



ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:
**Canadian Mental Health Association,
Windsor-Essex County Branch**

Windsor, ON

On-site Survey Dates:
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May 11, 2011



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Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Canadian Mental Health Association, Windsor-Essex County Branch.

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

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Canadian Mental Health Association, Windsor-Essex County Branch only. Accreditation Canada does not release the Report to any other parties.

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

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About the Accreditation Report

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

Legend

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

-  Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.
-  Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.
-  Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.
-  Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.
-  Items marked with an arrow indicate a high risk criterion.

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

The Canadian Mental Health Association (CMHA), Windsor-Essex County Branch is one of the largest CMHA organizations in Canada. Intensive case management forms the core programming of the organization, and it is supported by a number of programs, including such innovative service delivery as the operation of a community health centre (CHC) providing primary care services to CMHA clients.

The organization conducts a community needs review on an annual basis and a formal community needs assessment every three years using a structured process. In addition, the organization participates in the Erie St. Clair Mental Health and Addictions Network, which meets weekly to monitor community needs. Services are regularly adjusted in accordance with community needs assessment and service utilization review. The organization has implemented a number of strategies to increase effective service provision. A case manager is now located on a daily basis at the local hospital's emergency department (ER) to reduce the reliance on hospital admissions.

The organization has achieved successful integration with other providers for service delivery. Two of the organization's Directors and the Accreditation /Quality Coordinator are providing integrated services with other agencies. Strategies toward meaningful functional integration on certain aspects of operations with two other Ontario CMHA branches are currently under development.

The organization is currently participating in a mental health review process, which was initiated by the Local Health Integration Network (LHIN) and involves numerous community partners. Additional integration opportunities are anticipated. The organization is moving to systems, such as financial software, to better support potential integration opportunities.

The organization is affected by the economic downturn conditions of the community in which it operates. Reduced fundraising revenues have resulted in less United Way funding, which in turn, have had an impact on health promotion resources. At the same time, the rate of depression in the community is rising.

The organization has emphasized awareness of client and staff safety and has developed a comprehensive emergency plan and risk management plan. Regular drills regarding fire safety and other components of the emergency plan are evident. The organization has an active Code White strategy, which includes regular debriefing.

The organization relies on a large group of dedicated community volunteers. In 2009, a review of volunteer participation was conducted and resulted in changes to the volunteer program. While the number of volunteers overall was reduced, the remaining volunteers are more active. Furthermore, volunteer programming to include direct client contact was initiated via the Friendly Visitor program, which commenced in the summer of 2010. This program includes an extensive training component for volunteers. Volunteer contributions are recognized via annual events.

Several initiatives have commenced, stemming from the previous accreditation survey in 2008. Staff awareness of the organization's quality program has improved with targeted training, increased communication and availability of information on the intranet, and inclusion of quality on agendas for all unit meetings. The structure of quality improvement reporting has changed with the establishment of a quality working group, with broad representation from senior, operational and front line leadership. Staff report that quality improvement and performance monitoring has become embedded in the day to day work and that the quality working group structure reduces the stress associated with reporting. Strategies to recognize and celebrate involvement in quality initiatives have been introduced.

The organization has and continues to face a number of challenges. Over the past several months, key leadership at the executive level and finance have been absent. The organization has used the services of a private financial firm to mitigate the impact of these temporary absences.

The organization has been challenged to continue providing a full range of necessary services within allocated budgets. Careful position management and delayed recruitment to vacancies where possible are some of the strategies in place. Currently, the organization is in collective bargaining negotiations and the full impact of those negotiations is unclear. The organization is also experiencing capital funding challenges. It has previously relied on operational surpluses to support capital upgrades and projects. A capital reserve fund is in place.

The organization recognized the ongoing challenges of internal communications. Staff continue to report some degree of dissatisfaction with their opportunities for input to decisions that impact on their work and also for communications in general. A number of strategies have been implemented to improve timely, regular internal communications. The organization is encouraged to continue developing strategies to address these staff concerns.

The organization is in the midst of a major policy project, moving policies and procedures to a new system. The project has become more time intensive than anticipated, with activity underway to reduce the overall number of policies by approximately one third. The organization has put contingency strategies in place to make policy documents available to staff as an interim measure.

The organization is currently facing the challenge of sixty five (65) psychiatric in-patients being moved into the area from the St. Thomas Hospital in London. By way of the Mental Health and Addictions Advisory Network, the organization is working with community partners. The Local Health Integration Network has initiated a mental health review for the area.

The organization is commended for holding a recent wellness fair for staff. This fair included screening for hypertension and diabetes. A significant number of staff were found to be hypertensive and as a result, several strategies are in process of implementation, including education and cooking classes provided by a qualified nutritionist.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

The CMHA-WECB is committed to ongoing quality improvement and the development of a culture of safety in the organization. We believe the Accreditation Canada process supports that commitment and we are proud that the report indicates we meet 98.5% of the criteria in the standards of excellence.

