ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Central Regional Integrated Health Authority

Grand Falls-Windsor, NL

On-site survey dates: May 5, 2013 - May 10, 2013

Report issued: June 19, 2013

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

Accredited by ISQua

About the Accreditation Report

Central Regional Integrated Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in May 2013. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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 Accreditation Specialist 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,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

Central Regional Integrated Health Authority's accreditation decision is:

Accredited (Report)

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

1.2 About the On-site Survey

- **On-site survey dates: May 5, 2013 to May 10, 2013**

- **Locations**

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

  1 Bay d'Espoir Community Health Centre
  2 Bell Place Community Health Centre
  3 Botwood Community Health Centre
  4 Brookfield/Bonnews Health Centre
  5 Carmelite House
  6 Central Health Regional Office
  7 Central Newfoundland Regional Health Centre
  8 Connaigre Peninsula Community Health Centre
  9 Dr. Hugh Twomey Health Centre
  10 Grand Falls-Windsor Community Health
  11 Green Bay Community Health Centre (CONA & Hewlett)
  12 Green Bay Health Centre (Valley Vista & Hospital)
  13 James Paton Memorial Regional Health Center
  14 Lewisporte Health Centre
  15 New World Island Community Health Centre
  16 Notre Dame Bay Memorial Health Centre
  17 St. Alban's Community Health Centre

- **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 Leadership
  2 Governance

  Population-specific Standards

  3 Maternal/Child Populations
  4 Public Health Services

  Service Excellence Standards

  5 Managing Medications
  6 Operating Rooms

7 Reprocessing and Sterilization of Reusable Medical Devices
8 Developmental Disabilities Services
9 Surgical Care Services
10 Critical Care
11 Emergency Department
12 Infection Prevention and Control
13 Home Care Services
14 Ambulatory Care Services
15 Biomedical Laboratory Services
16 Diagnostic Imaging Services
17 Laboratory and Blood Services
18 Long-Term Care Services
19 Medicine Services
20 Substance Abuse and Problem Gambling Services
21 Blood Bank and Transfusion Services
22 Community-Based Mental Health Services and Supports Standards
23 Obstetrics Services
24 Emergency Medical Services

- **Instruments**

  The organization administer:

  1 Governance Functioning Tool
  2 Patient Safety Culture Tool
  3 Worklife Pulse Tool
  4 Client Experience Tool

1.3 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 (Working with communities to anticipate and meet needs)	117	9	0	126
 Accessibility (Providing timely and equitable services)	128	4	1	133
 Safety (Keeping people safe)	653	31	18	702
 Worklife (Supporting wellness in the work environment)	201	1	0	202
 Client-centred Services (Putting clients and families first)	233	4	9	246
 Continuity of Services (Experiencing coordinated and seamless services)	92	2	0	94
 Effectiveness (Doing the right thing to achieve the best possible results)	988	65	21	1074
 Efficiency (Making the best use of resources)	95	4	2	101
Total	**2507**	**120**	**51**	**2678**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	43 (97.7%)	1 (2.3%)	0	34 (100.0%)	0 (0.0%)	0	77 (98.7%)	1 (1.3%)	0
Leadership	46 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	131 (100.0%)	0 (0.0%)	0
Public Health Services	47 (100.0%)	0 (0.0%)	0	68 (100.0%)	0 (0.0%)	0	115 (100.0%)	0 (0.0%)	0
Maternal/Child Populations	3 (100.0%)	0 (0.0%)	0	29 (100.0%)	0 (0.0%)	0	32 (100.0%)	0 (0.0%)	0
Diagnostic Imaging Services	63 (98.4%)	1 (1.6%)	3	59 (98.3%)	1 (1.7%)	1	122 (98.4%)	2 (1.6%)	4
Obstetrics Services	55 (90.2%)	6 (9.8%)	2	71 (94.7%)	4 (5.3%)	0	126 (92.6%)	10 (7.4%)	2
Infection Prevention and Control	47 (94.0%)	3 (6.0%)	3	43 (100.0%)	0 (0.0%)	1	90 (96.8%)	3 (3.2%)	4
Ambulatory Care Services	36 (97.3%)	1 (2.7%)	1	72 (96.0%)	3 (4.0%)	0	108 (96.4%)	4 (3.6%)	1
Biomedical Laboratory Services **	16 (100.0%)	0 (0.0%)	0	35 (97.2%)	1 (2.8%)	0	51 (98.1%)	1 (1.9%)	0
Blood Bank and Transfusion Services **	41 (100.0%)	0 (0.0%)	1	17 (100.0%)	0 (0.0%)	0	58 (100.0%)	0 (0.0%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Community-Based Mental Health Services and Supports Standards	18 (100.0%)	0 (0.0%)	0	104 (92.9%)	8 (7.1%)	0	122 (93.8%)	8 (6.2%)	0
Critical Care	28 (93.3%)	2 (6.7%)	0	84 (92.3%)	7 (7.7%)	2	112 (92.6%)	9 (7.4%)	2
Developmental Disabilities Services	34 (100.0%)	0 (0.0%)	1	74 (97.4%)	2 (2.6%)	0	108 (98.2%)	2 (1.8%)	1
Emergency Department	29 (93.5%)	2 (6.5%)	0	78 (96.3%)	3 (3.7%)	14	107 (95.5%)	5 (4.5%)	14
Emergency Medical Services	33 (84.6%)	6 (15.4%)	0	109 (86.5%)	17 (13.5%)	0	142 (86.1%)	23 (13.9%)	0
Home Care Services	41 (100.0%)	0 (0.0%)	0	52 (100.0%)	0 (0.0%)	0	93 (100.0%)	0 (0.0%)	0
Laboratory and Blood Services **	80 (100.0%)	0 (0.0%)	1	95 (100.0%)	0 (0.0%)	0	175 (100.0%)	0 (0.0%)	1
Long-Term Care Services	24 (100.0%)	0 (0.0%)	0	72 (100.0%)	0 (0.0%)	0	96 (100.0%)	0 (0.0%)	0
Managing Medications	74 (98.7%)	1 (1.3%)	1	48 (100.0%)	0 (0.0%)	4	122 (99.2%)	1 (0.8%)	5
Medicine Services	26 (100.0%)	0 (0.0%)	1	60 (88.2%)	8 (11.8%)	1	86 (91.5%)	8 (8.5%)	2
Operating Rooms	67 (97.1%)	2 (2.9%)	0	27 (90.0%)	3 (10.0%)	0	94 (94.9%)	5 (5.1%)	0
Reprocessing and Sterilization of Reusable Medical Devices	36 (92.3%)	3 (7.7%)	1	55 (96.5%)	2 (3.5%)	2	91 (94.8%)	5 (5.2%)	3
Substance Abuse and Problem Gambling Services	21 (95.5%)	1 (4.5%)	5	60 (87.0%)	9 (13.0%)	2	81 (89.0%)	10 (11.0%)	7
Surgical Care Services	27 (93.1%)	2 (6.9%)	1	60 (92.3%)	5 (7.7%)	0	87 (92.6%)	7 (7.4%)	1

Total	**935 (96.8%)**	31 (3.2%)	21	1491 (95.3%)	73 (4.7%)	27	2426 (95.9%)	104 (4.1%)	48

* Does not includes ROP (Required Organizational Practices)
** Some criteria within this standards set were pre-rated based on the organization's accreditation through the Ontario Laboratory Accreditation Quality Management Program-Laboratory Services (QMP-LS).

1.5 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			
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Home Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Long-Term Care Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Managing Medications)	Unmet	3 of 4	2 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Home Care Services)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Leadership)	Met	4 of 4	0 of 0
Medication Reconciliation At Admission (Ambulatory Care Services)	Unmet	2 of 5	0 of 2
Medication Reconciliation At Admission (Community-Based Mental Health Services and Supports Standards)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Critical Care)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Emergency Department)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Home Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Obstetrics Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Surgical Care Services)	Unmet	1 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Ambulatory Care Services)	Unmet	2 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Community-Based Mental Health Services and Supports Standards)	Unmet	0 of 3	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication Reconciliation at Transfer or Discharge (Critical Care)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Emergency Department)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Home Care Services)	Met	3 of 3	2 of 2
Medication Reconciliation at Transfer or Discharge (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Obstetrics Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Surgical Care Services)	Unmet	1 of 4	0 of 1
Surgical Checklist (Operating Rooms)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Home Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Managing Medications)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Two Client Identifiers (Substance Abuse and Problem Gambling Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Managing Medications)	Met	1 of 1	0 of 0
Heparin Safety (Managing Medications)	Met	4 of 4	0 of 0
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Home Care Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Long-Term Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Managing Medications)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Met	1 of 1	0 of 0
Infusion Pumps Training (Surgical Care Services)	Met	1 of 1	0 of 0
Medication Concentrations (Managing Medications)	Met	1 of 1	0 of 0
Narcotics Safety (Managing Medications)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Antimicrobial Stewardship (Managing Medications)	Unmet	4 of 4	0 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand Hygiene Audit (Infection Prevention and Control)	Met	1 of 1	2 of 2
Hand Hygiene Education And Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Unmet	0 of 3	0 of 2
Falls Prevention Strategy (Surgical Care Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Surgical Care Services)	Met	3 of 3	2 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Surgical Care Services)	Unmet	2 of 3	0 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Central Regional Integrated Health Authority is commended on preparing for and participating in the Qmentum program. This is the second largest health region in Newfoundland and Labrador. It was formed in 2005 with the amalgamation of three health regions. The organization has worked to integrate services and programs across the region and simultaneously deliver a continuum of healthcare services to its population of approximately 94,000 residents.

Since the previous accreditation survey in 2010, Central Regional Integrated Health Authority (Central Regional IHA) has prioritized quality and safety in both strategic and operational planning. As a result of the work done, many deficiencies identified in the previous survey and subsequent report has been addressed and work is ongoing to address more. The organization has many accomplishments of which it can be proud. The board and leadership team are committed to the delivery of safe, quality health services. They want their organization to be characterized by transparency and accountability to the people they serve.

The board of trustees for Central Regional IHA is a committed group of dedicated people that volunteer their time to attend board meetings and participate in sub-committees and community advisory committees. They provide good stewardship of resources and can be counted on to support the administrative team in its work.

Community partnerships are established, and of note are the Community Advisory Committees (CACs) attended by members of the board, which promote community engagement in the communities they represent. Several things contribute to their success: the participation of the community development nurses; the primary health care staff; the recognition they receive on the board agendas and the resources and support they are given by the organization's Communications resource. The strategy; "Central Speaks" was highlighted by community partners as a successful and productive strategy to engage the public and receive feedback on seniors' strategies.

Community partners' would like to encourage the organization to increase its promotion of community awareness and citizen engagement in the two regional centres. Rural residents feel engaged with the region and know what services are available and what services are needed in their communities. This was not as apparent in the regional centres of Grand Falls-Windsor and Gander.

The organization will face budget challenges for 2013-14 and have yet to be confirmed but despite this uncertainty and the interim status of the chief executive officer (CEO), there is strong leadership and direction at the senior level. Work continues on meeting the objectives of operational plans in all program and service areas. The day-to-day work of providing service and support continues despite the financial uncertainty, announced changes to the nursing model of care and the collective bargaining process that began when the union agreements expired at the end of March 2013.

There are several challenges the leadership team will face in the upcoming year. They include: confirming the operating and capital budget; making adjustments in services to ensure a balanced budget; responding to any new provincial directives; working on the 2014-17 strategic plan and stabilizing the management structure.

Solid leadership commitment to the quality and safety agenda is noted. The challenge of sustaining the gains made to date and providing the resources needed to achieve further improvements and address identified gaps is acknowledged.

Insofar as staffing and worklife many staff members that work for the Central Regional IHA are dedicated to the organization, their work and the people they serve. They demonstrate compassion and enthusiasm for their work. In 2012, the organization conducted its staff survey focusing on: "Mental Health at Work." Education is underway to educate managers on key issues related to the area of mental health and a healthy workplace and worklife. The selection of this workplace wellness initiative was selected by the organization with the objective of improving worklife as well as reducing the stigma of mental illness.

There are a variety of educational and professional development opportunities available to management and non-management staff members and physicians. Many are delivered by the organization. There are some external opportunities, which are not available within the organization but supported by the organization. An example would be the online certificate program available to the community development nurses and offered by the Public Health Agency of Canada.

Concerted effort has been made across the organization to complete performance appraisals. The organization is encouraged to continue working on its succession planning program that focuses on developing people from within the organization to fill vacancies.

It is recommended that the organization review its position descriptions following any changes in its structure or in the roles of health care providers. Many position descriptions were last reviewed in 2007. There is a need to review staffing levels across the region for consistency in programs and services, particularly in long-term care (LTC).

Regarding delivery of care and services, the organization recognizes the approach to solving the region's systemic issues of utilization and access must include physicians, the public and all service areas. The systemic issues are everyone's issue.

There are examples of innovative practices across Central Regional HIA improve access and quality of care. One example is the inclusion of a registered nurse (RN) from the inpatient mental health unit on the Code Blue team in the hospital in Grand Falls. Another example is the telehealth program where a pharmacist at a regional centre works with a pharmacy technician at a rural site via telehealth to check inpatient medication orders and preparations prior to their being dispensed and administered.

There are numerous examples of innovative models of care such as dementia bungalows, restorative care and integration of mental health and addictions.

The variation in Emergency Medical Services (EMS) in the region is an area that requires attention. Although there is hope that the recent provincial review on EMS will help direct change, the EMS quality team is encouraged to continue the work on the standardization of operational procedures according to best practices in EMS.

Safety engineered needles are not present in surveyed areas of the organization, although syringes used for subcutaneous insulin injections do have safety engineered needles to protect the care provider from needle stick injuries. The no re-capping policy however, and presence of disposable sharps containers does not provide the level of practice considered to be best practice.

The organization is encouraged to build on the work of the Primary Health Care Model, with further integration of rural teams and by implementing the full model across the region.

It is noted some implemented required organizational practices (ROPs) are at a stage of evaluation, and are showing improvement is required. For example, the Do Not Use abbreviations are not used consistently. Interventions are required that could improve compliance. Also, the plan-do-study-act (PDSA) cycle needs to

continue.

Clients that were interviewed by the surveyor team are generally satisfied with their care and care providers in all care settings and service areas surveyed. Patients waiting in the emergency (ER) department for admission expressed discomfort with hallway stretchers and found it difficult to rest with the lights and activity going on around them. Some patients interviewed expressed frustration with long wait times in the ERs in Gander and Grand Falls-Windsor.

Patients have been surveyed by the organization to determine their satisfaction with services and the results indicated in the 2012 survey show a high level of satisfaction with services. Some service areas have conducted their own satisfaction surveys or have been part of a provincially led survey. In the case of the maternal-child service group, results of their most recent survey served as the impetus for identifying the Baby Friendly quality initiative as a quality improvement (QI) project. There is an identified plan in some service areas to conduct client satisfaction surveys every two years.

A challenge for the organization is keeping the public well-informed of changes to care delivery models and services and engaging them in the process where possible. The organization is encouraged to look at ways to increase public awareness and promote citizen engagement with the health region in the two larger communities of Gander and Grand Falls- Gander.

