ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

CHSLD Chateau sur le lac

Ste-Geneviève, QC

On-site survey dates: November 1, 2021 - December 8, 2021

Report issued: April 4, 2022

About the Accreditation Report

CHSLD Chateau sur le lac (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in November 2021. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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

A Message from Accreditation Canada

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

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

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

Thank you for your leadership and for demonstrating your ongoing commitment to quality by integrating accreditation into your improvement program. We welcome your feedback about how we can continue to strengthen the program to ensure it remains relevant to you and your services.

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

CHSLD Chateau sur le lac (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

As part of the Qmentum accreditation program, the organization has undergone a rigorous evaluation process. Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed this organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

This report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

The organization is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

Accreditation Decision

CHSLD Chateau sur le lac's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: November 1, 2021 to December 8, 2021**

- **Location**

  The following location was assessed during the on-site survey.

  1. CHSLD Château sur le lac

- **Standards**

  The following sets of standards were used to assess the organization's programs and services during the on-site survey.

  System-Wide Standards

  1. Infection Prevention and Control Standards for Community-Based Organizations
  2. Leadership Standards for Small, Community-Based Organizations
  3. Medication Management Standards for Community-Based Organizations

  Service Excellence Standards

  4. Long-Term Care Services - Service Excellence Standards

- **Instruments**

  The organization administered:

  1. Worklife Pulse
  2. Canadian Patient Safety Culture Survey Tool: Community Based Version

Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements. Each criterion in the standards is associated with a quality dimension. This table shows the number of criteria related to each dimension that were rated as met, unmet, or not applicable.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	12	2	1	15
Accessibility (Give me timely and equitable services)	10	0	0	10
Safety (Keep me safe)	111	11	19	141
Worklife (Take care of those who take care of me)	34	2	2	38
Client-centred Services (Partner with me and my family in our care)	55	6	6	67
Continuity (Coordinate my care across the continuum)	7	0	0	7
Appropriateness (Do the right thing to achieve the best results)	136	27	15	178
Efficiency (Make the best use of resources)	6	0	0	6
Total	**371**	**48**	**43**	**462**

Overview by Standards

The Qmentum standards identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that are used to measure the organization's compliance with the standard.

System-wide standards address quality and safety at the organizational level in areas such as governance and leadership. Population-specific and service excellence standards address specific populations, sectors, and services. The standards used to assess an organization's programs are based on the type of services it provides.

This table shows the sets of standards used to evaluate the organization's programs and services, and the number and percentage of criteria that were rated met, unmet, or not applicable during the on-site survey.

Accreditation decisions are based on compliance with standards. Percent compliance is calculated to the decimal and not rounded.

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Leadership Standards for Small, Community-Based Organizations	36 (92.3%)	3 (7.7%)	1	63 (91.3%)	6 (8.7%)	1	99 (91.7%)	9 (8.3%)	2
Infection Prevention and Control Standards for Community-Based Organizations	20 (100.0%)	0 (0.0%)	14	33 (82.5%)	7 (17.5%)	7	53 (88.3%)	7 (11.7%)	21
Medication Management Standards for Community-Based Organizations	40 (100.0%)	0 (0.0%)	5	34 (87.2%)	5 (12.8%)	8	74 (93.7%)	5 (6.3%)	13
Long-Term Care Services	48 (87.3%)	7 (12.7%)	1	87 (89.7%)	10 (10.3%)	2	135 (88.8%)	17 (11.2%)	3
Total	**144 (93.5%)**	10 (6.5%)	21	217 (88.6%)	28 (11.4%)	18	361 (90.5%)	38 (9.5%)	39

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Patient safety incident disclosure (Leadership Standards for Small, Community-Based Organizations)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership Standards for Small, Community-Based Organizations)	Unmet	5 of 6	0 of 1
Patient safety quarterly reports (Leadership Standards for Small, Community-Based Organizations)	Unmet	0 of 1	0 of 2
Patient Safety Goal Area: Communication			
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership Standards for Small, Community-Based Organizations)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
The "Do Not Use" list of abbreviations (Medication Management Standards for Community-Based Organizations)	Unmet	4 of 4	2 of 3
Patient Safety Goal Area: Medication Use			
High-Alert Medications (Medication Management Standards for Community-Based Organizations)	Met	5 of 5	3 of 3
Narcotics Safety (Medication Management Standards for Community-Based Organizations)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Patient safety plan (Leadership Standards for Small, Community-Based Organizations)	Unmet	2 of 2	0 of 2
Patient safety: education and training (Leadership Standards for Small, Community-Based Organizations)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership Standards for Small, Community-Based Organizations)	Unmet	1 of 3	0 of 1
Workplace Violence Prevention (Leadership Standards for Small, Community-Based Organizations)	Unmet	6 of 6	1 of 2
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards for Community-Based Organizations)	Unmet	0 of 1	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Education and Training (Infection Prevention and Control Standards for Community-Based Organizations)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards for Community-Based Organizations)	Unmet	0 of 1	1 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Long-Term Care Services)	Unmet	5 of 5	0 of 1
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Suicide Prevention (Long-Term Care Services)	Unmet	4 of 5	0 of 0

Summary of Surveyor Team Observations

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

General comments Château sur le lac

Chateau sur le Lac is a long-term care centre located in the district of Ste-Geneviève in Montreal and is on the territory of the Montréal West Island Integrated University Health and Social Services Centre (Montréal West Island IUHSSC). The Long-Term Care Center is a private, non-subsidized establishment located at 16289, boulevard Gouin, in Montreal. The facility has 50 licensed permanent accommodation places spread over 3 floors, including 26 single rooms, 12 double rooms. However, at the time of the visit, 36 places were occupied. A ministerial visit to assess the living environment took place in 2019. The facility was previously accredited by the Conseil Québécois d'Agrément.
The values, mission, and vision statements are posted in the lobby and provided to each resident when admitted. The values are evident when one enters and feels as though they are entering a home. The 2020-2021 strategic orientations are defined. Operational plans are also present.

Board of Directors and Senior Management

Given its private status, the composition of the Board of Directors is different from that of public establishments. Governance is provided by the director general and reports are made to the shareholder. The owner is the general director and plays an active role in promoting a culture of safe patient care to the residents of the facility. The leadership has a strong belief in the value of a small organization in providing humanistic, homelike care for residents.

For the aspect of communications with residents and families, several tools are in use. There is great availability of management as well as professionals with an "open door" management philosophy. During the pandemic several means were used to maintain the emotional bond with the relatives of the residents and the flow of information with the staff. The presence of a committed team and a well-established living environment are significant strengths.