The Qmentum process has resulted in increased engagement of the agency's staff, Managers, Directors and Board members in the accreditation process and quality improvement initiatives. Overall, all participants expressed a high level of satisfaction with the process and the on-site survey experience.

This report:

- accurately reflects the successes and challenges of the organization/
- confirms that this organization has shown consistent improvement over time/
- confirms that the organization will continue to build on action plans already in place to address any unmet criteria.

Through assessing our compliance with the standards we have learned the following:

- to celebrate our many achievements/
 - the process is affirming and confidence-building/
 - we have made great improvements in all areas of service/
 - we have a highly committed workforce/
 - we have developed a supportive, positive and innovative culture/
 - we demonstrate accountability to the people we support/
 - we protect the health, safety, and security of our staff and the people we support/
 - we provide a comprehensive wellness program to our staff/
 - through our commitment to quality improvement we improve the outcomes for our clients and the community/
 - we build on plans to further improve services/
 - we have excellent labour-management relations/
 - our ongoing quality improvement and safety processes are successful and sustainable/
- the next phase of our quality journey is both challenging and exciting/
- we are committed to providing training and professional development to our staff/
 - we have created and maintained an effective and innovative volunteer management program.

We thank the survey team for their recommendation to identify the City Centre Health Care and Navigating the Criminal Justice System as leading practices.

Immediate and Long Term Goals to Improve Quality of Care and Diminish Risk

The Accreditation Teams in place at CMHA-WECB will carefully review the action items identified as high priority and all recommendations for improvement. Action plans with identified outcomes and assigned accountability will be implemented.

We look forward to putting our new Framework for Ethical Decision Making into practice when the Ethics Committee completes a review of the Ethical Implications of Storing and Dispensing Sample Medications.

Information Management continues to be a challenge considering limited resources. Back-up systems to ensure ongoing communication in the event of emergency situation will be put in place.

Research is already underway to identify best practice processes for criteria for resource allocation and change management processes.

We will continue to build on our successes identified in the 2011 Accreditation Canada On-Site Survey.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

Leading practices are commendable or exemplary organizational practices that demonstrate high quality leadership and service delivery. Accreditation Canada considers these practices worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue.

Leading Practices

- are creative and innovative
- demonstrate efficiency in practice
- are linked to Accreditation Canada standards
- are adaptable by other organizations

Canadian Mental Health Association, Windsor-Essex County Branch is commended for the following:



Community Care Health Centre

The Vision of the Canadian Mental Health Association - Windsor Essex County Branch (CMHA-WECB) is “Mentally healthy people in a healthy society”. Windsor has been designated as “underserved” so it is difficult for all residents to access primary care. It is even more difficult for individuals diagnosed with severe mental illness. People with a mental illness require a different intensity of supports at different times and require services that are flexible and have the ability to increase or decrease the level of support depending on the person’s needs. Funding was sought for a Community Health Centre to integrate primary care with mental health services and to provide those services at one location. City Centre Health Care is a satellite of a separate organization, Windsor Essex Community Health Centre, and is a program of the CMHA-WECB located within the CMHA-WECB main offices. The Community Care Health Centre has been very successful and the multidisciplinary staff provide services to anyone without a family doctor who lives in the specified catchment area, and to anyone without a family doctor with a diagnosis of serious mental illness living anywhere in Windsor and Essex County.

(Community Health Services)

Overview by Quality Dimension

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	43	0	0	43
Accessibility (Providing timely and equitable services)	17	0	0	17
Safety (Keeping people safe)	107	1	9	117
Worklife (Supporting wellness in the work environment)	50	0	0	50
Client-centred Services (Putting clients and families first)	33	0	3	36
Continuity of Services (Experiencing coordinated and seamless services)	8	0	0	8
Effectiveness (Doing the right thing to achieve the best possible results)	175	4	4	183
Efficiency (Making the best use of resources)	22	1	0	23
Total	455	6	16	477

Overview by Standard Section

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

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	89	1	1	91
Effective Organization	102	4	0	106
Customized Infection Prevention and Control	47	0	2	49
Customized Managing Medications	44	1	7	52
Community Health Services	68	0	0	68
Mental Health Services	105	0	6	111
Total	455	6	16	477

Overview by Required Organizational Practices (ROPs)

All Required Organizational Practices (ROPs) have been met by the organization. There is no follow-up required.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

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

Findings

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

Planning and Service Design

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

Surveyor Comments

The organization conducts a community needs assessment on an annual basis, using a structured process. In addition, the organization participates in the Erie St. Clair Mental Health and Addictions Network, which meets weekly to monitor community needs. Services are regularly adjusted in accordance with community needs assessment and service utilization review. A community needs assessment has been newly conducted within the last month, using nursing students and health promoters to distribute and conduct surveys. In addition, the organization makes use of bi annual community needs assessments conducted by the United Way. Annual client surveys are also used to identify emerging needs. A number of program developments have taken place as a result of ongoing needs assessments and opportunities. Some examples include community treatment order (CTO) programming, supported employment services, and the development of an advisory committee on depression.