Section 2 Detailed Required Organizational Practices Results

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: Communication	
Medication Reconciliation At Admission The team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	· Obstetrics Services 9.5 · Community-Based Mental Health Services and Supports Standards 12.3 · Surgical Care Services 7.13 · Critical Care 7.6 · Emergency Department 8.3 · Ambulatory Care Services 8.3
Medication Reconciliation at Transfer or Discharge The team reconciles the client's medications at interfaces of care where the client is at risk for medication discrepancies (circle of care, discharge) with the involvement of the client and family or caregiver when medication management is a component of care, or as deemed appropriate through clinician assessment.	· Obstetrics Services 12.3 · Surgical Care Services 11.4 · Emergency Department 11.5 · Ambulatory Care Services 12.2 · Critical Care 12.5 · Community-Based Mental Health Services and Supports Standards 14.3
Dangerous Abbreviations The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	· Managing Medications 10.2
Patient Safety Goal Area: Infection Control	
Antimicrobial Stewardship The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	· Managing Medications 1.3

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Falls Prevention	
Falls Prevention Strategy The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	· Obstetrics Services 18.2
Patient Safety Goal Area: Risk Assessment	
Venous Thromboembolism Prophylaxis The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	· Surgical Care Services 7.7

Section 3 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

3.1 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.

3.1.1 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has developed research and evaluation capacity during the past three years, which can now be utilized for strategic planning purposes, to form an integrated approach.

A corporate improvement team that has been assembled. The program and service leadership currently in place provide the organization with the means to creatively and knowledgeably plan and design changes to the organization as required to meet budget requirements and to address the service needs into the future.

The existing collaborative relations with the other regional health authorities (RHAs) may become a noted and helpful strength in responding to the budget requirements, with a multi-regional and provincial strategy for service delivery for some program planning issues.

The organization is encouraged to pursue further information and education, to build greater community awareness of service delivery best practices and to increase the willingness to embrace changes in service delivery.

Encouragement is offered to: seek selected and strategic consultation with the provincial government; and increase understanding of the region's strategic plan and how the budget requirements can be accommodated within a change management approach that bridges to the next fiscal year and into the next three year planning cycle.

3.1.2 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria			High Priority Criteria
Standards Set: Governance			
13.8	The governing body regularly assesses its own functioning using the Governance Functioning Tool.		!
	13.8.1	The governing body monitors its team functioning by administering the Governance Functioning Tool at least once every three years.	
	13.8.2	The governing body has taken action based on its most recent Governance Functioning Tool results.	

Surveyor comments on the priority process(es)

The board members have good experience and know the region's population well. The board has a good level of understanding regarding the region's strategic operational plans.

The board is knowledgeable about and supportive of patient safety and quality improvement.

The board is familiar and discerning regarding the organization's external environment.

There is opportunity to increase the number of board members by up to six individuals. These additions would strengthen the representation across the region and also enable better sub-committee size.

It is suggested the board could go further in board succession planning.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is a good steward of its resources. The board of trustee's finance sub-committee meets regularly to review financial reports and expenditures. An analysis of variances is prepared by the vice president of finance and corporate services and discussed regularly at sub-committee and board meetings, providing context for the board regarding its operating and capital budget.

There is a well-documented policy and procedure on the capital equipment and capital renovation processes. Criterion for what constitutes a capital item or renovation is articulated in the policy, followed by a clear explanation as to how requests are submitted and reviewed.

The organization gathers input from internal and external stakeholders regarding resource allocation decisions. However, budgetary challenges in the 2013-14 fiscal cycle may necessitate a review of operational priorities that will not allow extensive consultation of external partners. The organization may have to rely on the work it has done to date and its current assessment of regional/community needs to make budgetary decisions.

Inclusion of the Foundation Board director on the capital infrastructure review committee promotes good communication between the organization and the main fundraising entity in the region. This helps ensure the Foundation Board has a clear understanding of the needs and priorities of the organization and allows it to serve as knowledgeable fundraisers, able to clearly communicate the organization's needs to funders.

Strong processes are in place for regular financial reporting to the board and for the annual report to stakeholders and communities. There are appropriate resource management controls in place such as external financial auditing, board oversight and meetings with provincial government representatives in the Ministry of Health and Community Services.

The organization has improved its capital budgeting process by designing a clearly documented process. The process requires all internal stakeholders namely, materials management, maintenance/biomedical and information management to be consulted on capital equipment requests to improve communication among and between departments. This helps to ensure that all aspects of a capital purchase have been considered including maintenance of the equipment, renovations required and information management impacts.

Another department to consider when purchasing capital equipment or when planning capital renovations is infection prevention and control (IPAC). It is important that IPAC be aware of cleaning, disinfecting and sterilizing requirements of new equipment as well as any protective IPAC measures that may be required during a capital renovation or building project.

Tracking of capital equipment is done using a spreadsheet. Additional electronic programming of the process could improve functionality of all aspects of the process including the capital list, request/compilation and approval documentation and communication.

The organization is encouraged to apply a similar assessment and prioritization process to strategic information management and technology (IMT) projects as it does to capital equipment and capital renovation projects. It also needs to ensure clear communication of which IMT projects are being prioritized and how that fits into the strategic direction of the organization and provincial direction.

3.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The relatively high level of staff experience and education, combined with the staff members' broad-based personal connection to the community and the organization will help sustain the organizational cultural during the anticipated changes in the next several months.

The investment in staff education and training in process improvement techniques, patient safety and evidence informed decision- making will prove helpful in planning and implementing program and service changes.

The increased employee recognition implemented by Senior Leadership and Human Resources and engagement opportunities initiated by multiple departments should be continued.

Internal communication and staff involvement in the implementation of the planned changes will need to be a sustained priority during the coming months. Additionally, sustained board awareness and timely support of leadership may become more needed than usual during the roll-out of the planned and anticipated changes.

3.1.5 Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the previous accreditation survey in 2010, the organization has completed an integrated quality improvement framework and built up its department of corporate improvement. This department does a good job of supporting quality improvement, safety initiatives and risk assessment and mitigation across the region. The organization's attention to quality and safety as one of its three strategic priorities has resulted in a shift in the culture of the organization.

The seventeen (17) quality teams in the organization are supported with education, training and documents on a variety of quality related topics including: leading quality improvement: developing a quality improvement (QI) plan and guiding the implementation of QI initiatives.

Guidelines for quality case reviews are thorough and documentation provides for follow-up of recommendations that come from the case reviews. The availability of guidance teams to provide support to QI project teams ensure the availability of resources for the project team and serve to facilitate the project teams' work across the organization.

Physician engagement is recognized by the organization as a key element necessary to the success of the quality management program, and efforts have been made to support physician participation in quality management. Adjusting communication and education sessions to suit physicians' schedules have greatly improved participation. Plus, clearly stating role expectations for chiefs of staff and the medical chief of rural services as well as the implementation of a single set of new medical bylaws have all contributed to increased physician engagement. This is a significant improvement over the past two years, as stated by physicians and staff interviewed during the on-site survey.

The organization uses many evidence-based and best practice tools to inform its quality work. Tools include: Lean; Health Care Management Review; Rural Secretariat resources to engage stakeholders; Clinical Efficiency Review; Contextualized Health Research Synthesis Program (A review of Age-friendly Acute Care strategies). These are some of the tools and information sources used by the organization.

The department of corporate improvement has good resources, with competent and enthusiastic professionals. Decreasing resources in this area would threaten the 'sustainability' of ongoing and future quality initiatives and put at risk the gains that the organization has made in the area of quality and safety,

The organization, staff, physicians and patients are exposed to considerable risk and safety threats in the regional ERs where long wait times and overcapacity have become a daily occurrence. Concerted improvement efforts across the region and across service areas will be required to address patient flow in the ERs and the numbers of alternate level of care (ALC) patients occupying inpatient beds in Gander and Grand Falls-Windsor.

Establishing and monitoring timelines for completion of quality case reviews is recommended. It is important the organization is able to demonstrate to both internal and external stakeholders, improvements in the

quality and safety of service. As the organization and its managers begin to collect and analyze more data they will be challenged to find meaningful ways to organize and communicate the findings to their stakeholders.

The organization has a plan to implement medication reconciliation during the next three years. Medication reconciliation is widely recognized as an important safety initiative that can reduce medication errors. The organization is encouraged to consider a shorter time frame to completely implement medication reconciliation at care transitions.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the 2010 accreditation survey, the organization has created one ethics committee structure with three areas of focus; research review, ethics consultation and promoting the use of core values as well as ethical principles in organizational decision-making. The organization has prioritized principle-based care and decision-making in both its clinical and non-clinical areas and has provided both support and direction to the ethics committee.

There is a mandate to the ethics committee to promote awareness and use of core values and ethical principles in organizational decision-making by the board trustees, physicians, staff and volunteers

There is a memorandum of understanding (MOU) and it has resulted in enhanced collaboration with provincial experts in ethics via the Provincial Health Ethics Network of Newfoundland and Labrador (PHENNL), established in 2012 as a result of collaboration in the province to provide ethics support to the four health authorities.

There is access to ethical expertise for consultations, policy review, systemic crisis issues of pandemic and drug shortage and education and professional development.

The organization's staff members are enthusiastic learners and also, ethics committee members.

There are experts and structures in place in the province and Central Regional IHA to engage communities and provide education and promote discussion among citizens on a variety of ethics issues.

Encouragement is offered that as the sub-committee on: "Bringing Your Values to Life" develops the course content and roll-out plan for the Fall of 2013, the committee is reminded to consider what measures it will use to evaluate the success of the program.

3.1.7 Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There are many examples of communication tools and strategies used by Central Regional IHA to inform its internal and external stakeholders of services offered, changes in services, programs and upcoming events. The: "News you can Use" is directed at managers and connects them and their staff with activities in the organization. Primary care newsletters in rural communities provide interesting local information about services and personal health issues.

The Communication Department brings both skill and creativity to their work. Hardcopy information sheets, newsletters, etc. are well-formatted, colourful and easy to read. Pictures are often used to help tell the story or put faces to names of staff and community participants. They support the communication needs of many departments and services in the region and provide knowledgeable support with media requests.

There are a significant number of communications strategies and materials that are developed outside of the Communications Department by program staff and their administrative support; for example, News You Can Use, Corporate Report Card, Primary Healthcare Newsletters, and many specific brochures and client information.

The region's website and intranet provides excellent up to date information and is well-utilized especially by internal stakeholders.

The Crisis Communication Plan is detailed and current with up to date contact names and numbers in the appendices.

The Situation-Background-Assessment-Recommendation (SBAR) communication tool implementation has begun. It is recognized as an excellent tool for improving communication.

Having Strategic Information Management and Technology take part in the Leadership Council and report directly to the VP of Quality, Planning and Priorities ensures they are a key supporter of many quality initiatives and understand the organization's strategic direction and priorities. This department is embedded into many quality teams and provides support and advice on the technological side of many projects. The department has technical and clinical people on its staff and this further helps in understanding the business of the organization. There are numerous projects underway in which IMT is involved. They are frequently called upon to re-prioritize and add projects and they have good systems in place to monitor progress. Putting the Risk and Safety Management Alert System (RASMAS) - for alert-recall management- and the client safety reporting system (CSRS) -for incident reporting- on-line has improved reporting thus improving assessment of risk and easier identification of problems and quality improvement opportunities.

The organization has demonstrated transparency and accountability in the communication with internal and external stakeholders. In turn this has promoted trust in those two groups.

The organization has a knowledgeable privacy department that has good resources. Staff members are well-versed in privacy legislation and in the organization's responsibility for health information protection.

The software program used by the department allows a proactive approach to auditing for privacy incidents and actual breaches in privacy. The department provides regular education to staff members and understands it is necessary to remind staff and physicians of their obligations regarding confidentiality on an ongoing basis. They have provided support to material management to ensure contracts have appropriate confidentiality clauses and have worked with physicians, including fee-for-service physicians to ensure a clear understanding of privacy legislation.

Most community partners at the focus group acknowledged the organization uses a variety of communication tools and solicits feedback from some stakeholders via primary care newsletters, and the Community Advisory Committees (CACs). However, there were some partners from the larger regional centres of Gander and Grand Falls that indicated they do not regularly receive information from the organization describing accomplishments, challenges, services available in the region, strategic direction or other information of interest. A directed mail out or mail out on request to community stakeholder organizations of the annual report or other documents of interest might improve communication in this area. Additionally, citizen engagement in these regional centres is recommended. During the on-site survey there were consistent comments made by patients in the two regional centres about the general lack of awareness about health services. These patients' suggestions were to have a link from the municipal websites to the Central Regional IHA website, to use the local newspaper to advertise and to ensure community physicians' offices and other key locations have posters/pamphlets that describe the services available, both in the hospital and in the community.

Celebrating the organization's successes and communicating these to internal and external stakeholders is also a recommended area in which to expand the communications. Telling the organization's story fits well with one of the organization's six values namely, that of accountability.

3.1.8 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)

Overall, Central Health buildings are well-maintained and meet the functional needs of programs and services. There is significant variation in age of buildings and equipment from newly opened to original frame construction more than fifty years old. There is much construction taking place across the region and staff members are challenged to manage construction projects as well as maintain day-to-day operations. This is particularly true of hybrid construction projects where staff members are involved in the construction improvements.

Overall, buildings are well-maintained and meet functional needs of programs and services. Most buildings are older and have required renovation to maintain safety and meet program and patient needs. While staff members report work has been slow, they acknowledge there has been steady improvement. Standards have been maintained during construction while impact on patient flow and service has been minimized. Public, patient and provider safety is the top priority during construction and renovations.

Capital planning is well done, particularly in locations where a master plan exists. Capital planning is an area that requires both local operational input as well as program input to meet mutual goals.

It is noted the leased spaces are not as well-maintained as those that are owned and operated by Central Health. The region should ensure that all contracts with landlords have a clause detailing maintenance standards and documented processes for monitoring compliance of these standards.

It is risky to name rural clinic treatment rooms as emergency rooms (ERs). Consistent naming of services will provide clarity to staff and communities about expectations and scope of services.

Renovations that would have a positive impact on functional flow and patient flow require frequent review as staff report that a small renovation would result in a large improvement in functionality or patient flow.

The organization has made considerable effort to improve the physical plants for LTC residents that live in regional facilities. Encouragement is offered to continue the work to enhance living and dining spaces, enlargement of doorways and washrooms and install automatic door openers.

Not all facilities are accessible by wheelchair owing to uneven entrances or heavy doors. This needs to be a priority for all facilities to align with organizational strategic direction to support an aging population.

3.1.9 Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has taken the time to develop an excellent framework to ensure there are plans, equipment and trained staff in case of an emergency. The framework is modified and localized for every building that houses health services in the region. A new code system is being implemented and the team is commended for the detailed planning, communication and training that is occurring across the region. A new code-a-month is a great way to introduce new information to staff members.

The organization is familiar with disasters (Code Orange) and has learned every time it is faced with hurricanes, power outages and storms. Examples are hurricane Igor and the Fogo Island ice blockade incident most recently in February 2013. The incident command system has been implemented and the debriefing template has allowed for opportunities to take the time to debrief and review what worked and identify areas for improvement. An example in the Fogo incident was the importance of partnering locally and provincially, as this time the coast guard had to help this community that was locked-in by weather.