However, the organization must face significant challenges: the increase in the number of customers who are now over 10 on the ISO-SMAF profile, adequate professional succession, monitoring and maintaining the mobilization after the present accreditation visit, commitment to continuous quality improvement, staff recognition and resident and family satisfaction are constant concerns. Therefore, integrated quality management with performance indicators, as well as a rethinking of the processes in place will be necessary. The organization is fully in the transition to a culture of measurement and is strongly encouraged to continue this path.

Community and Partners

The reorganization of the health and social services network has since 2015 made it possible to formalize relations with the Integrated University Health and Social Services Center (CIUSSS) which serves the territory to which the CHSLD belongs. CHSLD Chateau sur le lac is situated in the service area of the CIUSSS de l'Ouest-de-l 'Île-de-Montréal. It is recommended that Chateau sur le lac increase its collaboration with the Montreal West-Island CIUSSS since it is with them that partnerships and certain oversight and accountability on specific subjects must be supplied. The team constantly collaborates with other services and programs to identify needs, thus allowing the establishment and coordination of the continuum of care.

Given the recent changes in the complaints procedure and that it is the local commissioner of the CIUSSS to which the CHSLD belongs who will follow up on the complaints lodged, it is necessary to review and put in place means of communication with the residents and families to ensure that they are informed of the new procedure in force for filing complaints with the CIUSSS Complaints Commissioner. This last point can be made with the participation of the CIUSSS and the writing of an information capsule that would be disseminated in the information sent to residents and families and having the quality of services Commissioner at the vigilance committee meetings.

Staffing and Quality of Work Life

There is good solidarity between the employees. There are ad hoc accommodations that are made (work-personal life balance) and management does its best to respond to different requests as much as possible. The organization is encouraged to continue exploring with the tools it considers appropriate.

There is no significant staff turnover. Staff performance appraisal is carried out on a regular basis. An information kit for employees and residents is systematically distributed and includes instructions on the safety of residents and employees and we encourage timely review of the content in terms of literacy for the target clientele. Staff are relaxed and very interactive and caring with residents and families.

The organization has carried out the surveys requested by accreditation Canada pertaining to occupational safety components, and one on quality of life at work (Pulse). The organization is now encouraged to develop action plans to implement quality improvement initiatives.

Provision of Care and Services

The Chateau sur le lac has a formalized policy on resident- and family-centred care. Families, residents, and staff all work towards a common goal of making sure that the resident's experience is safe in a family-like atmosphere. The caring, devoted staff and managers interviewed work collaboratively with residents and their families to provide care that is respectful, compassionate, and competent.

The continuity of care is seamless; starting from the pre-admission process where prospective residents and families are explained the organization's admission process in the milieu along with the services which are provided. Families interviewed indicated that this personalized approach to their loved one's pre-admission was very much appreciated. The admission package is comprehensive and appreciated.
The residents and families interviewed indicated that they were regularly consulted regarding the extent to which they wish to be involved in their care. Individualized resident care plans are developed and regularly followed up in partnership with the resident and family.

The team keeps an up-to-date file on each resident. The organization complies with the laws in force on the protection of the privacy of residents and the confidentiality of information concerning them. For each resident, there is an assessment of the risk of developing pressure ulcers and performing the interventions required to prevent them. As a result, there are observation notes in the resident files.

Double identification according to Accreditation Canada standards is respected. A pain assessment tool is also used. We have observed that, in a systematic way, the medication reconciliation is respected.

It is suggested to better disseminate the statistical and audit results since this information also becomes an awareness tool and empowers each team member to provide safe and quality care.

Customer satisfaction

The staff are dedicated and attentive to the residents. The living environment approach has been implemented. Residents and families say they are welcomed and satisfied with the care and services. The participants , during phone interviews, emphasize the courtesy, warmth, and respect of the staff. They share a feeling of security amid the environment.

A customer satisfaction survey has been carried out by the organization. The action plan must now be implemented to address the few issues that were considered less satisfactory. The perception that customers feel respected and well supported by competent, dedicated, and respectful staff contributes to providing human warmth and quality of service. To maintain this satisfaction rate, the establishment will have to deploy means that will ensure the retention and stability of staff, essential to the continuity of services and the maintenance of expertise.

Finally, the entire team is deeply committed and dedicated.

Detailed Required Organizational Practices

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Safety Culture	
Patient safety quarterly reports The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.	· Leadership Standards for Small, Community-Based Organizations 14.10
Patient safety incident management A patient safety incident management system that supports reporting and learning is implemented.	· Leadership Standards for Small, Community-Based Organizations 14.4
Patient Safety Goal Area: Communication	
The Do Not Use list of abbreviations A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.	· Medication Management Standards for Community-Based Organizations 1.5
Patient Safety Goal Area: Worklife/Workforce	
Patient safety plan A patient safety plan is developed and implemented for the organization.	· Leadership Standards for Small, Community-Based Organizations 14.1
Preventive Maintenance Program A preventive maintenance program for medical devices, medical equipment, and medical technology is implemented.	· Leadership Standards for Small, Community-Based Organizations 9.7
Workplace Violence Prevention A documented and coordinated approach to prevent workplace violence is implemented.	· Leadership Standards for Small, Community-Based Organizations 2.10

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Infection Control	
Infection Rates Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.NOTE: This ROP only applies to organizations that have beds and provide nursing care.	· Infection Prevention and Control Standards for Community-Based Organizations 11.2
Hand-Hygiene Compliance Compliance with accepted hand-hygiene practices is measured.	· Infection Prevention and Control Standards for Community-Based Organizations 8.4
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy To prevent falls and reduce the risk of injuries from falling, a risk assessment is conducted for each resident and interventions are implemented.	· Long-Term Care Services 8.6
Suicide Prevention Clients are assessed and monitored for risk of suicide.	· Long-Term Care Services 8.9

Detailed On-site Survey Results

This section provides the detailed results of the on-site survey. When reviewing these results, it is important to review the service excellence and the system-wide results together, as they are complementary. Results are presented in two ways: first by priority process and then by standards sets.

Accreditation Canada defines priority processes as critical areas and systems that have a significant impact on the quality and safety of care and services. Priority processes provide a different perspective from that offered by the standards, organizing the results into themes that cut across departments, services, and teams.

For instance, the patient flow priority process includes criteria from a number of sets of standards that address various aspects of patient flow, from preventing infections to providing timely diagnostic or surgical services. This provides a comprehensive picture of how patients move through the organization and how services are delivered to them, regardless of the department they are in or the specific services they receive.

During the on-site survey, surveyors rate compliance with the criteria, provide a rationale for their rating, and comment on each priority process.