The organization has and continues to experience considerable change. Strategies for managing change are developed on an ad hoc basis. Use of a consistent, formal change management process will be beneficial.

A family council was established in 2010. A consumer council is also in place and was involved in the strategic planning process. The organization is encouraged to continue with its consideration of developing a volunteer council. Focus groups for staff and community partners are used to gather input to the strategic plan.

Detailed operational plans are developed for each of the areas in keeping with the organizational strategic goals and objectives. An extensive scorecard reporting mechanism is used to reflect progress and achievement of operational plans. This is then rolled up organizationally, into a summarizing balanced scorecard containing key organizational indicators. The organization has reviewed its quality metrics, and continues to do so on a regular basis to ensure that the collected data remain relevant and useful. The organization has put a formal recognition program in place to celebrate successes in quality initiatives and to recognize other contributions of staff members.

The organization hosted a two day: "Make it Work" conference in the fall of 2010, targeting local employers. Feedback from the conference was positive. In addition, an employer breakfast is hosted as part of Mental Health week.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders follow a formal process to manage change.	4.7	

Resource Management

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

Surveyor Comments

There is a process in place for managers to have input to budget projections, based on program need. These are compared against funding allocations and strategies are developed to address funding shortfall. While a number of factors are considered on an ad hoc basis such as risk to clients and legal requirements, the organization would benefit from the development of an enduring set of criteria against which to assess potential resource allocation strategies.

Currently, the organization is in the process of converting to a new financial software package to better support future integration opportunities.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders follow set criteria to guide resource allocation decisions.	9.2	↑

Human Capital

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

Surveyor Comments

A ten (10) member board of directors is in place. A matrix model is used to promote balanced, broad representation on the board of directors. Board members are also involved in several operational committees. New board members are selected by a board development committee that interviews and nominates candidates, based on the matrix. There is a requirement that at least one board member be francophone. An orientation process is in place for new board members, including orientation to the policy governance model, which is done by an external resource.

Delegation of authority to the CEO is achieved with a list of "do's and don't's", which is articulated as a component of the CEO report at each of the board meetings. The board meets 10 times per year. The board receives regular reports from the Director of Operations and other directors.

The board evaluates its own functioning, both as a group and individually on an annual basis.

The governing body evaluates the performance of the CEO on an annual basis. The governing body is currently considering strategies to implement a more comprehensive, evidence based and structured evaluation process for the CEO. Consideration of strategies for a 360 degree evaluation is encouraged.

Organizational structure has been used as a succession plan during the recent absence of the CEO. The board has determined this strategy as successful, as minimal disruption in services and operations has been experienced.

The organization is commended for achieving a 100 percent compliance rating with exit interviews for the past two years. Knowledge gained from exit interviews is used to identify opportunities for improvement. In addition, the organization has recently adopted a tool for stay interviews and is developing implementation strategies. The initial iteration of stay interviews will be conducted on approximately one third of agency staff that have volunteered to participate in the process.

The organization has achieved approximately sixty six (66) percent compliance with annual performance appraisals (PAs) for all staff, falling short of the ninety (90) percent target. Currently, a short form is used for probationary reviews and a long, comprehensive form is used for annual reviews. The organization is considering a strategy for bi annual review cycles for staff that have exhibited stable, acceptable performance for six consecutive years or more, as well as considering movement towards a strength based model for performance evaluation.

A thorough learning needs assessment was completed in 2008 and updated in 2011. The assessment is completed via staff surveys and PAs and includes organizational priorities, such as training in cognitive behavioural therapy. A number of mandatory training components are in place, and all staff meetings are used to provide targeted training. Professional development is considered and involves an applications process. Knowledge transfer is an expected outcome of professional development participation.

A wellness program is evolving and includes a number of mechanisms aimed at promoting work life balance. Staff are able to use accumulated illness leave to care for ill family members. Staff that are addressing ongoing family issues may request a reduced work week, and telecommuting is available for staff that meet specific criteria.

The organization is commended for holding a recent wellness fair for staff. This fair included screening for hypertension and diabetes. A significant number of staff were found to be hypertensive and as a result, a number of strategies are being implemented. These include education and cooking classes, provided by a qualified nutritionist.

The organization regularly assesses management span of control against best practices. The LEAN methodologies are being used in attempt to best align staff to managers.

The organization relies on a large group of dedicated community volunteers. In 2009, a review of volunteer participation was conducted and resulted in changes to the volunteer program. While the number of volunteers overall was reduced, the remaining volunteers are more active. Furthermore, volunteer programming to include direct client contact was initiated with the Friendly Visitor program, which commenced in the summer of 2010. This program includes an extensive training component for volunteers. Volunteer contributions are recognized by way of annual events. A structured process is in place for application, interviewing, selection, orientation and evaluation of volunteers.