Mock disasters are also planned such as the one in the Botwood area in the past year that used a ship explosion scenario as the table-top disaster exercise: "Operation Fire Down Below." The steering group is working on developing a guideline of when mock disasters should occur. Encouragement is offered to look at both mock and real disasters as learning opportunities and plan schedules accordingly

Partnerships with community municipalities, provincial agencies, public health (PH) and infection prevention and control (IPAC) are evident and observed in many communities and documented in plans

Another commendable practice is the monitoring of vaccines, especially in community clinics that are not open evenings and weekends. A triple check system is in place where vaccine refrigerator alarms are triggered and sent to the health centre, and the option of another monitored refrigerator and coolers for transport.

The team has used the ethics framework to make decisions during the drug shortages, which has been a longer standing emergency and has taken much time in the last year. The team will also be using a similar framework as it tackles the movement of blood products across the region.

During the on-site survey a great communications plan was demonstrated, with electronic notifications to Bookmarks for code information and weather advisory notifications to public and staff to name a few. It is noted this was a first in the province and is used by other regions.

Fire plans are up-to-date, and include regular drills which are tested and monitored. An excellent creative option for leased spaces that does not have an alarm system in Botwood, are the whistles with flashlights that staff carry with their name tags.

The majority of staff members understand the plan and how to execute in emergencies.

The team has terms of reference and meets regularly. Encouragement is offered to develop a work plan for

ongoing development and monitoring.

3.1.10 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)

Patient flow is an issue in Central Health. This has been recognized as an increasing problem for several years that is compromising access and quality of care. There are multidisciplinary teams that work on this issue (ED, EMS, DI, medical and administrative staff). This is not a problem that is focused on a single department, but is an organizational issue. This team gathers information from several sources and works to develop ways and means to reduce overall pressures. At any given time there is up to 30 per cent of inpatient beds occupied by ALC patients in the major sites plus up to five being held in the ED hallway (Grand Falls). In the community there are long waiting lists for the long term care beds that are available.

Integral to solutions is the continuing education of the public. With about 60 percent of ED visits to the major sites triaged at Canadian triage acuity scale (CTAS) 4-5 level, this can overwhelm appropriate response to the grey area of CTAS level 3 patients. Engagement of the public in this issue could be a partial solution along with developing further community options such as, working with private clinics to extend hours. The integration of bed management for both rural and urban has been implemented to some extent, but still requires full buy-in by the public and some staff members.

The ED tends to bear the brunt of the operational impact and has undertaken some specific actions. The trigger tool for ED overcrowding is now essentially always at level 4 (which calls into question its usefulness). Inpatient units can respond with overcapacity beds. A recent review by an external group has suggested some changes to the physical layout of the ED(Grand Falls) to improve flow, such as setting up a dedicated emergency registration desk and the implementation of an NP fast track. Innovations such as these will help flow largely within the ED. The proposal to set up a community Rapid Response Team is also encouraged. The implementation of a daily morning bed need forecast via email has been well-received by all units at Grand Falls, and units respond as best they can through expediting discharges.The team is encouraged to push discharge 'prediction' on the part of medical staff. Real time data tends to be well-received and responded to by medical staff within appropriate patient safety parameters.

There have been several initiatives within the DI department that have dramatically reduced wait times for major modalities; for example, CT wait time have sharply decreased from four months to little or no wait time at both the James Paton Memorial Regional Health Centre and Central Newfoundland Regional Health Centre. A clinical validation project for Ultrasound wait-lists is proving effective in reducing that list. A shift from body part booking practices to urgency classification and date in scheduling has increased throughput in ultrasound.

The dramatic drop in wait times for urgent colonoscopy in one year from 30 to 18 days in the 50th percentile and from 237 to 29 days in the 90th percentile demonstrates what can be done when focus is put on a serious patient issue by staff and physicians who begin to approach a problem from a system perspective.

There is not a simple answer to flow issues such as 'build more beds', but that could be part of the answer. Inherent in this is the question of the type of bed or space that is most appropriate to the population needs. This requires some detailed evaluation and then, of course, fiscal decision-making. The results so far in addressing the flow/access issue with the working group are showing success and the team is commended. It

is apparent that 'discipline silos' are being taken down and the team is able to influence their respective discipline communities in accepting that this is a common issue that requires mutual support in solving for the benefit of the patients.

3.1.11 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: Infection Prevention and Control		
12.9	The organization appropriately contains and transports contaminated items to the reprocessing unit or area.	!
Standards Set: Operating Rooms		
12.5	The operating room team appropriately contains and transports contaminated items to the reprocessing unit or area.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
1.4	The organization designates a trained and competent individual with the accountability for coordinating all reprocessing and sterilization activities across the organization, including those performed outside the medical device reprocessing department.	
3.2	The organization limits access to the medical device reprocessing department to appropriate team members, and posts clear signage limiting access to all entry points.	!
3.3	The medical device reprocessing department is designed to prevent cross-contamination of sterilized and contaminated devices or equipment, isolate incompatible activities, and clearly separate different work areas.	!
3.4	The medical device reprocessing department has a specific, closed area for decontamination that is separate from other reprocessing areas and the rest of the organization.	!
12.2	As part of the quality management system, the team engages in an annual review of reprocessing and sterilization activities, with formal reports provided to the organization's senior management.	

Surveyor comments on the priority process(es)

The Central Regional IHA follows a life cycle process and path for all medical devices and equipment. The selection process follows provincial guidelines, is open and involves user staff members to ensure the medical devices and equipment are appropriate to the needs of the population and the qualifications of the staff. All new medical equipment is entered into a database so that it can be tracked during its life cycle and appropriate preventive maintenance carried out as well as the recording of any ongoing repairs or user issues.

With the new OR development at Grand Falls, the flow pattern for clean/contaminated items will be separate in the OR suite, but there will remain a common pathway via the service elevator, which has possible public access. There is no immediately evident solution to this issue. The endoscopy suite at Grand Falls has a

reprocessing area that allows for only minimal separation of clean/contaminated items and has a single access point for both clean and contaminated items. There may be some redevelopment options to redesign the flow pattern here.

Reprocessing is the responsibility of the sterilization processing department (SPD) except for the DI department which is responsible for its ultrasound reprocessing. There is no contracting-out of reprocessing services and there is no reprocessing of single use devices.

The training of reprocessing personnel follows an in-house certification course that is mandatory. It is strongly suggested that the organization consider a Canadian national level standard as the minimum qualification for staff going forward as this is becoming the norm across the country. The morale of staff members that were in the SPD during the on-site survey was excellent with many comments on the positive work environment and mutual support for and by management. There was not full agreement however, as to whether or not performance reviews had been recently completed.

The physical plant of the SPD has undergone some upgrades recently including new equipment and an overhaul of the air handling unit to stabilize temperature and humidity. The SPD flow pattern at Grand Falls is acceptable, but there are several areas of concern regarding access issues. Although the doors are marked, it is not in a way that "stands out" and doors are easily accessed by anyone walking by. Within the contaminated area there is no requirement for shoe coverings. The separation of clean/contaminated is less than optimal, as using a doorway to pass carts through to the clean side from the contaminated side is a questionable practice. It is recommended that the organization review these issues.

It is recommended that the SPD develop an annual report to senior management that demonstrates the demand-driven resource needs of the SPD to do its job in response to new and differing reprocessing requirements generated by OR throughput.

3.2 Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

- Promoting and protecting the health of the populations and communities served, through leadership, partnership, innovation, and action.

3.2.1 Standards Set: Maternal/Child Populations

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness
There is good evidence of integration across the community and acute care continuum of maternal-child services with a strong role played by Population and Public Health Program in coordinating prenatal screening and prenatal information exchange with the maternity unit. Maternal/Child Services has an active regional quality improvement team that has prioritized the Baby Friendly philosophy as a desired future initiative. The decision to do this came about as a result of client satisfaction surveys done by phone that combined pre and postnatal experiences. Clients asked for more consistent messaging around breastfeeding, skin to skin philosophy, etc. The province has written standards for "Education and Support for Pregnancy, Birth and Early Parenting". Central Health is represented on the Childbirth Education Advisory Committee and has input into the standards set for education and support programs. The province provides direction and significant support and investment in the area of maternal-child services. The Ministry of Education is providing support to parents through a play/interaction package that will be made available to all parents at the time of their baby's immunizations. (i.e. 2 mos, 4 mos, 6 mos, 12 mos and 18 mos). A good partnership exists between Population and Public Health and the school system. Health is frequently called upon to deliver sexual health education and answer health-related questions that students may have. Data is collected regionally and forwarded to the province for analysis. The finding are reported to the health regions who can then benchmark their own results with other health regions. This data does inform the region's maternal-child education and support programs. The roles of the public health nurses are clearly delineated. For example, the community development nurses

do not carry a clinical caseload. The remaining public health nurses divide their roles into one with a 0-4 years of age focus and one with a 4-21 years of age.

The Team recognizes the importance of providing consistent information through their literature and educational programs. Clients also were asking for more consistent information. They have worked together and with the province to ensure that written material directed at the maternal-child population is standardized and reviewed on a regular basis to reflect current knowledge.

The Maternal - Child Quality Team is encouraged to use their knowledge of change management in implementing the upcoming plan to move the timeline criteria for submitting the Prenatal Education and Support Screening Tool to the Obstetric Unit. The current guideline of submitting the tool four weeks before the estimated due date is being changed to eight weeks. This change in the submission time guideline has come about as a result of best practice information from the literature and from other health regions in the province and will provide for improved communication and planning in the event of a delivery before the due date.

The Quality team and representatives to the Provincial Childbirth Education Advisory Committee are encouraged to familiarize themselves with emerging literature on ante-natal and post-partum depression. Some Canadian jurisdictions are mandating completion of a depression scale such as the Edinburgh Scale a routine part of pre-natal assessments to promote early detection and intervention.

The Team is encouraged to continue their efforts in the area of obesity and gestational diabetes as a risk for developmental delays by sharing information within the team and other stakeholders.

The Team is encouraged to sustain their gains in health promotion and prevention by purposefully including in their operational and education plans repeated and regular offerings of programs that were successful in the past. (i.e. targeted anti-smoking campaign in young teens)

The Team is encouraged to continue building great relationships with the following community partners; Child Youth and Family Services, Healthy Baby Clubs, Family Resource Centre and participate in joint awareness campaigns.

Clients interviewed stated there was a general lack of awareness of all of the maternal-child services available in Grand Fall- Windsor and Gander and although the Team does do some advertising of services more will need to be done or additional strategies developed to increase awareness.

Having clerical staff remind clients of their appointments the next day is an option if there is an issue with missed appointments in Public Health.

Creating a more inviting physical environment at the Queensway location is challenging because of the long hallways however it may be a helpful exercise to see what could be done to make it more inviting.

3.2.2 Standards Set: Public Health Services

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Population Health and Wellness

In the Central Health Region, Population and Public Health reports directly to the Senior VP of Quality, Planning and Priorities. Staff in this service area have worked to integrate their services with other regional health services to complement health protection and health promotion programs. Chronic Disease prevention and management also falls under this Service as does community clinical services provided by public health nurses.

Many programs within Population and Public Health have positive, measurable outcomes such as the 0-2 years immunization rates, diabetes education and healthy eating/activity education, with some indication there is a decrease in the incidence rate of obesity and diabetes in the region based on CIHI data.

The organization is involved in healthy public policy development and support. Nutritional food guidelines have been in place in the schools in the region since 2008.

The success of the community-based program for chronic diseases - Improving Health My Way - has had positive feedback from the majority of the 230 people who have attended.

Primary Health Care Teams are successfully established in six communities with plans to expand to another three communities. These interprofessional teams include the community development nurses from Public Health. Together they provide accessible health care services based on the needs of the community. The primary health care approach aligns with the goals of population wellness. Communities and individuals are encouraged to participate in preventative, promotive, curative, rehabiliitative and supportive services. The teams lead numerous consultative and capacity building initiatives in the communities they serve.

In some smaller rural communities Public Health has combined the roles of Home Care and Public Health Nurse to optimize service in rural communities.

The community development nurses are supported financially by the organization to take on-line skills enhancement courses sponsored by the Public Health Agency of Canada which will increase the region's capacity in outbreak management, infection prevention and control, biostatistics, surveillance activity, research and communicable disease control.

Lactation consultants travel across the continuum to provide service and support.

Consistent attention to updating community profiles every three years provides information to the organization and helps identify the need for types and quantity of services and programs.

Population and Public Health is positioned to influence policy within the organization and in regional and provincial forums. The tobacco strategy is a good example of how the service is involved with smoking reduction at both a policy development and an implementation level.

The organization has recognized the need to build capacity around program evaluation. In the past year workshops on how to do research using the logic model have been provided to staff within Population and Public Health.

The idea of using television monitors in a variety of regional health facilities to present health information is about to be piloted at one site and if successful, could be more widely used to promote health and increase awareness on a variety of organizational initiatives.

There is an opportunity for further integration across the care continuum in the area of stroke strategy.

There is a need for further outreach and community engagement in the two regional centres of Grand Falls-Windsor and Gander. There also may be opportunities to look to community partners to strategize ways to promote communication with residents in these communities and increase awareness of health and related health services (i.e. links with municipal website, health fair, family resource centre).

The Program is encouraged to investigate opportunities for longitudinal research projects with partners that would demonstrate the impact of population and public health programs,

Ongoing interpretation of the role of primary health care and population and public health within the organization so that all staff and physicians understand the roles of staff and the services and programs offered in this large service.

The organization is encouraged to develop and implement a comprehensive evaluation plan that will measure the success of its programs and services.

In order to support providers working at full scope of practice there is a need for all team members across service areas to understand their scope of practice as well as that of others. Clear understanding of everyone's role and scope will help promote teamwork.

3.3 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:

Clinical Leadership

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

Competency

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

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

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

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

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

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

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

Blood Services

- Handling blood and blood components safely, including donor selection, blood collection, and transfusions

3.3.1 Standards Set: Ambulatory Care Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.1	The team works together to develop goals and objectives.		
2.2	The team's goals and objectives for ambulatory care services are measurable and specific.		
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
6.2	The team receives clients at the service area in a manner that respects their privacy and confidentiality.		
8.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.		ROP
	8.3.1	The team provides documented rationale for the selection of target clients or populations to receive formal medication reconciliation.	**MAJOR**
	8.3.2	There is a demonstrated, formal process to reconcile client medications at the beginning of service, and periodically as appropriate for the client or population receiving services.	**MAJOR**
	8.3.3	The team generates or updates a comprehensive list of medications the client has been taking prior to the beginning of services (Best Possible Medication History (BPMH)).	**MAJOR**
	8.3.5	The team provides clients and their providers of care (e.g. family physician) with a copy of the BPMH and clear information about the changes.	**MINOR**
	8.3.7	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**

12.2	The team reconciles the client's medications with the involvement of the client, family, or caregiver at interfaces of care where the client is a risk of medication discrepancies (transfer, discharge), when medication therapy is a significant component of care. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.	ROP
12.2.1	The team provides documented rationale for the selection of target clients or populations to receive formal medication reconciliation, and the risk points during service delivery where reconciliation will be conducted.	**MAJOR**
12.2.2	There is a demonstrated, formal process to reconcile client medications at interfaces of care where the client is at risk of medication discrepancies (transfer, discharge), and periodically as appropriate for the client or population receiving services.	**MAJOR**
12.2.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**

Priority Process: Decision Support

16.1	The organization has a process to select evidence-based guidelines for ambulatory services.	!

Priority Process: Impact on Outcomes

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ambulatory care quality improvement (QI) committee is a multidisciplinary group of staff representing services that have clients coming to see them on an appointment basis. Programs represented included rehabilitation, mental health, respiratory therapy, infection control, data quality and chronic disease management. While all staff members work primarily with their own programs, the unifying factor is clients are seen on an scheduled basis in a clinic setting. For the most part, the team plans services for their clients and communities in their respective program and not as an ambulatory care team.