Priority process comments are shown in this report. The rationale for unmet criteria can be found in the organization's online Quality Performance Roadmap.

See Appendix B for a list of priority processes.

INTERPRETING THE TABLES IN THIS SECTION: The tables show all unmet criteria from each set of standards, identify high priority criteria (which include ROPs), and list surveyor comments related to each priority process.

High priority criteria and ROP tests for compliance are identified by the following symbols:

!	High priority criterion
ROP	Required Organizational Practice
MAJOR	Major ROP Test for Compliance
MINOR	Minor ROP Test for Compliance

Priority Process Results for System-wide Standards

The results in this section are presented first by priority process and then by standards set.

Some priority processes in this section also apply to the service excellence standards. Results of unmet criteria that also relate to services should be shared with the relevant team.

Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership Standards for Small, Community-Based Organizations		
1.5	Policies addressing the rights and responsibilities of clients/residents are developed and implemented with input from clients/residents and families.	
1.6	Input is sought from clients/residents and families during the organization's key decision-making processes.	

Surveyor comments on the priority process(es)

The management team has access to the demographic data transmitted by the CIUSSS and the ministry. A new strategic plan (2020-2021), which is a follow-up to the one that ended in 2019, takes into account the reorganization of the network, the current needs of the community and the ministerial orientations. For the next cycle, the organization is encouraged to have the participation of stakeholders such as partners, residents, and families. The new strategic plan encompasses seven priorities which include resident satisfaction, best practices, training, continuous quality improvement, new strategies for human resource attraction and retention and providing opportunities for the CHSLD to be better known within the community.

Operational plans for the various issues are included in the planning. The monitoring of the strategic plan and the analysis of the operational plans are carried out by the management. The organization is encouraged to review the identification of the objectives and have them better specified to monitor their progression. The annual report considers the different challenges that were faced by the organization during the pandemic.

It should also be emphasized that the strategic orientation has made it possible to emphasize the constraints of the organization, to consider the opportunities that can be seized and to have an evaluative look at the resources.

The organization has an Organization Plan with the organizational chart, hierarchical structure, and services. At the time of our visit, some key positions were vacant, and this reflects a broader challenge affecting the healthcare sector.

The surveyors noted the great willingness of the organization to ensure that a living environment and appropriate interventions are updated for residents. The team and staff demonstrate flexibility to personalize care and services, creativity and openness on the part of all to allow optimal response to the specific needs of residents. There is the conviction of offering a living and working environment imbued with humanity, with the resident at the Centre of concerns. Everyone in their own way and according to their skills helps to create a living environment that is warm and reassuring for the resident. The programs and services are evaluated by considering the application criteria to ensure relevance for the resident.

Since this is a private-contracted establishment, there is no board of directors, but rather owners. The establishment is in contact with several partners and discussions with partners confirm the existence of harmonious and constructive relations. Nevertheless, Chateau sur le lac is encouraged to enhance the partnership with the West-Island University Integrated Health and Social Services Centre in terms of possibility of training, clinical and integrated quality tools to move the organizational towards a culture of measurement.

We encourage the organization to survey residents and their families for a satisfaction assessment and, considering the results, sets up quality improvement plans.

Priority Process: Resource Management

Monitoring, administering, and integrating activities related to the allocation and use of resources.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Budget planning and development priorities are established in line with the orientations of the strategic plan. There is a structured budget resource planning and management process. In view of its non-subsidized status, the Centre does not have a board of directors as in a public facility. Governance is provided by the Director General and CEO of the organization, and he reports to shareholders. The allocation and reallocation of resources are based primarily on criteria of well-being of residents and safety.

The financial control and monitoring mechanisms (periodic, quarterly) are exercised by the director general, cost shifts are analyzed to help optimize the use of resources as well as procurement. Thus, there is close monitoring of the use of resources, which does not prevent adjustments from being made when warranted.

Despite tight management of the budget component, there is always the challenge of the workforce and the tools available to private centres under strict regulations versus the tools available in the parallel public sector, which creates situations of potential inequity. For example, monetary incentives for nurses, the granting of full-time positions, which can negatively influence the continuum of services offered to residents in the private sector because they lack the capacity to rival such offers.

Priority Process: Human Capital

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership Standards for Small, Community-Based Organizations			
2.10	A documented and coordinated approach to prevent workplace violence is implemented.		ROP
	2.10.7	The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy.	**MINOR**

Surveyor comments on the priority process(es)

Château sur le lac does not have a human resources department per se, and most of the administrative work is carried out by the office of the director general. Employees are loyal, and state that they remain with Château because of its size, the friendly staff that know each other, good teamwork, respect, strong collaboration.

Human resource development priorities have been identified and monitoring is ensured at the management level. There is the great challenge of the workforce which is omnipresent. The main challenges of the organization, among others, the attraction of staff due to the scarcity of qualified workforce and the power to guarantee hours by incumbent positions. An effort that is put on the stability of staff is aimed at mitigating staff turnover. It is believed the outcome will be increased satisfaction for the residents and the reduction of overtime or mandatory overtime.

There are several human resource management policies that have been revised and updated. The work-task description functions are all well identified and contain a component related to patient safety. A welcoming and orientation program is in place for new workers. There is a performance appraisal policy and the employee files we consulted indicated that such evaluations were carried out on a constant basis.

Training is also very present in the activities of the Centre. Several themes have been discussed since the last accreditation visit. These trainings are the fruit of observations and suggestions from supervision and the concern for always providing resident safety. For example, the different color codes for emergency measures; pressure wound dressing; infection prevention to name a few.

The employee files consulted contained attestations of membership in the professional order and the license to practice, if applicable. It shows the commitment to respect the policy to prevent violence and harassment at work and the code of ethics and respect for confidentiality. The organization is asked to

harassment at work and the code of ethics and respect for confidentiality. The organization is asked to have quarterly reports of the implementation of work-life policy since this is the element which is lacking to respect the required organizational practice of the Accreditation Canada process. It was possible to consult the training register containing the subjects covered during the year.

Premises are set up to allow staff to rest. There is accommodation for work-life balance situations, but accommodations are made on a case-by-case basis and the employees met were aware that this was possible to the extent possible.

Our meetings with families, residents and employees enabled us to identify the improvement in the work climate of the teams dedicated to the quality of care for residents. Stability of resources requires structured support at all levels of the organization. There are recognition activities to highlight the contribution of employees regarding their involvement, their autonomy, their versatility, and their sense of belonging to the mission and values of the organization. We encourage continuing with informal recognition with the different categories of jobs active at the Centre.

The organization is encouraged to finalize the action plan to address the results of the Worklife Pulse tool and the Canadian Patient Safety Culture Survey Tool for which the management has obtained detailed results.

Priority Process: Integrated Quality Management

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership Standards for Small, Community-Based Organizations			
3.6	The spread and sustainability of quality improvement results is promoted and supported.		
14.1	A patient safety plan is developed and implemented for the organization.		ROP
	14.1.2	There is a plan and process in place to address identified patient safety issues.	**MINOR**
	14.1.4	Resources are allocated to support the implementation of the patient safety plan.	**MINOR**
14.4	A patient safety incident management system that supports reporting and learning is implemented.		ROP
	14.4.5	All recommended actions resulting from the analysis of patient safety incidents are reviewed and the rationale to accept, reject, or delay implementation is documented.	**MAJOR**
	14.4.7	The effectiveness of the patient safety incident management system is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Gathering feedback from clients/residents, families, and team members about the system • Monitoring patient safety incident reports by type and severity • Examining whether improvements are implemented and sustained • Determining whether team members feel comfortable reporting patient safety incidents (e.g., based on results from the Canadian Patient Safety Culture Survey Tool).	**MINOR**
14.10	The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.		ROP
	14.10.1	Quarterly patient safety reports are provided to the governing body.	**MAJOR**

14.10.2	The quarterly patient safety reports outline specific organizational activities and accomplishments in support of the organization's patient safety goals and objectives.	**MINOR**
14.10.3	The governing body supports the patient safety activities and accomplishments and acts on the recommended actions in the quarterly patient safety reports.	**MINOR**
15.2	Performance indicators are selected and regularly monitored as part of the quality improvement plan.	!
15.4	Action has been taken on the client experience tool results.	!
15.7	Reports about the organization's performance and quality of services are shared with the team, clients/residents, families, the community served, and other partners and stakeholders.	
15.8	The results of the organization's quality improvement activities are communicated broadly, as appropriate.	!

Surveyor comments on the priority process(es)

The organization is at the beginning of its path towards a culture of measurement. In this respect the Centre is encouraged to make an effort to identify indicators with the SMART approach. This method involves an analysis process to better define the objective with "smart" criteria: specific, measurable, achievable, realistic, temporally defined. The same principle can be applied to different action plans, in particular the security plan and the integrated quality program which directly affect the strategic orientations.

During our survey it was noted that quarterly reports on user safety are not produced. In part, this was explained by the fact that the director general is also the shareholder of the facility and is aware of the situation since he is at the facility. Nevertheless, we must recommend that such reports be produced, and the risk management committee and the integrated quality management committee be activated to have a global perspective on patient safety and quality of care. There is information given to employees, residents, and families on the culture of safety.

Staff indicate that incident / accident reports are followed up by managers. However, the organization is encouraged to analyze and share with staff the tendencies observed in the statistics and share the corrective actions which have been applied.

As for complaints to the Service Quality and Complaints Commissioner, there have not been any. It should be mentioned that since this year and the provincial reorganization for the aspect of complaints to commissioners, there is a new process, and it is the commissioner of the CIUSSS of the serving territory who is responsible for processing the complaint on behalf of a resident or member of his family. Residents and families tell us that if a problem arises the administration works with the family to find acceptable solutions. The organization is also asked to invite the Service Quality and Complaints Commissioner to meetings of their Vigilance Committee.

A patient-safety plan is formally not outlined, however, there are actions that address the different sectors that contribute to the risk associated with the resident; the organization of work; equipment, materials, supplies, work environment, and building; information; to organizational factors. The organization is encouraged to draw up the safety plan soon and add SMART objectives, this is also a required organizational practice for the Accreditation Canada process.

The medication reconciliation policy is in place and roles for each is well established. Relevant stakeholders receive training.

The transparency of the organization should be emphasized regarding the declaration and disclosure of incidents and accidents. The process put in place for the declaration is clear and known to teams, residents, and families through the development of training on the subject. The next step now is to share the results of the analysis of incidents and accidents since the declaration improves the quality of care and services in the organization. Such a process will allow the identification of Quality improvement initiatives to be developed and implemented within the various service areas and committees with the participation of staff, residents, and families. The comité de vigilance (watchdog committee) serves to monitor the recommendations made and the follow-up actions taken.

The results of the Canadian Patient Safety Culture Tool allowed the organization to obtain feedback from staff on the perception they have on safety matters within the organization. Now Château sur le lac must provide an action plan to address these concerns to promote a blame-free culture for reporting, and to clarify the difference between human errors and negligence of duties and responsibilities, and disciplinary actions. We encourage the organization to continue its efforts in a formative approach to the reporting of incidents and accidents.

The results of the Work Like Pulse Tool were also received and now require did not require an action plan. These results reflect how employees perceive their job, the training and development opportunities, their relationship with their co-workers and managers, and their safety and health ensured in the workplace.

For the information technology component, the facility has an information asset security policy that is applied. Data security is performed automatically daily. The server locations are secure.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a conceptual ethical framework that applies to residents and staff. It is available in the welcome package but also posted in different areas of the facility. The Code of Ethics for residents is also available and can be found in the welcome packages given at admission. Employees sign a declaration of allegiance regarding confidentiality. This form can be found in the employee's file. The comments of residents and families as well as our findings confirm that confidentiality is respected.

Staff know the procedure for obtaining information that touches on an ethical dilemma, staff refer to their immediate supervisor. The facility has a policy on harassment and discrimination.

The organization has access to a Local Complaints Commissioner who produces annual reports and intervenes when necessary. It is suggested that the CHSLD Château sur le lac hold thematic sessions with the staff and families of residents to raise their awareness and promote reflection on the themes addressed, for example confidentiality, level of care, end of treatment or abuse. The meetings of the vigilance committee should also include the Complaints Commissioner of the Montréal West Island Integrated University Health and Social Services Centre.

An end-of-life program is developed as well as training. Levels of care are systematically discussed with the family upon admission or when the resident's situation changes. Situations involving dysphagia problems and the use of restraints are discussed with the family. The organization adopts the intervention philosophy of having no restraints and favoring alternative measures. Information on various subjects is part of the documentation included in the Resident Welcome Guide.

Although there is no research conducted in the centre, it is recommended that this be stated in the framework. The organization is also encouraged to consider the use of the framework for decisions such as resource allocation. This can assist them in ensuring all elements in a decision have been considered. The ethical issue which will potentially pose the greatest ethical challenge, to the organization and staff, in the future is the legislation on around the end of life and assisted medical aid to dying. The organization is cognizant that educational activities will need to be put in place to sensitize, prepare, and accompany the staff if confronted with such a situation.

Priority Process: Communication

Communicating effectively at all levels of the organization and with external stakeholders.

Unmet Criteria	High Priority Criteria
Standards Set: Leadership Standards for Small, Community-Based Organizations	
7.3 Input is sought from the organization's partners to evaluate the effectiveness of their relationships with the organization.	

Surveyor comments on the priority process(es)

The organization is encouraged to assess whether a revised communication plan should be adopted which would take into account the strategic objectives and harmonize information management. The plan should include both internal and external communication and have among objectives: publicizing the mission, vision and values of the organization; be an essential lever for achieving organizational objectives; coordinate communications and the dissemination of information to residents, families, staff, managers, volunteers and partners.

The effectiveness of each communication strategy that will be adopted should be evaluated with the results of satisfaction questionnaires completed by employees, families, and residents. Modifications made to the communication plan are then made as needed.

The stratification of information goes through senior management. A communication and memo book exists for updating information. The organization is encouraged to clarify what type of information goes into the communication book to ensure that pertinent clinical information that must be in the patient's chart is recorded in the chart. Access to the medical chart is stated in the list of resident rights as well as how to exercise that right. There are no electronic patient records, and all medical files are in paper format.
The organization is also encouraged to review the different policies and procedures to assure itself that it has the updated revision in their documentation.

The leisure calendar of activities should be accrued with a variety of activities which would encourage participation. Communications between employees and management are open.

The resident and family Welcome Guide, along with the Employee Welcome Guide contain relevant and useful information. Conversations with residents and family regarding information sharing allowed us to confirm that this channel is functional and appreciated. The organization is encouraged to continue to reinforce collaboration with its partners, particularly the Montréal West Island Integrated University Health and Social Services Centre (Montréal West Island IUHSSC).

For the information technology (IT) safety component, there are backups which are made on a regular basis. In terms of confidentiality, there is concern among staff for information security and the preservation of confidentiality. All staff sign the respect of confidentiality agreement when hired.

Priority Process: Physical Environment

Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Chateau sur le Lac is located on the banks of the Riviere des Prairies. Several residents' rooms as well as the dining room have windows overlooking the backyard and river views.

There is an outdoor patio available for use during the warmer months.

Resident rooms are spacious and bright. Hallways are well lit.

In keeping with the season, Christmas decorations adorn the walls and are set up in common areas within easy view.

Housekeeping and maintenance staff maintain the space, which is clean.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Within the context of the current COVID19 pandemic, the organization has been able to update their pandemic plan in collaboration with their CIUSSS and with Public Health directives.
Consistent with these directives the outbreak management measures are still in place and are followed by the team members.

The organization contracted with an external consultant to develop/update their current Disaster and Emergency preparedness plan which was finalized in October 2021. The staff has received training about this updated plan and when asked can articulate their roles and responsibilities particularly in case of an evacuation.
There is an entente with another nearby CHSLD to shelter the residents of the Chateau sur le Lac should the need arise.

There are sprinklers and smoke detectors installed in all wings and on all floors;these are regularly inspected and maintained by an outside company.

The home's location on the banks of the Riviere de la Prairie makes it susceptible to flooding; a sump pump is available to use should this occur. The maintenance team routinely ensures that the sump pump is in working order.

Nursing team members have use of battery operated walkie- talkies.

An up-to-date list of the residents is always kept at the main entrance

Emergency lighting is located in key areas are activated in the event of a power outage; and the home has a supply of flashlights that are kept fully charged

The organization is encouraged to pursue its efforts to have a generator installed as a back up system in case of a power outage.

The development and implementation of a training calendar may be useful in ensuring that the staff has the opportunity to review and practice each of the different measures outlined in the plan on a regular basis.

Priority Process: People-Centred Care

Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership Standards for Small, Community-Based Organizations		
6.2	When developing the operational plans, input is sought from team members, clients/residents and families, volunteers, and other stakeholders, and the plans are communicated throughout the organization.	
Standards Set: Long-Term Care Services		
16.8	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from residents and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families.	!

Surveyor comments on the priority process(es)

Within the organization, we find a human approach centered on the needs of residents and loved ones. Relatives are involved in sharing their knowledge of the resident. The teams are dedicated and invested in the safety and quality of interventions. The notion of people-centered care has been named as a force within the organization by residents, relatives and by the residents' committee.

The care and services are personalized. The hours of sleep, meals, the desire for isolation is respected in the organization while promoting socialization and retention of achievements. Relatives are involved in daily life and are stakeholders in meeting the needs of residents, both in terms of nutrition and the choice of interventions.

The teams have the desire to make a partnership with the resident and his relatives and they are encouraged at the management level in this way. The workers are committed to maintaining fluid and human communication with the residents' relatives. Calls and meetings are frequent even outside the formal framework of interdisciplinary meetings.

The establishment is encouraged to have a more involved creative leisure department. The activities should be varied and present during weekends.

The teams have a holistic approach to residents and know how to put the individual at the heart of actions at all stages of their journey, from admission to end of life. There is an open dialogue between staff, residents, and families. When a family asks something, the organization answers quickly.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The majority of admissions at Château sur le Lac occur through the mécanisme d'accès à l'hébergement. Future residents and their families are asked for details as to what type of facility they are looking for and their financial possibility. This information is then given to an intermediary who takes charge of finding a CHSLD that can accommodate the required needs of the resident. There are established criteria that are identified for the admission and flow of patients. There is an attempt to minimize wait times and care is taken to assure that there are no barriers in providing the care that is needed for the resident. When the resident cannot be given, the services required an appropriate reference is made to assure the continuity of care.

Château sur le Lac has a policy that there are no temporary admissions of less than three months. A welcome guide is given to new residents upon admission. The guide contains a wealth of information that can support family members on the care and services offered. The intake process allows residents and their families to respond to their concerns by sharing information that is abundant. There is support provided to the family in the process of placing their loved one in care. It is suggested to move now to the step of evaluating the experience of the resident who can provide details on the items that can be improved in the care and assistance processes in place by putting forth specific action plans.

Priority Process: Medical Devices and Equipment

Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.

Unmet Criteria			High Priority Criteria
Standards Set: Leadership Standards for Small, Community-Based Organizations			
9.7	A preventive maintenance program for medical devices, medical equipment, and medical technology is implemented.		ROP
	9.7.2	There are documented preventive maintenance reports.	**MAJOR**
	9.7.3	There is a process to evaluate the effectiveness of the preventive maintenance program.	**MINOR**
	9.7.4	There is documented follow up related to investigating incidents and problems involving medical devices, equipment, and technology.	**MAJOR**

Surveyor comments on the priority process(es)

The organization uses glucometers that are provided to the residents by the pharmacy and are specific to the use of each resident who requires them.

There is one suction pump on their emergency cart for which preventive maintenance is performed regularly and routinely in conformity with guidelines provided by the CIUSSS.

The organization does not sterilize equipment; the medical devices and equipment on hand are not sterilizable. The organization does not have any facilities for sterilization

There are processes for preventive maintenance, however reports are not documented.

It is recommended that the organization develop and implement preventive maintenance report sheets

Service Excellence Standards Results

The results in this section are grouped first by standards set and then by priority process.

Priority processes specific to service excellence standards are:

Infection Prevention and Control for Community-Based Organizations

- Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Medication Management for Community-Based Organizations

- Using interdisciplinary teams to manage the provision of medication to clients

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

- Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.

Episode of Care

- Partnering with clients and families to provide client-centred services throughout the health care encounter.

Decision Support

- Maintaining efficient, secure information systems to support effective service delivery.

Impact on Outcomes

- Using evidence and quality improvement measures to evaluate and improve safety and quality of services.

Standards Set: Infection Prevention and Control Standards for Community-Based Organizations - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Infection Prevention and Control for Community-Based Organizations			
4.6	Compliance with infection prevention and control policies and procedures is monitored and improvements are made to the policies and procedures based on the results.		
5.1	A multi-faceted approach to promote infection prevention and control activities is used within the organization.		
5.2	Team members, clients/residents and families, and volunteers are engaged when developing strategies for promoting infection prevention and control activities.		
5.6	The effectiveness of activities to promote infection prevention and control are evaluated regularly and improvements are made as needed.		
8.4	Compliance with accepted hand-hygiene practices is measured.		ROP
	8.4.1	Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).	**MAJOR**
	8.4.2	Hand-hygiene compliance results are shared with team members and volunteers.	**MINOR**
	8.4.3	Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	**MINOR**
9.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients/residents and families, and improvements are made as needed.		

11.2	Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization. NOTE: This ROP only applies to organizations that have beds and provide nursing care.	ROP
11.2.1	Health care-associated infection rates are tracked.	**MAJOR**
11.2.3	Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body.	**MINOR**
13.1	Infection prevention and control activities are regularly evaluated.	
13.2	Performance measures are monitored for infection prevention and control.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control for Community-Based Organizations

The organization is to be congratulated for not having any COVID -19 outbreaks during the first wave of the pandemic!

Over the past 20 months the infection prevention and control activities have been focused on responding to the needs related to the pandemic. To this end, policies and procedures were revised and updated; staff received a lot of training related to basic precautions and additional precautions. The CIUSSS also provided support for infection prevention and control actdivities during this time; one of their infection prevention and control advisors provided guidance for arranging the physical environment. Support has also been provided by the CIUSSS in vaccinating the residents.
In addition one RN and one LPN were sent for a 10 hour training on COVID-19.

Public health directives regarding allowing visitors access to the home are strictly followed: all visitors are required to perform hand hygiene; their temperature is checked and they are provided a clean mask at the door prior to entry.

All staff have received training in hand hygiene practices and in donning and doffing Personal Protective equipment.
The resident welcome package includes information related to infection prevention and control.

As pandemic restrictions are lifted, the organization is encouraged to begin/resume the identification, monitoring and evaluation of infection prevention and control activities and to share the results of these with the entire team. There are already some monitoring tools available within the current policies and

procedures, the organization is encouraged to implement their use. It is also suggested that one of the priorities should be to implement regular hand hygiene audits.

The organization would also benefit from regular input from an infection prevention and control expert who could provide guidance and feedback when infection prevention and control policies are developed/revised, when making decisions about selecting materials and supplies for the home and when initiating renovation and construction projects.

Standards Set: Long-Term Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
4.5 The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care	
7.7 Translation and interpretation services are available for residents and families as needed.	
8.6 To prevent falls and reduce the risk of injuries from falling, a risk assessment is conducted for each resident and interventions are implemented. 8.6.6 The effectiveness of fall prevention and injury reduction activities (e.g., risk assessment process and tools, protocols and procedures, documentation, education, and information) are evaluated, and results are used to make improvements when needed.	ROP **MINOR**
8.9 Clients are assessed and monitored for risk of suicide. 8.9.2 The risk of suicide for each client is assessed at regular intervals or as needs change.	ROP **MAJOR**
11.1 Policies and procedures for POCT are developed with input from residents and families.	
11.2 Responsibility for overseeing the delivery of POCT and maintaining quality is assigned to a health care professional.	
11.3 Orientation and training on POCT policies and procedures is provided to all health care professionals delivering POCT.	
11.4 The date and time of the point-of-care test, the individual carrying out the test, the results of the test, and the action required when the results are outside the normal range are recorded in the resident's record by the health care professional who conducts the POCT.	!

Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from residents and families, teams, and partners.	
15.3	There is a standardized process, developed with input from residents and families, to decide among conflicting evidence-informed guidelines.	!
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from residents and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with residents, families, teams, organization leaders, and other organizations, as appropriate.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from residents and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Presently the residence is operating without the benefit of a Director of Nursing to guide the nursing team. This important leadership position has a significant impact as there is no one to ensure that current nursing policies and practices are adequately maintained and to provide direction and structure for the nursing team.
It is recommended, while the organization is in the process of recruiting someone to fill this role, that the organization assign or appoint someone in the interim to coordinate the activities of the nursing team, to ensure that the quality of nursing care is maintained at a high level.

The team and residents would also benefit from having regular input from other disciplines in care and service planning- such as physiotherapy, occupational therapy, nutrition and recreation.

Priority Process: Competency

Team members consistently reported that they had received performance evaluations.
Team members also confirm that they have received education and training on a variety of topics. There is a "Plan de formation 2020-2023" and based on discussions with various team members this plan has been followed.

Staff members are encouraged to follow up on opportunities to enhance and expand their skills.

Attendance records and outlines of in-house trainings were not available for review.
The organization is encouraged to continue to follow and implement the current plan de formation.
It is recommended that attendance records and copies or outlines of the information presented be stored so that in case of absence or departure they can be accessed and/or referred to when determining future educational activities

Priority Process: Episode of Care

Care team members are warm, receptive, respectful, caring and dedicated to their work and to the residence itself.
Residents appear to be clean and neat. Great care is taken to respect the residents' privacy and dignity.
Team members make every effort adhere to the residents' wishes and preferences related to their care.
Resident rooms are decorated to their personal preference, but with attention and in conformity with universal fall precautions (uncluttered, call bell within reach, etc.) It is evident that the residents feel comfortable with the staff; and the staff know the residents.

Hot meals are available, generous portion sizes. Menu plans are adapted based on feedback from residents and families. Residents may choose to have their meals in their rooms, or if they prefer to eat at different time, their food is held for them until they are ready to eat.

There are books available for the residents to read, and the TV room has a big screen TV. Some residents have TVs in their rooms.
During the pandemic, in accordance with Public Health directives, many activities and stimulation exercises were cancelled or postponed.
Recently, Public Health has allowed some limited activities to resume, these are lead by the PABs, in addition to their regular functions.

As the pandemic restrictions are eased (and in accordance to Public Health guidance) the organization is encouraged to re-introduce recreational and rehabilitation activities for the residents.

Priority Process: Decision Support

Resident charts are well organized and complete. Each shift charts using a different color ink.
There are standardized documentation tools. Therapeutic nursing plans are updated as necessary.

Charts are stored in the RN office, in a closed cabinet.

The organization may wish to consider implementing a regular process for chart audits

Priority Process: Impact on Outcomes

Selection of evidence-informed guidelines, development of policies and procedures and initiating and maintaining quality improvement activities was largely the responsibility of the Director(s) of Nursing.

There has been a turnover of Directors of Nursing at the residence in recent years, each time without transfer of knowledge.

At the time of this survey, there is no Director of Nursing in place.

The nursing care team did not have access to the quality indicator data collection tools or to any data that may have already been collected.

There are several policy and procedure binders available, some in the nurses' office, some in the Director of Nursing office. Many of the binders are generically labelled, so that it is sometimes necessary to pull out several binders before finding the policy/procedure that you were searching for. Some binders have a table of contents at the front to facilitate the search, others do not. Some documents are found in more than one binder. There are some binders that contain hard copies of some of the Online Care Methods.

The organization may wish to consider creating a computerized shared folder where all of this information and data can be stored and which would be accessible so that in the event of the DON's absence; care team quality improvement initiatives can continue.

It would be beneficial for the team to review and simplify their method of storing and classifying their policies and procedures. The organization could consider having these documents available electronicallly, in a shared drive so that documents can be easily revised and updated and with only the current version available. If feasible, the organization might wish to subscribe to the "Online Care Methods" as a supplement to the policies and procedures currently in place.
It is suggested that guidelines are established for the use of the internet for information related to care so that the organization can ensure that care team members are using information from evidence based, legitimate sources.

It is recommended that care team members participate in some way in the revision and/or development of care policies and procedures, and in the selection of evidence-informed guidelines.

Standards Set: Medication Management Standards for Community-Based Organizations - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management for Community-Based Organizations		
1.5	A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.	ROP
1.5.7	Compliance with the Do Not Use List is audited and process changes are implemented based on identified issues.	**MINOR**
5.3	The effectiveness of training activities for medication management is evaluated and improvements are made as needed.	
6.1	Team members have access to accurate, standard, and up-to-date medication information and tools.	
23.3	Process and outcome indicators for medication management are monitored.	
23.4	The information collected about the medication management system is used to identify successes and opportunities for improvement, and improvements are made in a timely way.	
23.5	Evaluation results are shared with teams.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management for Community-Based Organizations		

The organization has an entente with a Uniprix pharmacy to provide service and support to residents and staff.

The majority of the residents are served by this pharmacy; the Director works to encourage the residents who are served by other pharmacies to make the switch to ensure consistency of service and practice; as well as to ensure the safety for the residents.

The Uniprix owner/pharmacists visit the home on a regular basis, providing support to the other members of the team. They review the stock medications (including the emergency supply medications) and will update the list as necessary.

The pharmacists review the residents' charts and medication profiles monthly and will provide recommendations.
The pharmacists are available by telephone not only to respond to questions and concerns of staff, but

also respond to residents and families as required.

Residents' medications are supplied in dispil format or unidose format. Emergency (night cupboard) medications are provided in strips. The organization minimizes its use of high alert medications. High dose/high potency narcotics are not stocked.

Two CPS dated 2016 were seen in the medication room. The care team states that they do not have any other medication information tools at hand.
The pharmacists will provide drug information sheets when needed.

It is recommended that up-to-date, standard medication information tools are made available to the nursing care team.

It is also recommended that the care team identify specific, measurable indicators to follow so that they can evaluate their medication management system. This process may be facilitated by sharing information (bi-directional) with their partner pharmacist regarding medication events and analyzing these events together.

It may also be of benefit to the care team to organize on site information sessions presented by the pharmacists when medications that are new to the team are in use within the residence, or when new drugs become available. This will also promote safety and security in the medication management process.

Instrument Results

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

Canadian Patient Safety Culture Survey Tool: Community Based Version

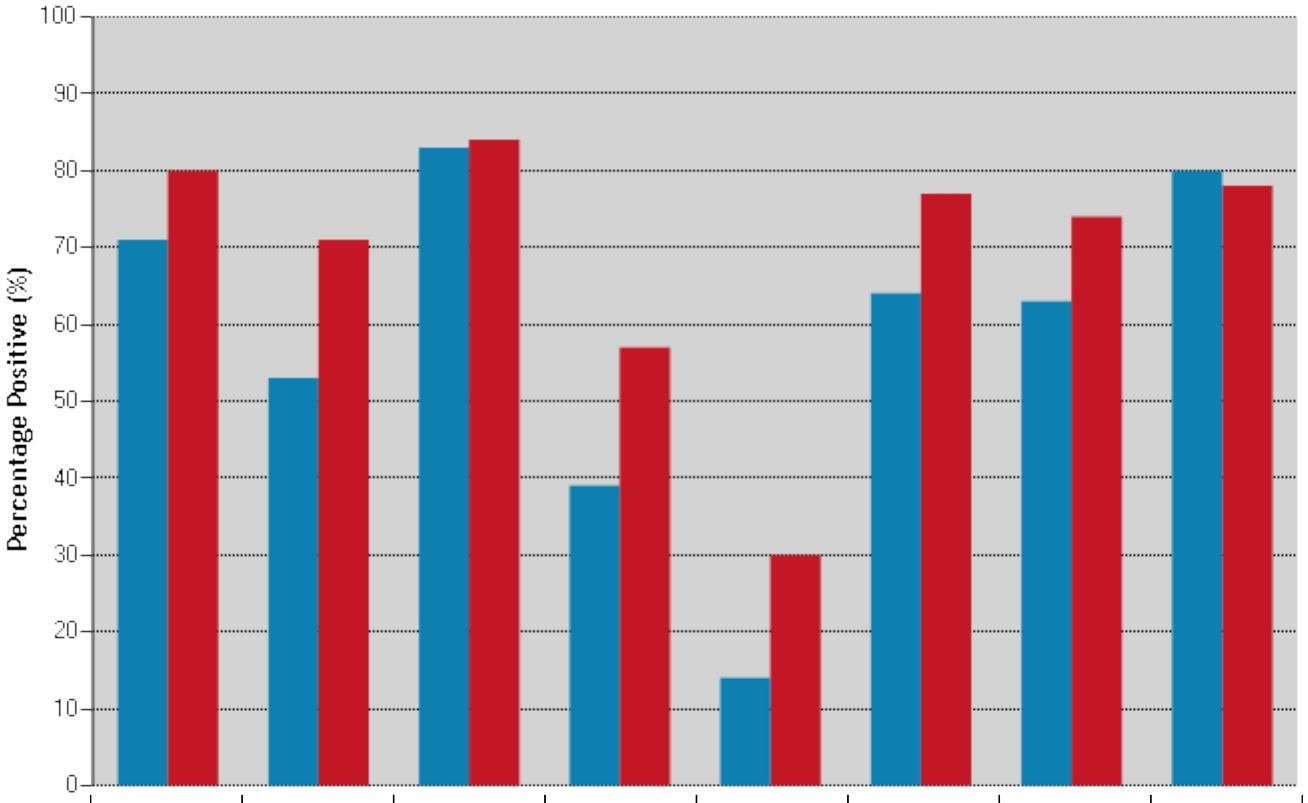
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations with the Patient Safety Culture Tool, an evidence-informed questionnaire that provides insight into staff perceptions of patient safety. This tool gives organizations an overall patient safety grade and measures a number of dimensions of patient safety culture.

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: August 7, 2020 to December 19, 2020**
- **Minimum responses rate (based on the number of eligible employees): 32**
- **Number of responses: 32**

Canadian Patient Safety Culture Survey Tool: Community Based Version: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	71%	53%	83%	39%	14%	64%	63%	80%
	80%	71%	84%	57%	30%	77%	74%	78%

Legend

CHSLD Chateau sur le lac

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2021 and agreed with the instrument items.

Worklife Pulse

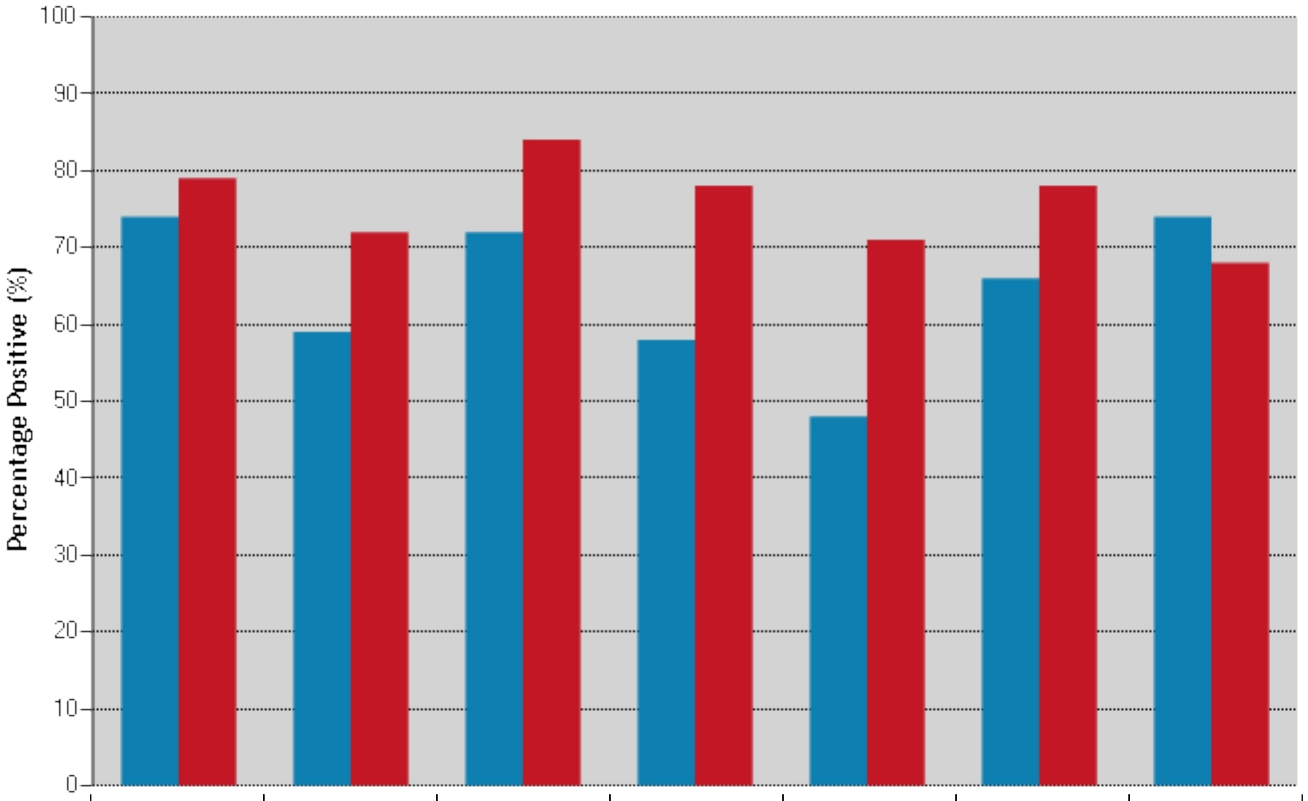
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

Organizations can use results from the Worklife Pulse Tool to identify strengths and gaps in the quality of worklife, 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. By taking action to improve the determinants of worklife measured in the Worklife Pulse tool, organizations can improve outcomes.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: August 7, 2020 to December 18, 2020**
- **Minimum responses rate (based on the number of eligible employees): 32**
- **Number of responses: 32**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	74%	59%	72%	58%	48%	66%	74%
	79%	72%	84%	78%	71%	78%	68%

Legend

CHSLD Chateau sur le lac

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2021 and agreed with the instrument items.

Appendix A - Qmentum

Health care accreditation contributes to quality improvement and patient safety by enabling a health organization to regularly and consistently assess and improve its services. Accreditation Canada's Qmentum accreditation program offers a customized process aligned with each client organization's needs and priorities.

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 15 business days.

An important adjunct to the Accreditation Report is the online Quality Performance Roadmap, available to client organizations through their portal. The organization uses the information in the Roadmap in conjunction with the Accreditation Report to ensure that it develops comprehensive action plans.

Throughout the four-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, develop action plans, and monitor progress.

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
Communication	Communicating effectively at all levels of the organization and with external stakeholders.
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety.
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services.
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings.
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.
Principle-based Care and Decision Making	Identifying and making decisions about ethical dilemmas and problems.
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources.

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Priority Process	Description
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge