (that is, our ability to respond on all fronts as a priority) is very difficult because of staff resources and time constraints.

### Survey Findings - On-site Report:

The on-site report was received at the conclusion of the surveyors briefing to our Hospital staff and identified that we had met 93% of the standard-criteria. Our review of the on-site report identified a discrepancy from what the surveyors had reported to our senior team. This discrepancy involved the Emergency Department's inability to provide strategic imperatives during its survey. The imperatives were later provided to the surveyor, who acknowledges he would change this in his report. Unfortunately, it still remains. This error was reported to Accreditation Canada. This item will be corrected in the Forecast Report. A preliminary review has been completed to identify organizational themes and to assist teams in identifying opportunities to collaborate together in developing and implementing process improvements.

### Moving Forward:

Prior to the survey visit North Bay General hired a full-time Patient Safety Coordinator. This new position will assist the current accreditation teams which had developed work-plans to address potential gaps related to compliance with the required organizational practices for patient safety. With the results of the accreditation survey now known, each of the accreditation teams will develop further work-plans to address each of the standards that have been rated as high priority for action. Our goal is to reach each of these standards.

## 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	
<b>Population Focus</b> <ul style="list-style-type: none"> <li>▪ Working with communities to anticipate and meet needs</li> </ul>	93	94	91
<b>Accessibility</b> <ul style="list-style-type: none"> <li>▪ Providing timely and equitable services</li> </ul>	96	96	93
<b>Safety</b> <ul style="list-style-type: none"> <li>▪ Keeping people safe</li> </ul>	91	95	86
<b>Worklife</b> <ul style="list-style-type: none"> <li>▪ Supporting wellness in the work environment</li> </ul>	96	96	91
<b>Client-centred Services</b> <ul style="list-style-type: none"> <li>▪ Putting clients and families first</li> </ul>	97	97	92
<b>Continuity of Services</b> <ul style="list-style-type: none"> <li>▪ Experiencing coordinated and seamless services</li> </ul>	96	98	92
<b>Effectiveness</b> <ul style="list-style-type: none"> <li>▪ Doing the right thing to achieve the best possible results</li> </ul>	92	94	86
<b>Efficiency</b> <ul style="list-style-type: none"> <li>▪ Making the best use of resources</li> </ul>	96	97	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 %
<b>Culture</b>			
Adopts client safety as a written, strategic priority or goal	Unmet	Met	76
Produces quarterly reports on client safety, including recommendations from adverse incidents	Unmet	Unmet	77
Has a reporting and follow-up system for sentinel events, adverse events, and near misses	Unmet	Met	88
Discloses adverse events to clients and families	Met	Met	82
Conducts one client safety-related prospective analysis per year	Unmet	Met	61
<b>Communication</b>			
Educates clients and families about their roles in promoting safety	Met	Met	63
Ensures effective information transfer at transition points	Unmet	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 %
<b>Communication</b>			
Uses verification processes and other checking systems for high-risk activities	Met	Met	87
Conducts medication reconciliation at admission	Met	Met	36
Conducts medication reconciliation at transfer	Met	Met	34
Uses two client identifiers before administering medications	Unmet	Unmet	84
<b>Medication Use</b>			
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
<b>Worklife/Workforce</b>			
Delivers client safety training and education at least annually	Met	Met	84
Develops and implements client safety plan	Unmet	Met	82
Defines roles, responsibilities, and accountabilities for client care and safety	Unmet	Unmet	61
Has a preventive maintenance program for medical devices, equipment, and technology	Met	Met	78
<b>Infection Control</b>			
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 %
<b>Infection Control</b>			
Monitors processes for reprocessing equipment	Met	Met	88
Administers the influenza vaccine	Met	Met	91
Administers the pneumococcal vaccine	Met	Met	86
<b>Falls Prevention</b>			
Implements a falls prevention strategy	Unmet	Unmet	56