Staff members recognize the efficiency of seeing clients individually or in groups in a clinic setting rather than visiting them individually at home. There are also benefits for provider safety as staff members are not working alone or requiring a home safety assessment. As long as there is transportation available and settings are accessible for seniors, this model of care is aligned with the strategic direction of the region to support aging populations.

Given that most members of the ambulatory care QI team were representing various programs, it was difficult to establish measurable goals and objectives as a group. Teams that provide ambulatory care within their programs such as for home care and mental health are encouraged to review the ambulatory care standards as they relate to that component of their service. In addition, rural clinics that utilize ambulatory care standards are encouraged to also consider primary care standards to guide their work.

Priority Process: Competency

Teams work well together to meet community needs within their own program areas. Rural clinics schedule appointments with consideration of client schedules and availability of transportation. Staff members report good support from maintenance personnel to maintain clinic areas and from biomedical personnel for preventive maintenance. There is excellent support from courier services to deliver sterilized equipment, pharmacy, and mail from larger centres.

Emergency preparedness is well done in the ambulatory care settings.

It is suggested that more integration across programs would assist with recruitment and retention. Every rural clinic has multiple services offered from one site however, staff members are rarely able to cover for each other.

Priority Process: Episode of Care

Teams providing ambulatory care are aware of patient confidentiality and in most settings are able to maintain privacy for discussions and records. Registration areas in some settings provide challenges for staff to maintain confidentiality however they are very attentive to privacy. Interdisciplinary teams meet as needed to coordinate services. Training is tracked in each program using the regional training matrix. This includes infusion pumps in some programs. Staff report their training needs are met and performance appraisals are up to date. Staff report excellent support from the laboratory, DI and pharmacy in ambulatory care.

Waiting rooms are not always visible from the registration areas in ambulatory care. Teams are encouraged to monitor the number of appointments missed in order to make improvements. Teams are also encouraged to monitor the length of time patients wait for services.

Staff members express readiness to reconcile medications and recognize the benefits in an ambulatory services setting.

Priority Process: Decision Support

Staff members' providing ambulatory care services in their program areas select best practice guidelines according to the populations they serve within their program. Each of the teams reviews their guidelines as part of their program area. Staff members use a hybrid of electronic and paper records in most ambulatory care settings, and maintain these well. Continuity is maintained by using an ongoing outpatient chart where episodes of care are documented over time.

It is noted client record storage is a challenge for this organization, and ambulatory care files are no exception. The organization is encouraged to work with the provincial government to implement a records retention policy.

Priority Process: Impact on Outcomes

Staff members that work in ambulatory care settings are particularly strong in compiling patient care information to transfer to other providers for further services. Records are well-maintained as all consults are held in one place over time.

Equipment is well-maintained. Staff members in ambulatory care settings do the initial cleaning and then equipment is transported safely to a larger centre for reprocessing.

Staff members report excellent support from laboratory, DI and pharmacy services. The clients interviewed in ambulatory care settings expressed satisfaction with services.

Encouragement is offered to the staffs providing service in ambulatory care settings to review outcome measures in their program areas. Sharing of successes will continue in the ambulatory care quality committee.

3.3.2 Standards Set: Biomedical Laboratory Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	
8.2 The laboratory informs individual requesters of analyses of their utilization patterns.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Laboratory	

The laboratory service is not yet reporting individual ordering practice patterns to chiefs of service to review laboratory test patterns for appropriateness and whether they are in alignment with best practice guidelines. The organization does not conduct an impact analysis when hiring a new physician or replacing one who has left the organization. As a result, the laboratory leadership finds out after the fact if there are variations in laboratory test ordering. The laboratory should be aware of what to expect of a new or additional physician practice.

There should be regular reviews to ensure that duplication of tests is not happening. One clinician noted that with some locums who are working for a limited period, do not make the effort to become familiar with the clinical system where results are available and therefore, are sometimes re ordering tests that do not need to be repeated.

At all three locations visited during the on-site survey, the laboratory personnel collecting samples are exemplary in their consistent practice in identifying the patient with at least two identifiers.

Point of care (POC) testing is supported with the addition of a POC coordinator that ensures all processes are in place to support appropriate POC testing and that quality assurance processes are in place and implemented. No POC device can be purchased in the region without a review and approval by the POC coordinator.

3.3.3 Standards Set: Blood Bank and Transfusion Services

Unmet Criteria	High Priority Criteria
Priority Process: Blood Services	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Blood Services
Blood and blood products required for trauma or severe hemorrhagic cases are kept on hand at outlying sites such as Harbour Breton due to the fact that it would take a minimum of three hours to obtain blood from a hospital site such as the Central Newfoundland Regional Health Centre. Four units of red cells are available. The team ensures it is replaced in time for the blood to be placed back in circulation prior to expiry date. Blood and blood products for use in therapeutic treatments are ordered from GFW site to ensure arrival in time for the patient's planned appointment. Currently, the Canadian Blood Services has been able to provide an adequate supply of blood and blood products but this does vary during the year. The organization has provided focussed education about blood and blood products, administration and safe handling of same. The nurses have been informed of Health Canada standards regarding temperature control and why blood can only be released at the time it is to be administered, that all reactions must be reported to the laboratory and significant reactions reported as an occurrence.

3.3.4 Standards Set: Community-Based Mental Health Services and Supports Standards

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.4	The organization's goals and objectives are specific and measurable.		
Priority Process: Competency			
	The organization has met all criteria for this priority process.		
Priority Process: Episode of Care			
12.3	The team reconciles the client's medication at the beginning of service with the involvement of the client and family or caregiver when medication management is a component of care.		ROP
	12.3.1	There is a demonstrated, formal process to reconcile client medications at each visit if medications have been discontinued, altered or changed.	**MAJOR**
	12.3.2	The team generates a Best Possible Medication History (BPMH) at the beginning of service when medication management is a component of care.	**MAJOR**
	12.3.3	The team conducts a timely comparison of the BPMH with medications prescribed, ordered, dispensed, or administered during service.	**MAJOR**
	12.3.4	The team communicates the BPMH and discrepancies requiring resolution to the appropriate health care provider, and documents actions taken in the client record.	**MAJOR**
	12.3.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
13.1	Crisis intervention services are available to any individual or family that contacts the organization.		
14.3	The team reconciles the client's medications at interfaces of care where the client is at risk for medication discrepancies (circle of care, discharge) with the involvement of the client and family or caregiver when medication management is a component of care, or as deemed appropriate through clinician assessment.		ROP
	14.3.1	There is a demonstrated, formal process to reconcile client medications at interfaces of care where the client is at risk of medication discrepancies (circle of care, discharge).	**MAJOR**

14.3.2	The team updates the client's medication list following each clinician consultation or visit to a health care practitioner within the client's circle of care.	**MAJOR**
14.3.3	The team provides the client with a copy of the up-to-date medication list, clear information about the changes, and educates the client to share the list when encountering providers in the client's circle of care.	**MINOR**
14.3.4	Upon notification that a client has been transferred or discharged, the community care organization communicates the most recent medication list to the next provider of care.	**MAJOR**
14.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
14.5	Following a transition or at the end of service, the team contacts individuals, families, and referring organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end-of-service planning.	
Priority Process: Decision Support		
18.3	The organization's process for guideline selection includes seeking input from staff, service providers, individuals, and families about the applicability of guidelines and their ease of use.	
Priority Process: Impact on Outcomes		
18.5	The organization shares benchmark and leading practice information with its partners and other organizations.	
19.3	The team regularly monitors individuals' and families' perspectives on the quality of its services.	
19.4	The team compares its results with other similar interventions, programs, or organizations.	
19.6	The team shares evaluation results with staff, individuals, and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Community mental health (MH) services are integrated with Substance Abuse and Problem Gambling Services. Team members have worked hard to make this a seamless service and are commended for these efforts. They plan services that include wellness, health promotion and community engagement to treatment services that range from counselling to active treatment with complex clients via the assertive case treatment (ACT) team.

The interdisciplinary team has been together for some time in most areas and members are familiar with one another's' skills. They know their communities well and although they offer a consistent suite of services, they tailor to the community as appropriate. Even though the region's population is aging, the team noted an

increase in the number of child and youth referrals as well as increased involvement with guidance counsellors in schools.

The team sets goals and objectives. Most recently, the team has been involved in the development of the regional working alone policy. Provider safety has been a focus for the past year with the enhancement of the home risk assessment and safety plan for home visiting. The team is encouraged to develop indicators in more areas to measure progress and determine outcomes of services.

The ACT team is based on a best practice model and has specific goals and objectives and is monitored based on process and outcome evaluation determined in the literature. The ACT fidelity scale shows the team is fully implemented and has now moved to outcome measures. For example, hospital stays have decreased 75 percent for the 50 clients the team serves. The team is beginning to use the World Health Organization's (WHO) Quality of Life (QOL-BREF) scale to determine if quality of life is improving. This is great work team!

The team participates in community events to raise awareness of mental health such as speaking at local events, in schools and churches and supporting wellness resource fairs. Mental health promotion is definitely a part of every team observed, even in the areas where resources are scarce, like the south coast.

The MH team was a partner in the survey of: Mental Health in the Workforce, with all staff members' of the region. This is a creative way to focus on staff health and raise awareness of the importance of good mental health for all and to decrease stigma.

Priority Process: Competency

The team actively recruits and welcomes students. This is one way the team learns and passes on experience.

The team members are competent and passionate about their work. They are encouraged to receive additional training and take advantage of this opportunity. In the rural areas staff members have more generalized roles so it is important to acquire extra training in areas like child and adolescent and addictions.

An employee assistance program (EAP) is provided by the region and it is delivered by the mental health team. Care is taken to offer services outside the employee's town and area to maintain privacy and confidentiality.

The team has identified areas where the ACT Team could enhance services with additional skill sets such as for employment preparation and training, as well as recreation therapy.

Priority Process: Episode of Care

The team is respectful of clients' privacy and does a good job of updating families but only if there is permission.

The ACT team collaborates with other health services and partner organizations in care. The clients in this program are high need and this creative staff group finds ways to connect clients to programs and services based on the goals clients have set in their care plan.

The ACT program operates seven days a week and is staffed into the evening hours to offer a wrap around service for its clients. Other mental health services do not appear to have flexible hours and therefore, would be encouraged to seek out opportunities to partner and offer some care in the evenings and weekends. The mental health inpatient unit is used in a collaborative way and relationships appear good.

Rural teams are working together to provide the best services the resources allow. They are creative in working with other community providers to address needs for example, using the school setting to target youth and teach youth how to stay healthy. Sessions for grade 6 students have been well-received and have resulted in more referrals for life difficulties that are often the first signs of risk. Great work teams!

The ACT program uses the inter resident assessment instrument (Inter RAI) model of assessment which is a clinical system that leads to diagnosis, risk factors and care plan. This is a quality health improvement project for the teams.

Assessments include both mental and substance abuse disorders, which is a real asset to client care. Addictions staff members are part of the team in this integrated service.

The ACT program offers medication-drop and observation to clients. The nurses have developed an in depth protocol for use by all team members to provide this service. Medications are prepared by the nurse and a process of signatures and checks to allow the team to deliver medications. An important aspect of this process is that the client must sign for the medications to ensure receipt and make them accountable for the medications

A new model of therapeutic planning was implemented this past year and seems to be working well to standardize the care planning process, yet ensure it is individualized. A benefit the staff noted was the estimated discharge time, which alerts them to begin discussion of goals related to discharge.

The only mental health crisis service available is the help line and to some extent the ACT team. Staff members frequently deal with crises and work longer hours however, a full crisis team is not available. The geography and numbers may not warrant this service, but does require review to confirm that contingency plans are in place.

The team needs to ensure that the care plan is used to document progress, measurements and evaluation of goal attainment.

Priority Process: Decision Support

The client chart is a combination of an electronic and paper record. Although the organization is encouraged to complete the electronic chart as soon as possible, it is understood that there are provincial considerations and funding that need to occur before it is complete. The charts are well-organized considering that two methods are in use.

The teams work well together and make decisions based on evidence and consensus. They find ways to problem solve and are encouraged by the leaders to find ways to work towards a 'client first' outcome.

The team is encouraged to review and evaluate the roles of CMHW and case management. Looking at the needs of the client population and best practise may lead the team to consider brief treatment models and supportive groups as other alternatives to treatment.

Priority Process: Impact on Outcomes

The ACT Team works alone in the evenings and weekends and has a good safety plan with regular check-in procedures. The team may want to review extended hours and staffing to enhance evening and weekend programming.

Safety pamphlets are given to clients and families and other safety checks, and safety planning with clients is part of the regular treatment plan.

Quality Improvement activities are part of the team's work. The team is currently involved in identifying outcome measurement tools in the new Youth Addictions Treatment Centre. This is being done using the tool, Global Appraisal of Individual Needs (GAIN), and obtaining feedback on health promotion workshops to name just two processes.

Client satisfaction surveys are the next step for this program and the organization is developing method options with the quality team. This is encouraged and local teams need to have this information to better plan programs and services that can be measured with the client base in the future.

The mental health and substance abuse team is encouraged to look at ways to continue 'down the road' of integration by moving towards full integration with primary care services. Seamless client access and service could be the outcome.

3.3.5 Standards Set: Critical Care

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.5	The team regularly reviews its services and makes changes as needed.		
2.1	The team works together to develop goals and objectives.		
2.2	The team's goals and objectives for its critical care services are measurable and specific.		
Priority Process: Competency			
3.10	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
Priority Process: Episode of Care			
6.2	The team uses standardized criteria to determine whether potential clients require critical care services.		
7.6	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	7.6.1	There is a demonstrated, formal process to reconcile client medications upon admission.	**MAJOR**
	7.6.2	The team generates a Best Possible Medication History (BPMH) for the client upon admission.	**MAJOR**
	7.6.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	7.6.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	7.6.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
12.5	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	12.5.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**

12.5.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
12.5.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
12.5.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
12.5.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
Priority Process: Decision Support		
15.1	The organization has a process to select evidence-based guidelines for critical care services.	!
15.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
Priority Process: Impact on Outcomes		
15.4	The team shares benchmark and best practice information with its partners and other organizations.	
Priority Process: Organ and Tissue Donation		
8.19	The team has access to data gathered on all deaths that occur in the ICU and has a process for reviewing that data to identify lost opportunities for donation.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Staff members are enthusiastic and committed to patient care and safety. Recruitment has improved during the past few years. With implementation of the new nursing model, orientation and training needs have been tracked and efforts made to keep all staff up to date. Staff members report that teams at both locations are supportive.