The organization enjoys positive management and bargaining unit relationships. A facilitated workshop that focused on management and bargaining unit communication has been conducted.

The organization has put a formal recognition program in place to celebrate successes in quality initiatives and to recognize other contributions of staff members.

No Unmet Criteria for this Priority Process.

Integrated Quality Management

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

Surveyor Comments

Staff awareness of the organization's quality program has been improved by targeted training, increased communication, availability of information on the intranet, and the inclusion of quality on agendas for all unit meetings. The structure of quality improvement reporting has changed, with establishment of a quality working group that has broad representation from senior, operational and front line leadership.

Staff report that quality improvement (QI) and monitoring has become embedded in the day to day work and the quality working group structure reduces the stress associated with reporting. Strategies to recognize and celebrate involvement in quality initiatives have been introduced. The quality working group receives quality improvement (QI) reports, based on each of the area's scorecard and on a scheduled basis. Reports are compiled and reported to the board quarterly. A number of QI projects are underway or have been completed. The organization is commended for steps it has taken in developing the quality working group to broadly increase staff engagement in quality monitoring and improvement initiatives and embedding quality into the day to day work of the organization.

A comprehensive safety plan is in place. It was developed in 2007 and updated in early 2010. This plan is designed to promote an organizational climate focused on client and staff safety and includes a client/patient safety checklist and a patient safety plan tool. Safety plans are also developed for staff members at risk, such as through domestic violence. A safety culture is now a standing agenda item on all monthly unit meetings and is discussed at every board meeting.

The organization has focussed on client and staff safety and has undertaken a number of improvement initiatives, such as the development and testing of an emergency plan. Potential safety risks are identified via occurrence and near miss reporting, are followed up, and lead to structural or procedural change. Specific attention has been paid to issues of building access control, as they relate to safety.

The organization reviewed practices around medication safety for clients' using pharmaceutical sample medications and as a result, has partnered with a local private pharmacy for storage and dispensing of medications, client teaching and monitoring, and maintenance of medication profiles.

The organization relies heavily on training as a tool to promote safety. Examples include non violent crisis intervention (NVCI), applied suicide intervention skills training (ASSIST), fire safety, domestic and workplace violence and bullying.

The organization has adopted failure modes effect analysis (FMEA) methodology as a quality improvement tool, and has completed a number of analyses. Internal resources knowledgeable in FMEA techniques have been used to train staff across the organization.

External resources such as local police and fire services have been used in partnership to assist in identifying safety concerns. As an example, a site review conducted by local police identified a safety issue related to the main entrance to the building. A team of staff and consumers was convened to develop strategies for addressing the concern.

A comprehensive occurrence reporting strategy is in place. Occurrence reports are regularly reviewed, including a risk categorization, and are trended over time.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

The organization commenced development of an ethics framework in 2008, with the formation of a committee. Using the expertise of the ethics resource centre and the University of Windsor, a comprehensive ethics framework has been developed and recently approved. The comprehensive framework includes policies related to ethics and whistle blowers and provides a decision making tool. Considerable staff education has been provided. The ethics framework and decision making tool have been tested with mock situations, but has yet to be put into use in a real situation. An evaluation of the framework and tool is planned, after its first three to four uses.

The organization is encouraged to assign a senior leader as "champion" for the implementation of the ethics framework.

The organization receives a small number of research requests per year. An independent research review committee from the local hospital or local university is used as the ethical review body for all research projects.

The organization is commended on its use of strategies to ensure that every front line and management employee is fully aware of the vision and mission of the organization.

An ethics culture survey is used and will be repeated annually to monitor trends over time.

No Unmet Criteria for this Priority Process.

Communication

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

Surveyor Comments

While the governing body regularly holds in camera sessions, the CEO is typically present. The board is encouraged to consider holding an in camera component without the CEO present, as part of its routine process for every meeting.

The organization participates in the Mental Health and Addictions Clinical Advisory Network and Access Group, which fosters positive working relationships with community partners. Community partners recognize the strengths of the organization as follows: responsiveness and willingness to get involved; excellent services for youth; giving direct, honest feedback; strong inter professional relationships; rapport with the community; knowledge of community; ability to form partnerships; success and growth over the last decade; expertise of individual staff; and, client advocacy and flexibility.

The organization inconsistently evaluates the usefulness of the data it collects. Currently, a hybrid clinical record is in place, with both electronic and paper records in use. A number of processes are in place that require duplicate data entry. For instance, requiring staff to collect clinical information on hard copy notes or forms and then later, enter the data electronically and shred the forms or notes. It is suggested that the organization use a methodology such as LEAN to map its current processes for documenting clinical information to identify an action plan for improvement. Furthermore, it is evident that some agency staff use personal 'net' books and laptops to collect client information in the field. While staff are instructed not to use identifiable information, the organization is encouraged to consider introducing formal strategies and guidelines regarding the acceptable use of personal equipment for collection of client information.

A communications plan is in place, and was developed in 2008 and updated in 2011. In addition, the organization has initiated a planning process around the use of social media as a communications tool. A Facebook page is currently in place and a number of videos are available via a utube page.

Thorough processes are in place for the regular audit of access to hard copy records. While the technology exists to audit access to electronic records, access reports have not been produced. In order to safeguard privacy and security of clinical information, the organization is encouraged to move forward with plans to implement a regular strategy to audit access to electronic information.

An information technology plan is in place and it is monitored on an infrequent basis. The organization has developed a strategy to review and update the plan over the summer of 2011. Currently, implementation of a major hardware upgrade is underway.

The organization recognizes its challenges with internal communications. Since receiving the work life pulse tool results, the organization has implemented the use of a weekly message newsletter that is circulated every Friday. Other internal communication strategies include CEO memos, regular unit staff meetings and all staff meetings. A formal, facilitated management and union communications workshop has taken place. The team is encouraged to continue strategies for ongoing monitoring to determine effectiveness of internal communications strategies.

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The organization produces a television show on a local cable station as a mental health promotion activity. Scripts and experts are provided by CMHA and the local station provides air time and production. Up to six, 30 minute programs are produced per year and air throughout the year.

The organization monitors local media and takes action to correct myths and otherwise advocates for reducing stigma.

The organization has an Intranet in place, which is used as an information reference and communication tool for staff. Policies and procedures are available electronically in many areas, though this availability has been affected by a change over process from one policy system to another. The organization is encouraged to continue with its strategies to complete the conversion of policies and procedures and thus, improving staff access to policies and procedures as quickly as possible.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization’s leaders regularly assess the quality and usefulness of its data and information, and improve the organization’s information systems.	13.5	
Sustainable Governance		
The governing body holds regular in-camera sessions without the presence of the CEO, senior managers, or clinical leaders.	9.5	

Physical Environment

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

Surveyor Comments

The organization is committed to maintaining a high level of focus on the physical plant. There is an active health and safety committee that ensures client and staff health is protected during any disruptions such as construction or renovations. Back up systems and plans are in place.

Physical areas are clean, well maintained, and attention is paid to safety. This is evidenced in posters and tags around codes, emergency telephones, and easy access to materials in case of spills, and proper procedures for cleanliness. There is an obvious pride in the team that cares for the physical plant, in their work.

Transition House reported that the relationship with maintenance is excellent and the building is in excellent shape.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

The organization has emphasized awareness of client and staff safety and has developed a comprehensive emergency plan and risk management plan. Regular drills regarding fire safety and other components of the emergency plan are evident. The organization has an active Code White strategy, which includes regular debriefing. The team worked with the county’s disaster planner for resource materials and guidance in developing the emergency plan.

Staff across the organization have been trained in all emergency codes at all staff training days. The team is commended for making emergency code information readily available and highly visible, with its inclusion on the back of identification (ID) tags and large hallway displays across the organization.

In response to a growing number of minor incidents and near miss reporting, the organization has implemented a formal process to improve fire safety training and awareness for clients, including the inclusion of fire safety information in lease agreements. Fire drill (code red) and code blue processes are tested on an annual basis, in addition to testing one other emergency plan element. Most recently, a mock code purple was conducted and involved 9-1-1 as a community partner. A thorough debrief was conducted and improvement initiatives were completed following the mock code purple. Debriefing opportunities are provided following all drills and incidents. The organization has staff members specifically trained in critical incident stress debriefing. The organization is encouraged to continue with its plans to test the telephone fan out process in 2011.

All staff and any volunteers interacting directly with clients receive non violent crisis intervention (NVCRI) training, with annual updates.

The organization does not have a back up system in place for telephone outages, but notes that personal cell phone numbers for all staff are on file. The organization is encouraged to document a plan to use personal cell phones as a back up strategy for telephone outages.

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

Criteria	Location	Priority for Action
Effective Organization		
The plan addresses back-up systems, communication processes, and emergency response systems needed during emergency situations.	11.4	↑

Medical Devices and Equipment

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

Surveyor Comments

The organization has minimal medical equipment on site, consisting of some point of care testing equipment and a small sterilizer. Specific clinical staff have been trained in preventative maintenance procedures and maintain a log of their equipment checks.

No Unmet Criteria for this Priority Process.

Direct Service Provision

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

Findings

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

Community Health Services

Clinical Leadership

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

Surveyor Comments

Data are collected in a variety of ways including health fairs, house to house surveys, client satisfaction surveys and other tools. This year, a community needs assessment was done and a number of initiatives will grow out of this work. One example is helping clients access Forgotten Harvest, which is a way of enabling people to have access to fresh fruits and vegetables.

There is clear evidence that the team collaborates extensively with the community, and that health and wellness is a focus. The team uses the balanced score card to develop goals and objective. Encouragement is offered to continue to develop measurable goals. There is a strong commitment to student placement.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

This is a cohesive, collaborative interdisciplinary team that delivers excellent service. Team members commented on how much they have appreciated the training they have received over the past few years.

The team has noted that it will have to ensure that it has a full complement of staff in order to continue to deliver services in a timely matter. There are a number of training opportunities, including yearly training on Code White, and work place and domestic violence.

The team has identified that there are some staffing issues lately, which may impact on its ability to deliver services in a timely manner.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The team is aware of how to access policies around all processes.

There is extensive coordination and discussion with the community. There is a liaison within the ER department at the hospital, which helps to prevent unnecessary admissions. Ethics are part of the regular discussions of the team. Clients felt that they would have no difficulty in making complaints as the team is very receptive to their concerns. The team is encouraged to ensure that clients are aware of the complaint process.

Client satisfaction surveys are done annually. Clients were very happy with the services of this team and felt they had received a very high standard of care.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

The team has identified the need for a technical system that is able to capture all the parameters needed for delivery of care. There has been ongoing education on technology and help is always available should they need it. The team members are actively involved in review processes and work to constantly improve their practice by examining best practice information.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Teams are encouraged to discuss any risks and are trained in non violent crises intervention. They are also aware of medication issues with clients and this is carefully monitored. Safety for clients and staff is an organizational priority.

There is a strong emphasis on safety and there is monitoring of clinical processes and outcomes. Teams were aware of disclosure policies and processes.

No Unmet Criteria for this Priority Process.

Customized Infection Prevention and Control

Infection Prevention and Control

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

Surveyor Comments

Clients are educated about infections and their prevention when they meet with their workers. In addition, pamphlets and other information are readily available.

There is annual, mandatory education on hand hygiene and compliance is checked by way of an annual self assessment evaluation and random spot checks. The compliance rate is reported on the scorecard and to staff at regular meetings.

Housekeeping disinfectants are a good example of how the organization is vigilant around standards for usage, contact time, shelf life, storage, dilution, and required personal protective equipment.

There is a process for cleaning and sterilizing, which follows ministry guidelines, and this includes checklists.

The organization follows national and international guidelines around infection control.

Dates for when sterilization occurred should be on the sterilized packages in the bin.

There is a plan for Pandemics, and for dealing with communicable diseases. During flu season there is emphasis placed on proper procedures and on staying well.

There is an annual infection control audit and strong linkages with Public Health.

No Unmet Criteria for this Priority Process.

Customized Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

There are good processes for managing medications across the organization. All staff are aware of the importance of safe practices and monitor clients carefully. All clinicians have taken a basic pharmacology course and some have taken the advanced course. They seek information from appropriate sources and they encourage clients to obtain information about their medications. There are several resources available to clients including pharmacists and other sources of information.

Where medications are kept in the facility, the storage appears to be adequate. There are ongoing discussions with physicians and pharmacists concerning protocols and other guidelines. Families, when appropriate, are actively involved.

Transition House has recently added two clients on Methadone. The organization will need to audit this on an ongoing basis.

At Transition House, when clients pick up their medications, it is noted in a log.

Sample medications are stored appropriately. There is an inventory review. The organization is encouraged to do an ethical review of sample medication utilization to assess and determine that processes meet best practice guidelines.

It is suggested that the organization conduct a utilization review of medications.

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

Criteria	Location	Priority for Action
The organization monitors medication use with an ongoing medication utilization review.	9.4	

Mental Health Services

Clinical Leadership

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

Surveyor Comments

The team is aware of issues in the community as many of the programs are directly in the community (for example housing, outreach, intensive case management, dual diagnosis and concurrent disorders).

The team is well aware of the mission and vision of CMHA, Windsor-Essex County Branch (WECB). The team is commended on its excellent coordination of services and for raising awareness of services and needs. The team uses a score card methodology to determine goals and objectives and in addition, the individual goals and objectives of the client are identified and scored.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

The organization is committed to ongoing training for staff and provides many opportunities. Safety is a strong focus. There is mandatory training in many aspects of care including non violent crises intervention, infection control, incident reporting, pharmacology and best practices.

The work spaces are clean, comfortable and welcoming for staff and clients. The teams meet regularly and discuss their functioning and examine pertinent data.

Performance review of all staff is done annually. The team meets regularly to discuss services and set priorities. They examine data as needed in order to make improvements.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

All clients are assessed with a common document, the OCAN and risks are identified. In the computerized record there are fields for client safety which are identified and scored. In addition, there are electronic reminders of when the document needs to be updated. The client has direct input into the assessment process.

It is suggested that the organization examine common pain assessment tools and ensure that there is consistency across the organization with regards to pain management.

Clients know where to access services in off hours. Wait lists and waiting times are part of the score card and are monitored regularly. There is an orientation check list that is reviewed with the client. The team is encouraged to review this with the client on a regular basis, as clients did not always remember about making complaints.

The Ontario common assessment of need (OCAN) identifies risk of suicide and staff have received training in the ASSIST program. Suicide potential is carefully monitored. The OCAN gives a place for both client and provider to determine care needs together. The plan is generated from this work. Goal monitoring is done at each clinical visit.

There is a process of medication reconciliation at the early intervention (EI) clinic, which is comprehensive and meets the standards.

It is strongly suggested that the organization conduct an organization wide review of sample medication utilization in the organization to ensure that the practice meets best practice and ethical guidelines and standards. Most clients take their own medications as this is an out patient/client service. Transition House clients' medications are stored in a locked cabinet. The home is supervised 24/7.

It is suggested that the team revisit the orientation checklist that is completed with the client on admission to ensure that the client understands all aspects of care.

Clients and families commented very favourably on the education they have received from staff and how helpful it had been.

Transition out of service is discussed with clients. The EI team is encouraged to pursue its "alumnae" program, as the family interviewed thought it would be very helpful to continue to have some contact until transition was complete.

There is an active ethics committee and teams bring up ethics issues on a regular basis at the meetings.

A FMEA on discharge planning was undertaken this year, and the results will be analyzed with needs for change identified.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

The records on every client are comprehensive, and the organization is encouraged to pursue any identified new technology support that will improve team communication and functioning.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

There is a falls prevention policy and guide. Staff can access information on falls prevention via the intranet. Clients who are at risk for falls can be identified via the screening tools and in client orientation.

Falls are tracked using the serious occurrence report. Clients reported a large amount of education around personal safety including instructions about medications, illness, taking care of ones self in general, and staying safe.

Personal safety is addressed in the client orientation document, and risk of self harm is identified and addressed. There is education on personal safety, food safety, fire safety, abuse, victimization, and so on.

There is ongoing data collection regarding services, clients' perspectives, and process and outcome measures in general.

No Unmet Criteria for this Priority Process.

Performance Measure Results

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


Instrument Results

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





Governance Functioning Tool



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

Summary of Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
	Organization	Organization	Organization	
1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	100	0	0	
2 We have explicit criteria to recruit and select new members.	100	0	0	
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	86	0	14	
4 The composition of our governing body allows us to meet stakeholder and community needs.	100	0	0	
5 Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	100	0	0	
7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	
8 We review our own structure, including size and sub-committee structure.	71	0	29	
9 We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	0	0	
11 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	86	0	14	

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12 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13 Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	67	0	33	
15 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	86	0	14	
16 Our governance processes make sure that everyone participates in decision-making.	100	0	0	
17 Individual members are actively involved in policy-making and strategic planning.	100	0	0	
18 The composition of our governing body contributes to high governance and leadership performance.	86	0	14	
19 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0	
20 Our ongoing education and professional development is encouraged.	100	0	0	
21 Working relationships among individual members and committees are positive.	100	0	0	
22 We have a process to set bylaws and corporate policies.	86	0	14	
23 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24 We formally evaluate our own performance on a regular basis.	86	0	14	
25 We benchmark our performance against other similar organizations and/or national standards.	86	0	14	
26 Contributions of individual members are reviewed regularly.	57	0	43	
27 As a team, we regularly review how we function together and how our governance processes could be improved.	71	0	29	
28 There is a process for improving individual effectiveness when non-performance is an issue.	57	0	43	

29 We regularly identify areas for improvement and engage in our own quality improvement activities.	71	0	29	
30 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	100	0	0	
31 As individual members, we receive adequate feedback about our contribution to the governing body.	57	0	43	
32 We have a process to elect or appoint our chair.	100	0	0	
33 Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	

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Patient Safety Culture Survey













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

Summary of Results

Number of survey respondents = 127 respondents








A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	5	14	81	
2 Good communication flow exists up the chain of command regarding patient safety issues	11	18	70	⚠
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	71	22	6	⚠
4 Senior management has a clear picture of the risk associated with patient care	16	22	62	⚠
5 My unit takes the time to identify and assess risks to patients	4	13	83	
6 My unit does a good job managing risks to ensure patient safety	2	10	88	
7 Senior management provides a climate that promotes patient safety	8	17	75	⚠
8 Asking for help is a sign of incompetence	87	9	4	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	91	4	5	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	25	19	56	⚠
11 I am less effective at work when I am fatigued	10	10	79	
12 Senior management considers patient safety when program changes are discussed	7	24	69	⚠
13 Personal problems can adversely affect my performance	29	18	53	⚠
14 I will suffer negative consequences if I report a patient safety problem	81	16	2	

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15	If I report a patient safety incident, I know that management will act on it	10	14	76	
16	I am rewarded for taking quick action to identify a serious mistake	20	39	42	
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	41	30	29	
18	I have enough time to complete patient care tasks safely	14	21	65	
19	I am not sure about the value of completing incident reports	77	14	9	
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	75	11	14	
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	13	27	60	
22	I have made significant errors in my work that I attribute to my own fatigue	89	7	3	
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	13	18	69	
24	I believe health care errors often go unreported	31	30	39	
25	My organization effectively balances the need for patient safety and the need for productivity	8	24	68	
26	I work in an environment where patient safety is a high priority	4	9	87	
27	Staff are given feedback about changes put into place based on incident reports	15	23	62	
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	7	16	78	
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	13	23	64	
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	8	24	68	
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	65	23	13	
32	My supervisor/manager overlooks patient safety problems that happen over and over	76	12	12	

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33	On this unit, when an incident occurs, we think about it carefully	7	18	75	
34	On this unit, when people make mistakes, they ask others about how they could have prevented it	7	20	73	
35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	6	10	84	
36	On this unit, when an incident occurs, we analyze it thoroughly	12	18	70	
37	On this unit, it is difficult to discuss errors	69	19	12	
38	On this unit, after an incident has occurred, we think long and hard about how to correct it	9	29	62	
B. These questions are about your perceptions of overall patient safety		% Good/Excellent	% Acceptable	% Poor/Failing	Priority for Action
		Organization	Organization	Organization	
39	Please give your unit an overall grade on patient safety	80	17	2	
40	Please give the organization an overall grade on patient safety	76	18	6	
C. These questions are about what happens after a Major Event		% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	9	14	76	
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	11	28	61	
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	23	31	46	
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	11	32	57	

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45 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	15	22	64	
46 Changes are made to reduce re-occurrence of major events	11	13	76	

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Worklife Pulse

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


Summary of Results

Number of survey respondents = 134 respondents

How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 I am satisfied with communications in this organization.	25	17	57	
2 I am satisfied with communications in my work area.	13	16	70	
3 I am satisfied with my supervisor.	16	19	66	
4 I am satisfied with the amount of control I have over my job activities.	13	16	71	
5 I am clear about what is expected of me to do my job.	6	7	87	
6 I am satisfied with my involvement in decision making processes in this organization.	27	30	43	
7 I have enough time to do my job adequately.	34	16	50	
8 I feel that I can trust this organization.	19	27	54	
9 This organization supports my learning and development.	6	8	86	
10 My work environment is safe.	6	15	79	
11 My job allows me to balance my work and family/personal life.	8	15	77	

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were...	14	52	34	
	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is...	48	46	6	
14 In general, would you say your mental health is...	51	42	7	
15 In general, would you say your physical health is...	46	43	10	
	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	91	9	0	
	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	86	7	7	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	83	8	9	
	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	1	19	81	

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	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	16	16	67	
21 Working conditions in my area contribute to patient safety.	5	19	76	

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)	% Formal medication reconciliation at admission
GREEN	Canadian Mental Health Association Windsor Essex County Branch	Mental Health Services (Mental Health Services)	01/04/2010 30/06/2010	100
GREEN	Canadian Mental Health Association Windsor Essex County Branch	Mental Health Services (Mental Health Services)	01/07/2010 30/09/2010	100
GREEN	Canadian Mental Health Association Windsor Essex County Branch	Mental Health Services (Mental Health Services)	01/10/2010 31/12/2010	100
GREEN	Canadian Mental Health Association Windsor Essex County Branch	Mental Health Services (Mental Health Services)	01/01/2011 31/03/2011	100
GREEN	CMHA-WECB, City Centre Health Care	Mental Health Services (Mental Health Services)	01/01/2009 31/03/2009	100
GREEN	CMHA-WECB, City Centre Health Care	Mental Health Services (Mental Health Services)	01/04/2009 30/06/2009	100
GREEN	CMHA-WECB, City Centre Health Care	Mental Health Services (Mental Health Services)	01/07/2009 30/09/2009	100
GREEN	CMHA-WECB, City Centre Health Care	Mental Health Services (Mental Health Services)	01/10/2009 31/12/2009	100
YELLOW	CMHA-WECB, City Centre Health Care	Mental Health Services (Mental Health Services)	01/04/2010 30/06/2010	87

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Medication Reconciliation at Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
GREEN	CMHA-WECB, City Centre Health Care	Mental Health Services (Mental Health Services)	01/07/2010 30/09/2010	100
GREEN	CMHA-WECB, City Centre Health Care	Mental Health Services (Mental Health Services)	01/10/2010 31/12/2010	100
GREEN	CMHA-WECB, City Centre Health Care	Mental Health Services (Mental Health Services)	01/01/2011 31/03/2011	100

Threshold for Flags

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

Appendix A - Accreditation Decision Guidelines

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

There are three possible accreditation decisions under Qmentum.

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

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

NOTES

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

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

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