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## 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 #
<b>Culture</b>	
The organization provides quarterly reports to the governing body on client safety, including changes or improvements following incident investigation and follow-up.	<ul style="list-style-type: none"> <li>Proactive and Supportive Organization 7.8</li> </ul>
<b>Communication</b>	
The team uses at least two client identifiers before providing any services or procedures.	<ul style="list-style-type: none"> <li>Substance Abuse and Problem Gambling Services 10.6</li> </ul>
<b>Worklife/Workforce</b>	
The organization clearly delineates the roles, responsibilities, and accountabilities of staff and other providers for client care and safety.	<ul style="list-style-type: none"> <li>Proactive and Supportive Organization 14.7</li> </ul>
<b>Falls Prevention</b>	
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	<ul style="list-style-type: none"> <li>Ambulatory Care 11.5</li> <li>Medicine Services 10.5</li> <li>Obstetrics/Perinatal Care Services 10.5</li> <li>Rehabilitation 10.5</li> </ul>
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	<ul style="list-style-type: none"> <li>Surgical Care 10.5</li> </ul>
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	<ul style="list-style-type: none"> <li>Diagnostic Imaging Services 12.7</li> </ul>

## 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	86	94	89
Proactive and Supportive Organization	85	96	86
Infection Prevention and Control	96	98	92
Managing Medications	90	94	92
Ambulatory Care	88	97	80
Critical Care Services	96	96	80
Diagnostic Imaging Services	96	96	88
Emergency Department Services	87	87	79
Medicine Services	92	96	72
Mental Health Services	80	90	78
Obstetrics/Perinatal Care Services	92	96	82
Operating Rooms	98	100	93
Rehabilitation	92	96	81
Substance Abuse and Problem Gambling Services	88	92	83
Surgical Care	94	97	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 * %
14.5	When making allocation decisions, the governing body considers ethics, values, and social costs and benefits.	Met	97
17.3	The governing body selects and monitors a balanced set of performance measures.	Unmet	82
17.6	The governing body monitors performance against goals and objectives, identifies opportunities for improvement, and takes actions to address them.	Unmet	86
20.2	The governing body makes client safety part of the governance and strategic planning process.	Met	87
21.2	The governing body anticipates financial needs and potential risks, including any shifts or trends in funding, and develops contingency plans, as appropriate.	Met	98
Proactive and Supportive Organization		Organization compliance status (Final Report)	National compliance rate * %
5.4	The organization has back-up or contingency plans and mechanisms to respond to crises or unanticipated challenges.	Met	93
8.8	The organization shares the results of the Worklife Pulse Tool with staff and service providers, and uses the information to make improvements.	Met	72
11.6	The organization is in a good financial position.	Met	91
16.1	The organization has a formalized and coordinated performance measurement system.	Unmet	68

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

Infection Prevention and Control		Organization compliance status (Final Report)	National compliance rate * %
6.1	All staff, service providers, and volunteers know their role in preventing and controlling infections.	Unmet	94
6.6	The organization specifically monitors staff members', service providers', and volunteers' compliance with the organization's hand hygiene policies and procedures, and provides them with feedback to increase compliance.	Met	76
Managing Medications		Organization compliance status (Final Report)	National compliance rate * %
1.8	The organization gives all staff and service providers ongoing information and education about medication errors.	Met	79
7.4	The organization stores medications intended for administration in client care units in labeled, unit-of-use containers.	Unmet	87
7.5	The organization's unit dose oral medications remain in the manufacturer's or pharmacy's packaging up to the point of drug administration.	Unmet	90
13.4	The pharmacy dispenses medications using a unit dose packaging system.	Unmet	77
13.5	The pharmacy dispenses tablet medications in a dose that can be tapered.	Met	94
13.7	The organization has a quality control procedure to prevent dispensing errors.	Unmet	93
19.7	The organization minimizes the use of multi-dose vials.	Unmet	94
21.2	The organization's error prevention strategies target the system, not the individual.	Met	95
Ambulatory Care		Organization compliance status (Final Report)	National compliance rate * %
11.7	The team identifies, reports, records, and monitors in a timely way incidents such as sentinel events, near misses, and adverse events.	Met	84
17.5	The team compares its results with other similar interventions, programs, or organizations.	Met	63

\* 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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Critical Care Services		Organization compliance status (Final Report)	National compliance rate * %
10.8	The team identifies, reports, records, and monitors in a timely way incidents such as sentinel events, near misses, and adverse events.	Unmet	94
Diagnostic Imaging Services		Organization compliance status (Final Report)	National compliance rate * %
12.9	The team identifies, reports, records and monitors incidents such as sentinel events, near misses, and adverse events in a timely way.	Unmet	88
Emergency Department Services		Organization compliance status (Final Report)	National compliance rate * %
1.2	The team proactively collects information about its referring organizations and providers.	Unmet	85
2.5	The team's strategies to manage overcrowding include how to identify other service options during high volume emergencies including alternate sites to refer clients for health care.	Unmet	86
6.3	The team quickly recognizes overcrowding in the Emergency Department and follows its policies to reduce overcrowding with clear supportive leadership.	Unmet	87
14.3	The team identifies, reports, records, and monitors in a timely way incidents such as sentinel events, near misses, and adverse events.	Unmet	81
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.

Mental Health Services		Organization compliance status (Final Report)	National compliance rate * %
10.2	The team carries out regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	Met	81
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	60
16.1	The team identifies and monitors process and outcome measures for mental health services.	Unmet	70
16.3	The team monitors the achievement of its goals and objectives.	Unmet	73
Obstetrics/Perinatal Care 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	72
Operating Rooms		Organization compliance status (Final Report)	National compliance rate * %
9.7	The team documents each object, instrument, device, and sponge handed to the surgeon during the procedure.	Met	98
Rehabilitation		Organization compliance status (Final Report)	National compliance rate * %
9.8	The team has a process to help staff handle ethics-related issues.	Met	75

\* 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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Substance Abuse and Problem Gambling Services		Organization compliance status (Final Report)	National compliance rate * %
16.1	The team identifies and monitors process and outcome measures for substance abuse and problem gambling services.	Unmet	75
16.3	The team monitors the achievement of its goals and objectives.	Met	67
Surgical Care		Organization compliance status (Final Report)	National compliance rate * %
9.5	Prior to a procedure, the team provides the client with an opportunity to consent to organ donation.	Met	65

\* 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 20 and February 29, 2008. This table compares the results to national results obtained from January 1 to December 31, 2008.

Number of survey respondents = 13 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.	100	80	0	0	0	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.	83	85	0	0	17	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

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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.	83	91	0	0	17	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.	100	85	0	0	0	15
10 Our committees have clearly-defined roles and responsibilities.	100	96	0	0	0	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.	92	93	0	0	8	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”.	83	93	0	0	17	7
14 Our meetings are held frequently enough to make sure we make timely decisions.	92	96	0	0	8	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.	92	94	0	0	8	6
17 Our governance processes make sure that everyone participates in decision-making.	64	92	0	0	36	8
18 Individual members are actively involved in policy-making and strategic direction.	82	87	0	0	18	13
19 The composition of our governing body contributes to high governance and leadership performance.	92	92	0	0	8	8

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.	75	94	0	0	25	6
21 Ongoing education and professional development is encouraged.	100	90	0	0	0	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.	100	96	0	0	0	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.	92	72	0	0	8	28
26 We benchmark our performance against other similar organizations and/or national standards.	60	65	0	0	40	35
27 Contributions of individual members are reviewed regularly.	42	55	0	0	58	45
28 As a team, we regularly review how we function together and how our governance processes could be improved.	67	71	0	0	33	29
29 There is a process for improving individual effectiveness when non-performance is an issue.	55	54	0	0	45	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.	60	80	0	0	40	20
32 As individual members, we receive adequate feedback about our contribution to the governing body.	45	61	0	0	55	39

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## *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 November 26, 2007 and February 1, 2008. This table compares the results to national results obtained from January 1 to December 31, 2008.

Number of survey respondents = 345 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	12	11	19	14	69	75
2 Good communication now exists up the chain of command regarding patient safety issues	16	16	19	17	65	66
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	69	79	19	11	12	9
4 Senior management has a clear picture of the risks associated with patient care	23	20	26	24	51	56
5 My department takes the time to identify and assess risks to patients	9	8	16	11	75	81
6 My department does a good job of managing risks to ensure patient safety	6	6	14	10	79	84
7 Senior management provide a climate that promotes patient safety	16	13	22	20	62	67
8 Asking for help is a sign of incompetence	91	93	5	3	4	4
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	94	94	4	3	3	3
10 Telling others about my mistakes is embarrassing	60	67	15	12	25	21
11 I am less effective at work when I am fatigued	6	11	9	9	85	80
12 Senior management considers patient safety when program changes are discussed	14	13	37	30	49	57
13 Personal problems can adversely affect my performance	26	32	18	17	56	51

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	83	86	12	9	6	5
15 If people find out that I made a mistake, I will be disciplined	51	56	26	24	24	20
16 I am rewarded for taking quick action to identify a serious mistake	25	37	37	32	39	31
17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care	33	42	24	24	43	34
18 I have enough time to complete patient care tasks safely	23	30	29	20	48	50
19 Clinicians who make serious mistakes are usually punished	41	46	48	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	46	54	25	19	29	27
21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	28	34	23	20	49	46
22 I have made significant errors in my work that I attribute to my own fatigue	77	80	9	12	14	9
23 I believe that health care error constitutes a real and significant risk to the patients that we treat	10	14	17	15	73	71
24 I believe health care errors often go unreported	17	26	24	24	59	50
25 My organization effectively balances the need for patient safety and the need for productivity	19	20	37	27	44	53
26 I work in an environment where patient safety is high priority	8	10	21	13	71	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	12	14	28	24	61	62

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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
28 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	20	26	26	23	54	52
29 My supervisor/manager seriously considers staff suggestions for improving patient safety	13	15	22	18	65	67
30 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	68	69	22	17	11	14
31 My supervisor/manager overlooks patient safety problems that happen over and over	71	74	18	14	11	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	62	66	32	30	6	5
33 Please give the organization an overall grade on patient safety	48	53	41	39	11	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	8	9	23	21	69	71
35 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	16	12	22	19	62	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	15	11	36	32	49	56

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	15	16	37	34	49	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	19	17	50	37	31	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	16	17	24	19	60	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)	45	30	37	25	19	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	10	9	23	25	67	66
42 I take shortcuts which involve little or no risk to patient safety	74	77	21	17	5	6
43 I talk about patient safety issues with fellow workers	10	10	32	31	58	59
44 I engage in unsafe care practice in order to get the job done	95	95	3	3	1	2
45 I report the errors I make	0	3	8	9	92	89
46 I learn from errors made by my colleagues	1	3	11	15	89	82

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## Worklife Pulse

The Worklife Pulse Tool enables an organization to take the ‘pulse’ of its worklife quality. The Tool provides a snapshot of the work environment, as well as individual and organizational outcomes. Findings may be used to identify strengths and gaps in the work environment, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve worklife quality, and develop a clearer understanding of how worklife influences the organization’s capacity to meet its strategic goals.

The organization’s staff completed the Worklife Pulse Tool between November 26, 2007 and February 1, 2008. This table compares the results to national results obtained from January 1 to December 31, 2008.

Number of survey respondents = 483 respondents

How would you rate your work environment	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
1 I am satisfied with communications in this organization.	21	26	43	36	36	39
2 I am satisfied with communications in my work area.	20	20	29	28	51	52
3 I am satisfied with my supervisor.	15	15	22	21	63	64
4 I am satisfied with the amount of control I have over my job activities.	16	15	26	23	58	62
5 I am clear about what is expected of me to do my job.	7	9	14	15	79	77
6 I am satisfied with my involvement in decision making processes in this organization.	20	25	33	30	47	45
7 I have enough time to do my job adequately.	27	31	36	28	37	41
8 I feel that I can trust this organization.	25	24	35	29	39	47
9 This organization supports my learning and development.	13	18	26	26	61	56
10 My work environment is safe.	16	14	27	22	58	64
11 My job allows me to balance my work and family/personal life.	19	18	30	25	51	58

Individual Outcomes	% Not Stressful		% A bit Stressful		% Quite or Extremely Stressful	
	Organization	National	Organization	National	Organization	National
12 In the past 12 months, would you say that most days at work were...	13	19	43	42	44	39

	% Very Good/ Excellent		% Good		% Fair/ Poor	
	Organization	National	Organization	National	Organization	National
13 In general, would you say your health is...	71	64	25	30	4	5
14 In general, would you say your mental health is...	74	68	21	26	5	6
15 In general, would you say your physical health is...	63	59	27	33	10	8

	% Very Satisfied		% Somewhat Satisfied		% Not Satisfied	
	Organization	National	Organization	National	Organization	National
16 How satisfied are you with your job?	92	87	7	10	1	2

	% < 10		% 10 - 15		% > 15	
	Organization	National	Organization	National	Organization	National
17 In the past 12 months, how many days were you away from work because of your own illness or injury?	91	86	2	7	6	7
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to?	88	84	7	9	4	7

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	% Never/ Rarely		% Sometimes		% Often/ Always	
	Organization	National	Organization	National	Organization	National
19 How often do you feel you can do your best quality work in your job?	2	4	22	19	77	77

	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
20 Overall, I am satisfied with this organization.	10	16	29	26	60	59
21 Working conditions in my area contribute to patient safety.	10	10	27	22	63	68

### 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.

#### Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)		Notes received from the Organization
GREEN	North Bay General Hospital (Rehabilitation)	Rehab/CCC Team	01/04/2008 30/06/2008	93	All data includes Rehab and CCC combined.
YELLOW	North Bay General Hospital (Rehabilitation)	Rehab/CCC Team	01/07/2008 30/09/2008	79	
RED	North Bay General Hospital (Rehabilitation)	Rehab/CCC Team	01/10/2008 31/12/2008	64	
RED	North Bay General Hospital (Rehabilitation)	Rehab/CCC Team	01/01/2009 31/03/2009	72	

#### Threshold for Flags

RED: < 75/100  
 YELLOW: >= 75/100 AND < 90/100  
 GREEN: >= 90/100

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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	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2008 31/03/2008	0.26	Patient days from our Neonatal ICU were removed as per recommendations.
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2008 30/06/2008	0.24	
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2008 30/09/2008	0.31	
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2008 31/12/2008	0.062	
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2009 31/03/2009	0.48	

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

Health Care Associated Infection Rates - C-Section					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections	Notes received from the Organization
RED	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2008 31/03/2008	24	

Threshold for Flags

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

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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	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2008 31/03/2008	0.25	
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2008 30/06/2008	0.059	
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2008 30/09/2008	0	
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2008 31/12/2008	0.35	
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2009 31/03/2009	0.18	

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
YELLOW	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2008 31/03/2008	84	This data is only tracked for total knee replacement and does not include total hip replacement.
YELLOW	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/04/2008 30/06/2008	87	
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/07/2008 30/09/2008	93	Please note we are only collecting this information for our total knee surgeries.
YELLOW	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/10/2008 31/12/2008	84	Data is collected for total knee surgeries only.
GREEN	North Bay General Hospital (Infection Prevention and Control)	Infection Control Team	01/01/2009 31/03/2009	95	

### 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 7.8 14.7	January 2010
Obstetrics/Perinatal Care Services 10.5	January 2010
Rehabilitation 10.5	January 2010
Surgical Care 10.5	January 2010
Diagnostic Imaging Services 12.7	January 2010
Medicine Services 10.5	January 2010
Ambulatory Care 11.5	January 2010
Substance Abuse and Problem Gambling Services 10.6	January 2010
Governance 17.3	July 2010
Proactive and Supportive Organization 16.1	July 2010

Standards section and criterion #	Due Date
Infection Prevention and Control 6.1	July 2010
Managing Medications 7.4, 7.5 13.7	July 2010
Mental Health Services 16.1	July 2010
Diagnostic Imaging Services 12.9	July 2010
Emergency Department Services 2.5 6.3 14.3	July 2010
Substance Abuse and Problem Gambling Services 16.1	July 2010
Critical Care Services 10.8	July 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.