Staff members are aware of their referral sources and coordinate services with their respective emergency departments and surgical units. Physicians are engaged and meet the standard for daily visits. Staff members

report satisfaction with the level of support from pharmacy and diagnostic services. Necessary equipment is available. Information systems are well-utilized to coordinate patient care.

Encouragement is offered for teams to review services regularly and make changes as needed. Teams are also encouraged to develop measurable goals and objectives every year and monitor their progress to meeting their goals. Work such as implementing the acute myocardial infarction (AMI) bundle from Safer Healthcare Now is an example of an initiative which could have been developed as a team goal and progress monitored.

Patient flow was identified as a challenge in both locations. Planning for surge capacity seems daunting when no beds are available elsewhere in the organization.

Priority Process: Competency

Interdisciplinary teamwork is evident in both critical care units and staff report teams and managers are supportive of one another. Staff education is readily available and training needs are tracked using a regional training matrix. Credentials are up-to-date. Performance appraisals are conducted regularly. New staff report that their orientation was excellent and ongoing support continues from educators and other team members.

Patients and families report confidence in the skills and abilities of their care providers.

Efficiency, flexibility and staff satisfaction may increase as more staff members are trained to be able to work across units including critical care. Staff members in rural health have maintained competencies to work across entire sites including emergency departments, LTC, medicine and ambulatory care. In larger centres, staff members that are trained to work in both critical care and emergency departments expressed satisfaction with this opportunity.

Priority Process: Episode of Care

Patients and families expressed satisfaction with the services. They report being involved in care decisions and goal-setting. Families report they know who to approach if they have a concern.

While there are no outreach teams from Critical Care, the teams do monitor telemetry on other units and support medical and surgical staff as required. Staff members utilize the electronic health record fully to document their comprehensive and timely assessments.

The venous thrombo embolism (VTE) and previously mentioned AMI Safer Healthcare Now bundles have recently been fully implemented. Teams are encouraged to monitor outcomes to determine what differences result from this improvement initiative.

Transfer information is standardized and patients are well-prepared for transfer to a tertiary centre for further testing or treatment.

Encouragement is offered the teams at both locations to develop consistent admission criteria for intensive care services.

Implementation of consistent best practice guidelines is encouraged. This work has been recognized as needed by the quality council.

Management of sedation requires continued standardization, based on best practice.

Priority Process: Decision Support

Internal medicine specialists visit patients daily. Standard order sheets promote continuity of care and consistent practice.

Electronic documentation is comprehensive. Staff and physicians are proficient using Meditech. Transfer of information at transition points is well done using situation-background-assessment-recommendation (SBAR) format. Patients and families report they believe all information about them is transferred appropriately when they transition to another service or location.

Interdisciplinary rounds are held regularly and staff members report they are an effective mechanism for coordination of care.

The team is encouraged to adopt best practice guidelines, ensure their consistency across the region, and regularly evaluate these guidelines.

Priority Process: Impact on Outcomes

The use of two patient identifiers was consistently observed during the on-site survey. Patients and families confirmed they were always asked an identifying question when medications were given.

Staff members are aware of provider safety and regularly make recommendations to make care safer for both patients and themselves. Occurrence reporting training has increased reporting and investigation of incidents. Staff report they are familiar with the disclosure policies however, have rarely needed to use them.

There is written and verbal information about patient and family roles in safety. Patients reported they know they could ask staff to wash their hands, but have not needed to remind staff.

Huddles or briefings take place several times every shift to coordinate care, balance workloads and discuss safety issues.

The teams are encouraged to adopt consistent best practice guidelines and benchmark their outcomes across the region and province. The teams are also encouraged to review the recent patient satisfaction survey information and make improvements as needed.

Priority Process: Organ and Tissue Donation

While there is a provincial protocol available to guide organ donation, staff members report discussion of organ donation is rare and dependent on physician practice.

3.3.6 Standards Set: Developmental Disabilities Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.2	The team monitors clients' and families' perspectives on the quality of its developmental disabilities services.	
17.5	The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Developmental Disabilities Services Team is a subset of Regional Rehabilitation Services that is directly overseen by Child Development and Support Services, but involves close collaboration with other areas such as Speech Language Pathology (SLP). The funding for the service is provincial and gives the team a mandate, program tenets, and a set of four major goals.

The team was unaware of any community health needs assessment process that might look at development al disabilities. There are five yearly health needs assessment done through public health. It is suggested that areas of concern regarding developmental disabilities be included in future surveys or, if done, that the information be made available to this team.

All information for planning is based on past caseload and current referral numbers and patterns. There is good collaboration with external partners such as the NL Association for Community Living, Autism Society, Down Syndrome Society, People First and First Nations. Work with these groups includes sharing information at events and community advocacy.

Annual program reviews are done as per provincial direction toward their goals. The team also sets its own local goals in terms of quality improvement. These goals are based on meeting Accreditation Canada

standards and are monitored and reviewed regularly. The team has been successful in adding psychological services to the team, with application to the provincial funder in the area of early intervention.

Priority Process: Competency

The team is interdisciplinary, made up of social work, behaviour specialists, psychology, speech language pathology and others on an ad hoc basis such as physiotherapy. There is a physician resource available for consultations one day per month, and this is considered minimal for the needs of the program, but within the system constraints.

The opportunities for the team to develop skills is somewhat limited due to provincial funding issues, but there is good use made of tele/video conferencing and excellent access to web-based resources such as those of the Geneva Centre in Toronto.

Any given case may require coordination of several disciplines over time to appropriately deal with all its concerns. This coordination ability is fundamental to how the team operates with excellent communication, consultation and hand-offs.

Team member orientation is general to the region and specific to the team and facility. Re-orientation occurs after all lengthy leaves. All staff members are trained and retrained in non-violent crisis intervention. Those with hospital-based positions have received basic life support (BLS) training. All staff of this service has received training in work safety assessment.

The team is well-versed in ethical concerns as being fundamental to their discipline training and day-to-day work. The team has not had any formal exposure as yet to the new regional ethics framework and it is recommended that this happen soon.

Reference checks are done, including criminal background checks on hiring. Performance appraisals are done every two years and are up-to-date.

Priority Process: Episode of Care

The team accepts referrals from essentially any community-based source of individuals. There is a common assessment process to determine what services may be appropriate and whether or not there may be funding supports from government. Coordination is accomplished with other agencies that may be involved. There is essentially no wait-list for developmental disabilities services. Clients are rarely if ever refused service; there are cases where clients think more services are appropriate in which case there is a process for appeal to higher management.

When accepted, there is a complete assessment undertaken that considers a holistic view of the client's status, including their view of what can be expected. Regular updates are done on client status with full consideration of their level of understanding and concerns regarding privacy and confidentiality. Consent issues are paramount and involvement of appropriate substitute decision makers is routine. A major role of the psychologist is in helping clients and families with emotional support and acceptance of clinical reality and the grieving process. Education regarding the clients' rights is integral to the care process and appropriate support is given to access bureaucratic processes to obtain what is due. There is a legal obligation to report any abuse situations that may arise or become known.

The care processes are done well with appropriate notes made to mark the progress. Audits of charts are done on a yearly basis with feedback to the caregivers. Clients have the right to access their files in

accordance with regional policy. The team safely manages potential high-risk situations. A least restraint policy is in place but has never been required. In the community, any medical emergencies would be dealt with by accessing the ambulance system.

The team is just now looking at follow-up of clients after they leave the program. The specific effort involves the transfer of clients into the school system. Collaborative work with the schools will allow a formal evaluation of the hand-off in the fall. This is a commendable effort to close the loop on outcomes.

Priority Process: Decision Support

Every member of the team maintains their own discipline-specific record on every client and they are up to date. There is no formal and easy means of cross-discipline access to each others records. While this is not a major problem, it would be convenient and proactive to be able to see progress in all aspects of a case at one time. There are no issues of sharing the information verbally and team members do this regularly, having the appropriate consents in place. The individual support service plan serves as a means of coordination of care amongst the various team members. This issue was brought up during a client interview with frustration expressed at the many different records/plans and people she apparently had to talk to 'be heard'.

Team members receive required training in the technology that is available to them. The increasing use of telehealth is of great interest and would probably add to the team's outreach capabilities.

The team is proactive in pursing evidence-based information to improve their services. There are provincial guidelines in place for some aspects of their work.

Priority Process: Impact on Outcomes

The team has formal mechanisms in place to reduce risks to staff. Formal home safety risk assessments are done routinely, including the presence of tobacco use. Most of the work is accomplished in home visits and this entails driving. Vehicle safety is considered as is cellular telephone use and areas of coverage and there is use of the check in/check out process. Visits will be doubled up if deemed appropriate. All staff members are trained and retrained in these areas.

All incidents are reported, both client and employee. There is a disclosure policy in place and all have had orientation to it, but have never had to invoke it. The team meets monthly for a general meeting during which there is always a safety topic on the agenda, such as driving issues and codes.

The operational plan is reviewed yearly with the staff, but there is no means for input by client and families. It is recommended that the team develop a means to engage their client/family base in gaining their perspectives on the quality of service received. The team also does not compare their results with other like programs. Doing so could prove helpful in the continuous improvement cycle. Although the team does share its results with staff, including the client base and possibly the public could help with their advocacy efforts and benefit the program as well.

3.3.7 Standards Set: Diagnostic Imaging Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
11.11	The team implements standard views of each anatomic area to optimize imaging and minimize exposure to radiation.	
17.2	The team involves clients, families, and other organizations when evaluating the quality of its diagnostic imaging services.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The team participated in a lean management workshop at Gander. As a result, the team changed the staffing configuration to allow from extended hours for Ultrasound Services (USS) and successfully decreased wait times. The Director of Health Services responsible for Baie Verte identified that some USS volume from Gander would be done at Baie Verte to help address wait time issues. As a result, those that live in the Baie Verte/Springdale region are no longer asked if they prefer to go to Gander for an USS but have appointments made at the Baie Verte Health Centre.

At the Central Newfoundland Regional Health Centre, there was a bottleneck in ER for patients waiting to come to DI for imaging when there were no available porters. In consultation with the ER team, when no porter is available, it was decided that staff would transfer the patient to the DI department. The first consideration is that the nurse on duty transfer the patient but if unable to do so, the radiology technologist would go to ER to get the patient. The new Director has made great strides in developing a quality structure for the department. Goals and objects are linked with the Corporate strategic plan and are specific and measurable. There is a new focus on sharing information such as no-show and cancellation rates by modality with the whole team in order to emphasize the opportunities to improve service.

A large number of policies and procedures have been written or reviewed and are in the approval process. The team does not administer conscious sedation in the department. The manager at the James Paton Memorial Regional Health Centre has great expertise in diagnostic imaging and in nuclear medicine in particular. She is the designated radiation safety officer for the organization. All staff involved in nuclear medicine or who may handle any dangerous materials as are certified to handle dangerous goods as per provincial legislation requirements.

Based on the locations reviewed X-rays that are provided at Harbour Breton, Brookfield, Twillingate and St. Albans support both out-patient clinical activity and emergency patient care. Staff are on-call on a rotating basis off hours and will come in if called.

To the knowledge of the Chief of Radiology at the Central Newfoundland Regional Health Centre, there are no impact analyses done when a new physician is recruited to quantify the impact of a new physician's practice on diagnostic imaging. There is an assumption that when a physician is replaced there is no new cost which is only true if the practice and volumes are exactly the same as the practitioner being replaced. The administrative director should be involved in working with the Chief to complete physician impact analysis to ensure that any operational impact on the department has been identified and where required, an action

plan developed.

3.3.8 Standards Set: Emergency Department

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.2	The team's goals and objectives are linked to benchmarking of bed availability in the Emergency Department, time to admission, client diversion to other facilities, and wait times.		
Priority Process: Competency			
3.6	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
Priority Process: Episode of Care			
8.3	The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.		ROP
	8.3.1	There is a demonstrated, formal process to reconcile client medications for clients with a decision to admit.	**MAJOR**
	8.3.2	The team generates a Best Possible Medication History (BPMH) for clients with a decision to admit.	**MAJOR**
	8.3.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	8.3.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	8.3.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
11.1	The team applies standardized criteria to determine whether a client is fit for transfer of care.		!
11.5	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.5.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**

11.5.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
11.5.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
11.5.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
11.5.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
Priority Process: Decision Support		
8.7	The team uses evidence-based protocols to select diagnostic imaging services for pediatric clients.	
Priority Process: Impact on Outcomes		
16.1	The team identifies and monitors process and outcome measures for its Emergency Department services.	!
Priority Process: Organ and Tissue Donation		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team collects information on wait times and other parameters of care however, the team does not benchmark with other organizations.

At the James Paton Memorial Regional Health Centre the ED work space is adequate when patients are able to move to units or ICU but patient flow is poor much of the time. The admitted patients are housed in a relatively small four-bed unit where there is no privacy. Patients complain of being held on stretchers for several days before their transfer to the unit. The stretchers are uncomfortable and make sleep difficult to accomplish.

There is inadequate space in the Central Newfoundland Regional Health Centre as well as it provides for poor patient flow. Patients are kept in a hallway awaiting admission for sometimes, several days. The organization

has provided curtains to provide a little privacy but the overall arrangement is inadequate. In addition, the area for staff work is too dim, but the patients in the hallway have lights shining on them 24/7.

At the Central Newfoundland Regional Health Centre it is possible for an individual to enter the building and access the hospital wards and clinics 24/7. The ambulance paramedics are utilized as security guards when not out on a call. The space for the admitting clerk and triage nurse is tight. The team has created an ED waiting room which is a big improvement over the general space that was used previously. The ED waiting area is observed by camera from the ED nursing station.

Priority Process: Competency

There are no formal meetings to evaluate team functioning but some discussion is held during staff meetings.

Huddles take place during the day to coordinate services and adjust workloads according to number and level of patients waiting.

Members of the interdisciplinary team appear cohesive and staff report working co-operatively and collaboratively. Staff report excellent orientation to the ED. Orientation and all training, including infusion pump training and workplace violence prevention is tracked using a training matrix

Staff recognition currently is for long-term employment and retirement. Consideration could be given to providing recognition for exemplary care, response to unusual situations, and other things.

Priority Process: Episode of Care

Although the team collects information about medications from patients and requests information from pharmacy, there is no formal process for medication reconciliation. There is an overall organizational plan to introduce medication reconciliation to all programs. This has not yet occurred in the emergency program.

There are no formal criteria for admission. The decision to admit is made by the consultant physician. There are no formal criteria established to indicate need for transfer. Security is provided by paramedics when they are not on a call. There is a code white process in which all staff are oriented. When they are on a call, there is no formal security process.

Team measures wait times and tracks length of stay (LOS). The EMS personnel monitor off-load response times.

Designated staff manage triage functions, assign CTAS scores and manages the waiting area. Triage function is carried out in a closed office at the James Paton Memorial Regional Health Centre. Nurses observes the waiting rooms at James Paton Memorial Regional Health Centre and Central Newfoundland Regional Health Centre using camera monitors. One row of waiting room chairs at the James Paton Memorial Regional Health Centre is not visible when the door is closed so the triage nurse monitors visually between each patient.

Every effort is made to move pediatric patients to an inpatient unit in a timely manner.

Staff report responsive support from laboratory, DI and pharmacy to ED at all sites.

While there are no standardized criteria for transfer from the ED, information transfer is effective and uses established mechanisms.

The medication reconciliation process is managed in an incomplete manner at all sites.

Priority Process: Decision Support

Charts are paper-based in ED. The laboratory and DI results are available via the Meditech platform.

There is little research done in this program however, staff members are aware of the processes to be utilized in the case of a research project. This is true at both the larger EDs.

Pediatric patients are seen only rarely in all the EDs. There are pediatric crash carts that are coloured to support pediatric resuscitation but there is little else in terms of policy for pediatric patients.

Priority Process: Impact on Outcomes

The quality care team for ED shares best practice information across EDs.

Outcome measures are not collected by the James Paton Memorial Regional Health Centre team in a regular way but some information is provided to the Department of Health as mandatory reporting. It is unclear whether the EDs across the region see the compiled information or have an opportunity to benchmark against provincial or national norms.

The team keeps the ED waiting room under observation to assure that patients are safe and not deteriorating. The CTAS scores are re checked at one hour intervals.

Priority Process: Organ and Tissue Donation

It is difficult to assess compliance to these standards as compliance seems to be spotty and staff members are unsure of what their role might be in identifying potential donors. However, in the Central Newfoundland Regional Health Centre ICU there seems to be a better understanding of the provincial policies and this unit has referred potential donors to St. John's. Donor situations are always going to be rare in this region. A lead person should be appointed to work with the retrieval team from St. John's to assure proper understanding of the donation process. This person could act as a resource person and educator for the region.

3.3.9 Standards Set: Emergency Medical Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	The team collects information about its clients and the community.	
4.9	The medical oversight team regularly follows-up with referring and accepting physicians at local hospitals and alternate level of care facilities to identify issues, and review and improve patient care.	
Priority Process: Competency		
6.4	The interdisciplinary team evaluates its functioning annually, identifies priorities for action, and makes improvements.	
13.3	The communication centre provides ongoing education and training to the dispatch team on the emergency medical dispatch protocol.	
Priority Process: Episode of Care		
13.1	The communication centre uses a functioning 911 or other emergency number 24-hours a day, seven days a week to provide service.	!
13.2	The communication centre has an up-to-date emergency medical dispatch protocol for responding to service requests.	!
13.4	For each call, the communication centre has multilingual dispatchers or access to immediate translation services based on the demographics of the community it serves.	
13.6	The dispatch team follows the emergency medical dispatch protocol to assign the degree of urgency for each call and prioritize service.	!
13.7	The dispatch team provides pre-arrival instructions to callers who are at the scene, and documents the information it provided.	!
13.9	The dispatch team has on-site or online access to a senior paramedic or medical specialist to assist with complex triage situations and help determine the right destination for the patient's needs.	
13.10	The dispatch team provides the geographical location and directions should the EMS team require travel instructions.	
13.11	The dispatch team provides call updates to the EMS team and monitors the movement and safety of the EMS team at the incident scene and throughout transfer.	
13.12	Throughout the transfer, the dispatch team maintains communication with the EMS team at all times.	

13.14	The communication centre has processes to manage peak call times.	
15.1	The EMS crew informs the communications centre when they arrive at the incident scene and documents their travel time.	
16.2	The EMS crew consistently follows treatment protocols to provide the same standard of care in all settings to all patients.	!
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
14.1	The communication centre sets targets and tracks its times for responding to all calls.	!
14.2	The communication centre monitors and documents critical time points for each mission.	
14.4	The communication centre completes random case reviews for each member of the dispatch team to measure compliance with its emergency medical dispatch protocol.	
14.5	The communication centre uses information from random case reviews to identify strengths and areas for improvement.	
22.1	The team collects information about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
22.5	The team identifies and monitors structure, process, and outcome measures for its services.	
22.6	The team compares its performance results with other similar interventions, programs, or organizations.	
Priority Process: Infection Prevention and Control		
	The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The EMS services in Central Regional IHA are provided by a variety of providers with varying levels of training. Some are directly employed staff of the health region, and some are community or private providers with contractual agreements with the health region and the provincial department. In recent years, medical oversight and scope of services has been guided by central government through a provincial medical oversight office. Clients pay directly for ambulance fees.

The quality committee for EMS has been actively working to achieve standards and consistency across the

region. Much progress has been made since the previous survey, with particular strides made in the past eighteen months. Results from the self-assessment revealed that not all staff or contractors were aware of existing resources and structures.

Medical oversight of EMS is now provincial. Provincial program development has been steady but too slow for some regions that are ready to progress more rapidly. Leaders recognize the value of provincial consistency and are anxious to implement improvements.

Regulatory bodies are strict about re-testing and licensure and the organization ensures that staff and contractor training is up-to-date and meets regulations.

Given that not all persons working here are aware of the role of provincial medical oversight and more clarity of roles and responsibilities is needed. The medical oversight team is required to regularly follow-up with referring and accepting facilities to identify issues and review and improve patient care. To meet this standard, more collaboration is encouraged between the region and provincial body.

Priority Process: Competency

Staff credentials are tracked and monitored region-wide and by contracts. Staff members and contractors know they must maintain current credentials in order to offer services.

Training for cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS) is offered widely and staff utilize opportunities to maintain current certifications. Training records are up-to-date and accurate. Staff members report that training opportunities are available and they are supported to maintain and increase their competencies.

Staff safely is promoted and equipment is purchased to enhance patient and provider safety, one example being hydraulic stretchers. Staff report there are more improvement activities in place than in the past.

A communication centre dispatch system was identified as a priority by leaders of EMS. Until such time as this is done at a regional level or provincially, consistency of dispatch will be an area to minimize risk at the present time, staff who carry out the dispatch function require training and support. Staff members and contract personnel in the ten communities that have an EMS service have varying levels of training. Continued work toward one level of training is encouraged.

Priority Process: Episode of Care

Staff members follow protocols and standard operating procedures for assessment and treatment of patients and assess CTAS scores. Time frames are monitored for time of call, departure time, arrival and departure from incident scene and arrival at the ED. The appropriate consent is sought and documented. The transfer of information to ED staff is complete. Staffs of receiving EDs and clients that have used EMS services report satisfaction with EMS services.

In the absence of a communication centre for dispatch, those taking emergency calls utilize a consistent process and common form. As well, EMS personnel maintain periodic contact with the ED where they will transport the patient using cellular telephones or satellite telephones. While this reduces risks with the present processes, development of a communication centre is encouraged.

Further spread of 911 across the province will enhance consistency of emergency services. Leaders and staff are waiting for further program direction from the province. The Central Regional IHA staff members are

encouraged to focus on the work they can achieve locally while waiting for further program development from the provincial group. The quality roadmap highlighted numerous local activities to be considered for improvement work, and examples are local disaster plan testing, satisfaction surveys and worklife improvements.

Priority Process: Decision Support

The province has steadily increased the number of evidence-based protocols to be implemented by EMS across regions. There are established relationships with existing contracted EMS providers and this may be further enhanced if joint training for implementation of best practice protocols occurs with EMS staff and contracted providers and emergency departments.

Staff members are keen to continue with local improvements. The QI committee is encouraged to seek opportunities for research.

Staff members reported they were unaware of where to take ethical dilemmas that are occurring in their practice. More education on the area of ethics is encouraged.

Priority Process: Impact on Outcomes

Staff members are encouraged by the recent improvements. Most report they appreciate working in the ambulatory and ED settings as opposed to support services as they learn and develop relationships with sending or receiving teams. The EMS personnel report they benefit from participating in the safety briefings or huddles in the emergency departments.

Even though standards for a communication centre will not be met until further work is accomplished at the provincial level, regional staff can still work with the time frame information they have to initiate improvements. Random case reviews can be utilized to measure compliance with existing protocols.

Priority Process: Infection Prevention and Control

By way of staff observations the surveyor team noted excellent cleaning processes. Recent work has resulted in consistent cleaning products being used across the Central Regional IHA. Staff members report they have access to personal protective equipment (PPE) training and supplies. Staff members are aware of their safety and that of their patients. Staff members spoke proudly of the work they do.

It is suggested that expectations of contracted providers related to IPAC could be enhanced. Joint training may be considered to increase collaboration and shared goals.

3.3.10 Standards Set: Home Care Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Central Region is challenged by an aging population and a perceived shortage of LTC beds. The James Paton Memorial Regional Health Centre and the Central Newfoundland Regional Health Centre have an average of 30% ALC population on its medical wards. There is, however, an adequate supply of personal care homes in the Region and there is a pilot project in conjunction with the Department of Health and Community Services to introduce a higher level of care to personal care homes. A call was done for an expression of interest and this is being piloted in one personal care home in our region. Personal care homes are a major focus and source of significant workload. Clients being discharged “earlier and sicker” from hospital with attendant Home Care needs. The enhanced Home Care program responds to this fact and is coping.

The regional team identifies a need for a community physiotherapist and an additional occupational therapist to be added to the group. Currently there are many clients who would benefit from physiotherapy who are not able to access this resource in the community. The OT workload is too great for one OT to manage effectively.

There are staff safety issues at the Bell Place office. The 1st floor has no controlled access and is open to anyone who comes through the door during the work day. A security camera is being placed here but there needs to be a barrier system as well. On the 2nd and 3rd floors, clerical staff who meet clients as they enter the office have no protection in the case of a violent incident. An environmental risk assessment needs to be completed to determine the risks and make recommendations, such as a Plexi glass barrier.

Client satisfaction is solicited throughout the care cycle in the Gander area but this is not done throughout the Region.

The team makes every effort to keep younger clients out of institutions. They utilize alternate family care homes and individual living arrangements in unusual situations, Recently they have opened an Adult Therapeutic Residency for individuals with complex problems with a focus on behavioural training and eventual discharge home.

There is good opportunity for staff to interact at the various sites and the morale seems high. The information provided to clients and families is made clear by the providers and time is spent in assuring full understanding. Safety risks in the home are reported to appropriate authorities if necessary and noted in the clinical documentation. Infusion pump training is recorded for the portable units used by the nursing staff. There has been positive feedback on the orientation program staff members undertake, including for non-violent crisis intervention. All high alert medications such as methotrexate and narcotics have associated independent double checks.

Overall, the HC teams are innovative and well-connected to their clients. There appears to be a need for increased staffing in some areas particularly as more complex clients are being sent into personal care (PCH) facilities where nursing care is limited or absent.

Priority Process: Competency

There is an extensive community-specific orientation package for new employees and for staff transferring from acute care.

All staff members are trained in dealing with violent clients and in decreasing risk without restraints. Police have been called only rarely.

Performance reviews are completed at least once every two years.

Medications are administered by non-professional staff in personal care homes. The PCH staff members all receive training from the Home Care nurse, and there is concern that these individuals do not have adequate knowledge to safely administer injectables such as insulin.

Priority Process: Episode of Care

The major barrier for access to services is geography, as this is a large, sparsely populated region. All staff members are required to make extensive trips to provide clients with care. The extent of travel required to provide adequate care should enter into the equation when determining whether new staff should be hired. Despite the travel demands on staffing, they are able to meet regularly and share information important for ongoing client care.

The large number of ALC patients in medical beds is a huge challenge for the Central Regional IHA and for the home care (HC) team. Despite efforts to explain the role of HC to acute care providers, team members are frustrated by misinformation provided to hospital patients by acute care staff before the transfer of the patient to home care staff. This misinformation leads to misunderstandings and loss of trust by clients and family members. There needs to be closer control of information provided to patients who are about to be discharged and to their family members.

Home care (HC) is provided both through home care clinics and by nurse visits to clients in their homes and in

personal care homes. LTC facilities have on-site nursing staff. Personal care facilities are privately owned and operate under contractual arrangements. The Regional Health Authority is responsible for monitoring the personal care homes based on the regulations.

The Home Care program monitors personal care homes according to regulations and standards provided by the provincial Department of Health. Most homes maintain high standards but if complaints are received, investigations are completed with recommendations provided to the Board at Central Health, who according to the regulations, have the ultimate responsibility for monitoring and licensing personal care homes.

Medication reconciliation is done well and consistently by the HC team.

There appears to be a high degree of trust and appreciation for the HC team members. These feelings were strongly expressed by clients and family members. The team members are passionate in their support of their clients and their families. They provide high- quality service on a tight budget.

Priority Process: Decision Support

The team has established a number of guidelines to improve client safety and care. Included in these are the fall prevention strategy, home security assessment, slow pace rehabilitation facility, and policies associated with protective community residences.

Priority Process: Impact on Outcomes

The team provides data to the Department of Health, which is compared with that of other regions in the province. This information is scrutinized by team members and changes in both policy and care are developed from these data. Some of the data indicates that there is an opportuinty for education/training of staff regarding medication errors and how to ensure that policies and procedures are upheld.

3.3.11 Standards Set: Infection Prevention and Control

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
7.3	Information provided to clients and families is documented in the client record.	!
13.4	All endoscope reprocessing areas are equipped with separate clean and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Materials on prevention of infection are made available to patients and family members but this process is not documented on the patient chart.

The organization requires staff and physicians to remain away from work when they have possibly transmissible infections. If a staff member comes to work with an infection they are instructed to return home and not come to work until the infection is no longer transmissible. The policy should also be enforced for physicians as well as for other staff.

Immunization rates for residents in LTC facilities are more than 90 percent. This is outstanding and congratulations are extended.

Overall, housekeeping is outstanding in this organization. The pride that the staff take in their work is amazing. The entire team should be proud of the great job it is doing to protect patients and staff. Although housekeeping in the acute facilities is excellent, the housekeeping in continuing care clinics and administrative offices outside the acute centres is not as good. Housekeeping in some clinics is only two times per week despite the fact between 25 and 30 clients are seen daily.

Microbial simulation audits are done on a regular basis and the results are collected and utilized for improvements in housekeeping. Housekeeping staff members have an annual refresher course on infection control.

The infection prevention and control (IPAC) team has done an excellent job at all sites in maintaining high standards of infection control. The team is committed to tracing infections and educating staff and the public on both how they have an impact on infection spread. The team has had a positive impact on vaccination rates and is highly respected by staff across the organization.

The kitchen at the Central Newfoundland Regional Health Centre was extremely clean. Some repairs are being done in the kitchen. The area is cordoned off with drywall and a negative pressure process is in place to ensure that no debris or dust floats into the kitchen that could affect staff or food preparation.

There is a great deal of signage throughout the health centres that reinforces the patient, visitor and family's role in infection prevention and control

Safety needles are available in the following locations: Insulin syringes, blood collection needles (including butterfly and standard venipuncture and transfer devices). Dialysis and respiratory Therapy are also using some specialty safety needles (Fistulas, thoracentesis) IV Catheters have been trialed and selected for standardization, and will be implemented in this fiscal year. The organization should consider moving towards a 100% safety needle/needleless system.

3.3.12 Standards Set: Laboratory and Blood Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory

The Laboratory Director is responsible to ensure the standards are met for the services provided at all laboratories across the region. Much of the equipment has been standardized to enhance patient safety. The laboratory space at GFW the Central Newfoundland Regional Health Centre is divided into two spaces: one is in the health centre and provides service primarily to the ER and in-patient units, the other is in the west building and provides service to mostly out-patient services.

It is difficult to realize staffing efficiencies given that the organization has to operate two bio-chemistry labs to ensure ease of access. Although space is limited at Harbour Breton and St Albans, the space meets the needs of the service most of the time.

The Laboratory Director has begun a review of work processes. Opportunities for efficiencies has just commenced with the arrival of new regional leadership.

Online education is available from Washington University. Courses include testing to ensure learning has occurred. The manager can assign courses as required for regular maintenance of competencies or for remedial purposes. The results of the testing are available to the manager to add to the training matrix. The training is available to staff at all locations and staff interviewed have identified it as a real strength that has come out of the Ontario Laboratory Accreditation (OLA) accreditation experience. Where volumes are low, the online learning keeps technologists up-to-date with best practices.

In the event that the laboratory services are included in a research study, the team is well aware of the requirements for research and ethics committee approval prior to any participation begins.

The organization has added a Quality Assurance/Improvement Officer to ensure the department continues to meet or exceed OLA and Accreditation Canada standards. All policies and procedures have been written or updated, approved, circulated and staff trained to any changes. The training matrix is an invaluable tool to track the extensive training occurring with staff across the region.

The laboratories in Harbour Breton and St Albans are small but sufficient in space for the volumes processed. Staff members are on call every other day and rotate in turn and are called in if there is an emergency patient that requires blood work to be processed. According to staffs, they are called in about twice in a two-week period. The laboratory staff are all registered laboratory technologists.

The room temperature in the laboratories at both the James Paton Memorial Regional Health Centre and the Central Newfoundland Regional Health Centre are both an issue with some areas very cold and other areas extremely hot requiring fans to be in place. The temperature is being monitored and work-arounds are in

place. Until the total laboratory space is upgraded, it is likely to continue to be a problem but the physical plant team is aware and is working towards a solution.

3.3.13 Standards Set: Long-Term Care Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
Strong caring nursing leadership is noted for the long-term care services.
Priority Process: Competency
Staff communication and engagement will need to be a sustained priority during the change in staffing process.
Priority Process: Episode of Care
The surveyor team observed there was excellent dignified care being provided.
Priority Process: Decision Support
The surveyor team noted there are up-to-date records with the mix of electronic and paper documentation.
Priority Process: Impact on Outcomes
The identification of the resources needed to achieve the staffing goals and objectives will need to be a

priority during the change process.

3.3.14 Standards Set: Managing Medications

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
1.3	The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.		ROP
	1.3.5	The organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.	**MINOR**
6.3	Medications are stored in secure areas accessible only by authorized staff.		!
10.2	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.		ROP
	10.2.2	The organization implements the Do Not Use List and applies this to all medication-related documentation when hand written or entered as free text into a computer.	**MAJOR**
	10.2.6	The organization updates the list and implements necessary changes to the organization's processes.	**MINOR**
Surveyor comments on the priority process(es)			
Priority Process: Medication Management			

The regional pharmacy and therapeutics (P&T) team, and pharmacy lead have made significant improvements to the quality and safety of medication management since the organization's previous accreditation survey. The pharmacy was moved to a larger space at the the Central Newfoundland Regional Health Centre site and redesigned to ensure safety standards are met and the design is functional. The organization is commended for making these important improvements.

The Meditech system used currently is being amalgamated and updated as the former regions had two different versions. The target date for completion is December 2013 and the region is encouraged to meet this deadline to ensure everyone has access to the same upgraded system.

Standing order sets are being piloted at five rural sites currently, and will be standardizing these once the feedback from the pilots is analyzed.

Clinical pharmacy services are accessible to all staff. This was noted by staff in all areas of the region and especially in the remote areas of the region. A pharmacist is assigned to areas and this improves the relationship for consistency. Pharmacists regularly travel to sites. The pharmacists are available 24/7 to answer any questions and problem solve in a cordial manner. They also do regular audits to ensure policies

and procedures are followed.

In the redesign of the pharmacy, a good high-alert system was implemented with coloured bins, bagged medications with labels and so on. This same system has been implemented in all the medication storage areas.

The P&T committee is active and has terms of reference, minutes and a good work plan. The committee has been working on implementing the required organizational practices (ROPs), has implemented Tallman lettering, has an excellent process to review and update the formulary and was extremely hands-on around the drug shortage crisis.

Pharmacy and nursing have worked together to implement a new medication administration system on the inpatient units based on the Ottawa model of nursing care, which is an excellent example of team work and integration. The system moves to a model where every nurse gives assigned patients their medication, rather than having only one medication nurse. The polices, practices and education have been completed. In order to implement the system, new medication carts are needed and some have been purchased and are in use. The areas that do not have the proper equipment are having difficulty with accessing medications in a timely manner. This has led to the carts remaining unlocked at times, which is a safety concern.

Chemotherapy and IV drug preparation areas are well-designed now and procedures are done in a safe manner. A pass through and camera system has been implemented which allows for less movement in and out of the secure area by staff.

The unit dose system is used in all areas except LTC where a multi-dose blister pack system is used and is more economical for long stay areas.

The team is encouraged to review medication incidents/occurences on a regular basis to analyse for trends and patterns as this is not done on a regular basis in any other area.

The delivery of pharmacy services to small rural sites has been enhanced in the region. With the use of state-of-the-art telecommunications technology, pharmacists are able to provide pharmaceutical care to patients at a distance. A Telehealth pilot project involves having a pharmacist at a central pharmacy site in Central Regional IHA available to directly supervise a pharmacy technician at the Notre Dame Bay Health Centre, which is 100 Km away in Twillingate. This has been an excellent way to increase access and the team is commended on this innovation.

The P&T team has implemented the policy on DO NOT USE LIST for dangerous abbreviations. Audits show a high percentage of non- compliant physicians. A number of different approaches have been used however, no improvement has been noted. The team will be piloting a new order form with a printed list of DO NOT USE abbreviations and will be soliciting help from the vice president of medical services to help problem-solve this dangerous practice.

Medication utilization reports should be sent to nurse practitioners as well as physicians.

At Twillingate there is an area of risk related to the lack of casual relief for the pharmacy tech.

The P&T team is encouraged to request regular medication incident reports, and quarterly at a minimum to ensure there is accountability to review and analyze patterns and trends across the region. Currently, this is not occurring across the region on a regular basis.

3.3.15 Standards Set: Medicine Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	The team regularly reviews its services and makes changes as needed.	
2.2	The team's goals and objectives for its medicine services are measurable and specific.	
Priority Process: Competency		
3.2	Team members have position profiles that define roles, responsibilities, and scope of practice.	
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
14.5	The team shares benchmark and best practice information with its partners and other organizations.	
16.3	The team compares its results with other similar interventions, programs, or organizations.	
16.4	The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
16.5	The team shares evaluation results with staff, clients, and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The nursing team has been part of the organizational implementation of the 'Ottawa' staffing model, and has had input to design of team roles. Assignments can be changed if there is an issue with the nurse's knowledge, skill, or judgement. The change is moving along as expected. The licensed practical nursing (LPN) staff spoken with during the on-site survey expressed satisfaction with overall registered nurse (RN) support.

There is some angst among RN staff at Connaigre Peninsula Community Health Centre knowing there will be displacement of at least 2.0 full-time equivalent (FTE) RNs.

The leadership team and Chief of Family Medicine do not have access to performance data regarding length of stay, prominent admission diagnoses, length of time medicine patients are waiting for beds in ED. It is not clear if the medicine services leadership team is accountable for the medical patients admitted in ED from perspective of a 'pull' from medicine rather than waiting for a 'push' from ED staff. Goals and objectives are driven by the red and yellow flags from the accreditation roadmap but not appearing to be linked to the corporate strategic plan. The goals and objectives are neither specific enough nor measurable. The team is extremely caring, patient and calm with patients. According to an in-patient interviewed, the nurses provide great care, are kind and attentive. In witnessing an interaction between the manager and the patient, those feelings expressed by the patient could be easily validated.

Priority Process: Competency

The inter-professional team includes physiotherapists and a PT assistant, social work, dietician, occupational therapist and an OT assistant as well as medicine. The team is engaged in the Ottawa model of care implementation which includes an evaluation component.

The larger team is collaborative and because there are cross-assignments for the allied health professionals across departments, the transfer of much information is facilitated. The educator uses a training matrix. It includes all aspects of training and feedback from mandatory training such as infusion pumps to performance review tracking and lunch and learn modules. It is comprehensive and easy for the manager to access.

Team members are recognized by service awards, articles in the newsletter 'Pulse' about accomplishments, and in one-to-one feedback. The team recognizes that some of the smaller centres use the Pulse newsletter more readily than this team.

Priority Process: Episode of Care

Medication reconciliation is completed on admission and transfer in the acute care unit at Connaigre Peninsula Community Health Centre. It is not completed formally in the in-patient medical unit at Central Newfoundland Regional Health Centre. The team makes a good effort to identify Best Possible Medication History (BPMH) for each admitted patient. They use either the local pharmacy printouts which they add to the chart or the nurses call the patient's pharmacy to get a printout of all active medications. It will be an easy transition for the staff and physicians to use the formal medication reconciliation form. The team uses the Central Regional Integrated Health Authority Transit record to document all key issues related to a client being transferred to another community. There has been some vacancies in the family medicine group and some retirements for physicians with large practices. The Chiefs of Family Medicine in Gander and Grand Falls-Windsor have worked together to facilitate recruitment in each of their areas and have established walk-in clinics to provide access for those patients without a family physician. The use of the clinic is being monitored and recently there is a plan to add evening hours particularly on Mondays, the busiest day in the ERs. Both specialists and Family physicians can admit to medicine beds.

There is a specific scope of service for the hospitals in the organization. All tertiary services are provided in by Eastern Health. Patients are moved between Gander and Grand Falls-Windsor sites if there is excessive need at either site. Within the Newfoundland culture, families are an integral part of the care team. Case management meetings include the patient and family members. From an ethics perspective there was one family that wanted their loved one, a palliative patient, to receive nourishment via a feeding tube. The risk of inserting the tube and the chance of extreme gastric discomfort to the patient made the team uneasy to

move forward. The patient was unable to speak for herself so the team was communicating with the substitute decision maker. The team involved the family's chaplain and spent much time in several meetings to help the family understand it was not in the patient's best interests. The team did not need to access an ethicist but did use concepts from the ethical framework to work with the family to everyone's satisfaction.

The client record is online except for physician's orders. Staff members print out a copy of the patient profile at the beginning of the shift and can verify that the patient care plan be followed. Patients requiring an alternative level of care receive information about the appropriate services such as for rehabilitation or long-term care and are asked to identify their top three choices. At times, it is necessary to move a patient to a LTC bed outside of their community.

The patient is referred to community services, which is part of Central Regional IHA's clinical team. The community or public health contacts the patients for follow-up. Any concerns about the inpatient stay are communicated to the manager of the unit by the community clinician or if appropriate, an occurrence report is completed. An annual patient satisfaction survey gives feedback about service and transition of care as experienced by the patient and family.

Priority Process: Decision Support

The VTE regime is in place in the medicine program and it is evidence-based reflecting best practices. However, it is not evident that evidence-based practice is in place in other aspects of the medicine services.

Priority Process: Impact on Outcomes

The team does use two identifiers when providing service. In one case, it was observed that the patient's armband was on the bedside table. It had been removed by staff due the fragile condition of the palliative patient's skin. Another patient tore off their armband as quickly as the nurses replaced it. It may prove beneficial to use photographs for identification of confused or compromised patients where use of the armband is a challenge. Such a process is in place in long-term care.

The team is diligent in conducting the falls assessment and follows up with education of the patient and family regarding the risk of falling. One patient with whom the surveyor spoke understood clearly that she was not to get up without assistance and the call bell was within reach for her to be able to call.

From a communication and accessibility perspective, the staff members and physicians are well aware that there are some patients that are unable to read. According to the team members, the patients are generally open in asking for help or bring-in family members to assist with communication and obtaining consent. These patients are treated with every respect.

The client perspective is obtained in a patient satisfaction survey that is done yearly and also in review of compliments or complaints. It would be helpful to have more timely patient satisfaction data if it is to be used to evaluate service.

There is no follow-up with patients by the inpatient staffs following discharge. Doing so would ensure that discharge processes were sufficient and adequate to support the patient until seen by family physician or community care. Furthermore, follow-up telephone calls are extremely informative to review practice and service objectives in real time.

3.3.16 Standards Set: Obstetrics Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.2	The team's goals and objectives for obstetrics services are measurable and specific.		
2.7	The team provides mothers with 24-hour rooming-in facilities or access to private, comfortable and quiet rooms for feeding.		
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
3.3	The team develops standardized processes and procedures to improve teamwork and minimize duplication.		
3.4	The team uses structured communication tools to communicate clearly and effectively.		!
9.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	9.5.1	There is a demonstrated formal process to reconcile client medications upon admission.	**MAJOR**
	9.5.2	The team generates a Best Possible Medication History (BPMH) for the client upon admission.	**MAJOR**
	9.5.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	9.5.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	9.5.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
10.2	The team has policies and procedures for administering oxytocin and prostaglandin safely and appropriately.		!
11.2	The team supports and monitors skin-to-skin contact, and provides bedside care to the mother/baby dyad on a one-to-one basis.		!
11.3	The organization has an infant feeding policy.		!

11.4	The team applies standardized criteria when determining whether the mother and baby are fit for discharge from the postpartum or mother and baby unit.	!
12.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	ROP
12.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
12.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
12.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
12.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
12.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
Priority Process: Decision Support		

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
17.5	The team shares benchmark and best practice information with its partners and other organizations.	
18.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
18.2.1	The team implements a falls prevention strategy.	**MAJOR**
18.2.2	The strategy identifies the populations at risk for falls.	**MAJOR**
18.2.3	The strategy addresses the specific needs of the populations at risk for falls.	**MAJOR**

18.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
18.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
19.1	The team identifies and monitors performance measures for its obstetrics services.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The obstetrics team has strong medical and administrative leadership. At Grand Falls-Windsor site, the obstetricians work in a consultative role. All pregnant women are attached to a family physician that does obstetrical care. The six family physicians rotate call and are responsible for any patients admitted on their call day.

The obstetricians of which there are three, see every pregnant woman early in their pregnancy to assess for risk and give advice about prenatal screening. The family physician may take back the patient completely until time of delivery or the obstetrician may share care with the family physicians for moderate risk patients. The obstetricians run a clinic for assessments as referred by family physicians and are able to do urgent ultrasounds (USS) and bio physical profiles (BPP). Because the images cannot be captured using the picture archiving communications system (PACS), print outs of the images are kept with the patient chart. It would be most beneficial if the BPP and USS performed in the obstetrical unit by trained obstetricians were available in PACS in case the patient presented in an emergency to another centre.

At Gander site, almost all prenatal, intra partum and postpartum care are provided by the obstetricians. There are few family physicians able or willing to do obstetrics by choice or because of vacancies in human resources.

The team has written goals and objectives derived from the red and yellow flags shown in the Accreditation roadmap. They are neither specific enough nor measurable. The leadership is not clear on how the goals and objectives may or may not be aligned with the corporate strategic plan.

Priority Process: Competency

The staff members receive orientation and training based on a competency checklist. The staff self-identify learning needs and the educator validates that the staff members meet various specific competencies. All staffs in obstetrics, along with region-wide required competencies, are certified in neonatal resuscitation, fetal health surveillance, and breast-feeding.

The teams at both sites wish to receive a Baby Friendly designation from the World Health Organization and have just commenced the process to evaluate current breastfeeding practices and identify what still needs to be done. Sixty-three percent of women are discharged breastfeeding.

Recently, the organisation approved adoption of the managing obstetrical risk efficiently (MOREob) program. This initiative provides a focus on teamwork and ability of the inter-professional team to recognize and manage obstetrical risk effectively.

There are medical residents in obstetrics that are really attracted to GFW site as it is the largest minimally

invasive gynecological surgical service for the province of Newfoundland. The obstetrics team benefits from that interest and increasing medical support.

Priority Process: Episode of Care

In the event of escalation of workload and patient activity, the unwritten escalation protocol is activated. Due to geography and unavailability of other inpatient obstetrical units, closing the unit when in escalation or redirecting patients is not a viable option. Extra staff can be obtained in two ways. There are float nurses that may be in the health centre and who are trained for obstetrical care and can be pulled to obstetrics in an escalation crisis and/or full-time nurses are called in on overtime, and first giving consideration of travel distance. The family physicians on-call and obstetrics-on-call are also supportive and helpful in an escalation situation.

There is no specific protocol to follow for post-partum bleeding but nurses do respond quickly to start IV, contact on-call most responsible physician (MRP) and initiate treatment. On-call physicians, if not in-house, are able to respond quickly.

All patients booked for elective Cesarean section (C-section) attend the surgical pre-admit clinic and are assessed by anesthesia there. In the event of an urgent/emergent C-section the anaesthetist assesses the patient on arrival to OR.

Priority Process: Decision Support

The team currently accesses policies and procedures via the intranet or Meditech. It is cumbersome for staff members to have to check two locations to find a policy to support practice. The team needs access to meaningful data. Since the beginning of the fiscal year the organization has submitted perinatal data to the province. Comparative data are published at the end of the fiscal year which allows the team to benchmark and compare like services across the province.

All documentation other than physician orders are available on the Meditech system. All staff members and physicians have been trained to access the patient's health record that way. The fetal monitors are somewhat dated but are being closely monitored by biomedical engineers. The manager at GFW site does not have a summary of items, as the preventive maintenance is contracted out however, this depends on the biomedical staff to notify when it is due. The biomedical staff members believe it is the clinical manager's responsibility to monitor contracts. Some role clarification would be helpful in this regard.

Priority Process: Impact on Outcomes

The team has identified the significant risk of the location of the main OR being on a different floor than the birthing unit. In the event of an emergency C-section, the patient must be transported by elevator and once the baby is born the baby must be transferred via the elevator to the obstetrical unit. In the event of the baby being unstable, the team may in fact still be 'bagging' a baby while trying to transport to the resuscitation space from the OR. The organization has considered the issue and has provided the team with a key for the elevator. Unfortunately, the solution is still high-risk because a member of team must go down to the main floor to insert the key into the fire panel. On a shift there is no extra staff such as ward clerk that can be sent to insert the key so a clinician must go. The nurses on duty are busy preparing the patient for an emergency C-section. The staff member must then return to the obstetrical unit to assist in the transfer to the OR. A more appropriate decision is to have a key for the elevator that can be inserted at the fourth floor level in order to call the elevator immediately to the unit to facilitate the fastest move to OR as possible. The only other alternative is to relocate the obstetrics service on the same level as the ORs. There could be

some consideration to set up a C-section OR on the obstetrical unit but have it staff by OR staff. The insufficient volumes of patients having C-sections either electively or on an emergency basis would prevent the obstetrical staff members from maintaining a high level of OR nursing skills.

3.3.17 Standards Set: Substance Abuse and Problem Gambling Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.2	The team's goals and objectives for its substance abuse and problem gambling services are measurable and specific.	
Priority Process: Competency		
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
Priority Process: Episode of Care		
9.8	The team monitors whether clients achieve their service goals and expected results, and uses this information to identify and address barriers that are preventing clients from achieving their goals.	
11.5	The team continues to offer and provide services to families and caregivers if services are discontinued to the client.	
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support		
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
Priority Process: Impact on Outcomes		
14.5	The team shares benchmark and best practice information with its partners and other organizations.	
16.1	The team identifies and monitors process and outcome measures for its substance abuse and problem gambling services.	
16.3	The team compares its results with other similar interventions, programs, or organizations.	
16.5	The team shares evaluation results with staff, clients, and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The Substance Abuse and Problem Gambling program is integrated with Community Mental Health. Staff are members of the Community Mental Health program. The integrated team works on the model of co-occurring

disorders which ensures that all clients are assessed for addictions and mental health concerns.

An exciting development to increase resources for youth dealing with substance abuse is in the planning stages for the region. A new provincial youth addictions centre is being built with 12 inpatient beds, four of which are for detoxification. Staff members have been hired and are planning the programs currently and the centre will open in the fall 2013. This new program could complete this standards package in the future.

There are no specific goals for substances abuse and addictions however, the assertive community treatment (ACT) team goals and outcomes do integrate addictions.

Priority Process: Competency

Evaluating the integration of the Substance Abuse and Problem Gambling programs in Community Mental Health would be a good next step. The evaluation needs to also focus on how integrated this service is with all mental health services and possibly, link to a Primary Care model.

Priority Process: Episode of Care

The ACT team's assessment tool has a comprehensive substance and gambling review with the most up-to-date knowledge of addictions.

There is a complaints process for the region with follow-up by local managers and monitoring by the client relations coordinator. There is an indicator reported on the corporate scorecard.

The substance abuse staff members are not involved in medication management except for the ACT team which has a process where all team members are involved.

The organization does not have detoxification or specific treatment programs for addictions in the region. These services are accessed provincially and staff help facilitate this transition. At times, mental health inpatient beds in the region may be used for an urgent situation for example, a client in withdrawal.

Recent quality improvement initiatives included work on reducing wait-lists. The team has made improvements and is tracking their progress and benchmarking with other community teams.

Clients reported their services were responsive, timely and making a difference in their lives. Satisfaction was high. Clients reported being involved in setting their own goals and involving family and friends as they chose.

There is a focus on follow-up checks with clients after discharge.

Priority Process: Decision Support

The model of care is noteworthy and the region is encouraged to share its experiences once a review of the literature and best practices has been completed.

Priority Process: Impact on Outcomes

The team is encouraged to benchmark, share evaluation results and monitor client experiences.

3.3.18 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
1.3	The team uses evidence-based client care maps or pathways to guide them through steps in the procedure, promote efficient care and achieve optimal client outcomes.	
1.8	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
2.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
12.6	The organization transports contaminated items separate from clean or sterilized items, away from client service and high-traffic areas.	!
Standards Set: Surgical Care Services		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
7.1	The team uses a procedure-specific care map to guide the client through preparation for and recovery from the procedure.	
7.7	The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	ROP
7.7.2	The team identifies clients at risk for venous thromboembolism (VTE), [(deep vein thrombosis (DVT) and pulmonary embolism (PE)] and provides appropriate evidence-based, VTE prophylaxis.	**MAJOR**
7.7.3	The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	**MINOR**
7.7.5	The team provides information to health professionals and clients about the risks of VTE and how to prevent it.	**MINOR**

7.13	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.	ROP
7.13.2	The team generates a Best Possible Medication History (BPMH) for the client upon admission.	**MAJOR**
7.13.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
7.13.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
7.13.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
11.4	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	ROP
11.4.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
11.4.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
11.4.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
11.4.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**
14.1	The organization has a process to select evidence-based guidelines for surgical care services.	!
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
14.3	The team's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	

Surveyor comments on the priority process(es)

Surgical services are essentially divided between the two major sites. Orthopedics is done only at the Gander site. Lasers are used only at the GFW site. Each of the sites has an integrated team that displays high morale and a strong patient focus. This was evident in all care processes, from day admits to surgery, PACU and on the unit.

Staff members did report an inconsistency in the performance review process citing: "can't remember when" to "within the year". It is recommended that the performance review process be clearly set out for all staffs and followed. This would be a further morale enhancer. Orientation of new hires is complete and carefully monitored until both new and current staff members are confident in the required skill levels. The new staff training record application provides a clear means of determining an individual's status at a glance and this includes infusion pump training.

While the teams do exchange information and discuss current issues at their regular staff meetings, it is suggested that they look at formalizing a team assessment process on a periodic basis to set continuous improvement goals for their functioning. The teams including physicians are commended on the forthright manner in which behavioural issues are addressed and resolved.

The OR suite at Grand Falls site has been under redevelopment for some time and is due to be opened within months. This new set of five OR rooms and attendant support space will allow more appropriate space and equipment utilization for the mix of cases. Other issues such as IPAC concerns will be addressed by the re routing of patient flow and separation of clean/contaminated items. Flash sterilization is kept to a minimum with about six cases per month and these are essentially all dental instruments.

Clinical practice guidelines and care maps are not used at either site. These approaches have been shown to improve the quality of care and outcomes for selected clinical paths. It is suggested that the surgical teams review this opportunity to implement such tools appropriate to their case mix.

The GFW site has demonstrated the power of process change in the significant improvement (plus 30 percent) in on-time antibiotic administration by moving the place of administration from the unit to the holding area/OR theatre.

The OR teams have been using a safe surgery checklist (SSC) for about two years. They are keeping records and have recently completed a chart audit which shows good results. It is suggested that the teams implement a more detailed process audit on a periodic basis to assure all minor steps are included.

The VTE prophylaxis policy has been implemented but it is not fully accepted as yet across the surgical service. Orthopedics is well along, but other disciplines are working through the process. This should not be an issue for too long.

Medication reconciliation on admission or discharge is not well done on the surgical service. A policy is in place, but the uptake is slow on most inpatient units. It is generally done well for surgical patients coming in via the pre-admission process.

Both pressure ulcer prevention and falls prevention strategies are in place and adopted.

Section 4 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.

4.1 Governance Functioning Tool

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

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

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

- **Data collection period:**
- **Number of responses: 0**

Governance Functioning Tool Results

The organization did not complete the required tool during the assessment period.

4.2 Patient Safety Culture Tool

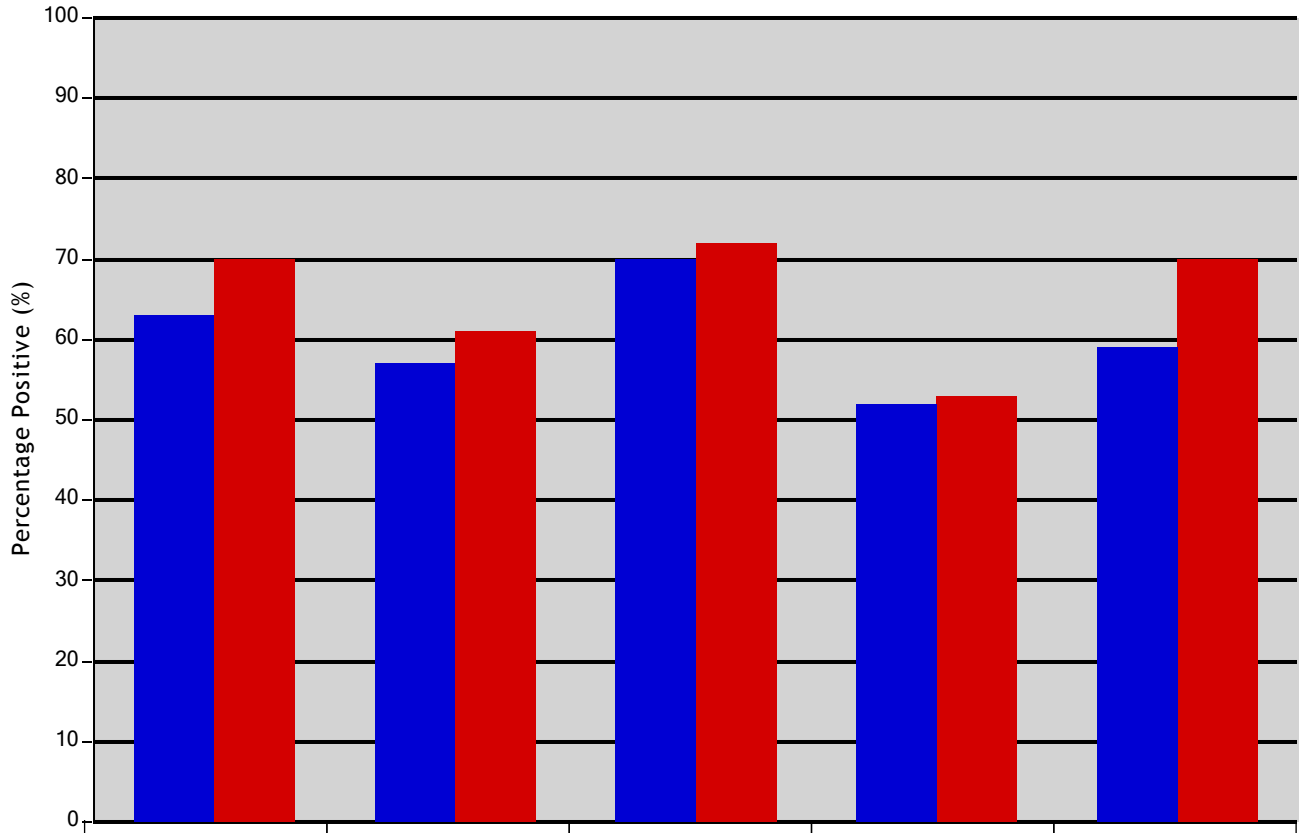
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: October 12, 2012 to November 20, 2012**
- **Minimum responses rate (based on the number of eligible employees): 334**
- **Number of responses: 642**

Patient Safety Culture: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	63%	57%	70%	52%	59%
	70%	61%	72%	53%	70%

Legend

Central Regional Integrated Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2012 and agreed with the instrument items.

4.3 Worklife Pulse Tool

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.

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

Client Experience Tool

Measuring client experience in a consistent, formal way provides organizations with information they can use to enhance client-centred services, increase client engagement, and inform quality improvement initiatives.

Prior to the on-site survey, the organization conducted a client experience survey that addressed the following dimensions:

Respecting client values, expressed needs and preferences,including respecting client rights, cultural values, and preferences; ensuring informed consent and shared decision-making; and encouraging active participation in care planning and service delivery

Sharing information, communication, and education,including providing the information that people want, ensuring open and transparent communication, and educating clients and their families about the health issues

Coordinating and integrating services across boundaries,including accessing services, providing continuous service across the continuum, and preparing clients for discharge or transition

Enhancing quality of life in the care environment and in activities of daily living,including providing physical comfort, pain management, and emotional and spiritual support and counselling

The organization then had the chance to address opportunities for improvement, and to discuss related initiatives with surveyors during the on-site survey.

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	Met
Provided a client experience survey report(s) to Accreditation Canada	Met

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. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

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 decision making regarding ethical dilemmas and problems.
Resource Management	Monitoring, administration, and integration of activities involved with the appropriate 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, innovation, and action.

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 overall goals and direction to the team of people providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	Using information, research, data, and technology to support management and clinical decision making
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	Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
Organ and Tissue Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
Organ Donation (Living)	Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge