ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Central Regional Integrated Health Authority

Grand Falls-Windsor, NL

On-site survey dates: September 16, 2018 - September 21, 2018

Report issued: February 8, 2019

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 September 2018. 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

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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.

Accreditation Decision

Central Regional Integrated Health Authority's accreditation decision is:

Accredited

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

About the On-site Survey

- **On-site survey dates: September 16, 2018 to September 21, 2018**

- **Locations**

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

  1. A.M. Guy Memorial Health Centre
  2. Baie Verte Peninsula Health Centre
  3. Bay d'Espoir Community Health Centre
  4. Bell Place Community Health Centre
  5. Carmelite House
  6. Central Newfoundland Regional Health Centre
  7. Dr. CV Smith Community Health Centre
  8. Dr. Y.K. Jeon Kittiwake Health Centre (Hospital)
  9. Grand Falls-Windsor Community Health (Queensway)
  10. Hope Valley Centre (Youth Treatment)
  11. James Paton Memorial Regional Health Center
  12. Lakeside Homes
  13. Lewisporte Health Centre (Community)
  14. Lewisporte Health Centre (North Haven Manor)
  15. St. Alban's Community Health Centre
  16. Therapeutic Residence

- **Standards**

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

  System-Wide Standards

  1. Infection Prevention and Control Standards
  2. Medication Management Standards

  Population-specific Standards

  3. Population Health and Wellness

Service Excellence Standards

4. Ambulatory Care Services - Service Excellence Standards
5. Biomedical Laboratory Services - Service Excellence Standards
6. Case Management - Service Excellence Standards
7. Critical Care Services - Service Excellence Standards
8. Diagnostic Imaging Services - Service Excellence Standards
9. Emergency Department - Service Excellence Standards
10. EMS and Interfacility Transport - Service Excellence Standards
11. Inpatient Services - Service Excellence Standards
12. Long-Term Care Services - Service Excellence Standards
13. Mental Health Services - Service Excellence Standards
14. Obstetrics Services - Service Excellence Standards
15. Perioperative Services and Invasive Procedures - Service Excellence Standards
16. Point-of-Care Testing - Service Excellence Standards
17. Public Health Services - Service Excellence Standards
18. Reprocessing of Reusable Medical Devices - Service Excellence Standards
19. Telehealth - Service Excellence Standards
20. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

1. Canadian Patient Safety Culture Survey Tool
2. Governance Functioning Tool (2016)
3. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	87	0	0	87
 Accessibility (Give me timely and equitable services)	115	5	0	120
 Safety (Keep me safe)	743	36	18	797
 Worklife (Take care of those who take care of me)	127	8	1	136
 Client-centred Services (Partner with me and my family in our care)	452	21	1	474
 Continuity (Coordinate my care across the continuum)	94	2	4	100
 Appropriateness (Do the right thing to achieve the best results)	1082	42	14	1138
 Efficiency (Make the best use of resources)	56	7	1	64
Total	**2756**	**121**	**39**	**2916**

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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Infection Prevention and Control Standards	37 (92.5%)	3 (7.5%)	0	28 (90.3%)	3 (9.7%)	0	65 (91.5%)	6 (8.5%)	0
Medication Management Standards	69 (94.5%)	4 (5.5%)	5	56 (93.3%)	4 (6.7%)	4	125 (94.0%)	8 (6.0%)	9
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	43 (97.7%)	1 (2.3%)	2	72 (93.5%)	5 (6.5%)	1	115 (95.0%)	6 (5.0%)	3
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Case Management	45 (97.8%)	1 (2.2%)	0	79 (98.8%)	1 (1.3%)	0	124 (98.4%)	2 (1.6%)	0
Critical Care Services	57 (95.0%)	3 (5.0%)	0	92 (88.5%)	12 (11.5%)	1	149 (90.9%)	15 (9.1%)	1
Diagnostic Imaging Services	65 (97.0%)	2 (3.0%)	0	66 (97.1%)	2 (2.9%)	1	131 (97.0%)	4 (3.0%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	67 (94.4%)	4 (5.6%)	0	102 (95.3%)	5 (4.7%)	0	169 (94.9%)	9 (5.1%)	0
EMS and Interfacility Transport	99 (91.7%)	9 (8.3%)	11	106 (89.8%)	12 (10.2%)	3	205 (90.7%)	21 (9.3%)	14
Inpatient Services	56 (93.3%)	4 (6.7%)	0	80 (94.1%)	5 (5.9%)	0	136 (93.8%)	9 (6.2%)	0
Long-Term Care Services	54 (98.2%)	1 (1.8%)	0	98 (99.0%)	1 (1.0%)	0	152 (98.7%)	2 (1.3%)	0
Mental Health Services	49 (98.0%)	1 (2.0%)	0	88 (95.7%)	4 (4.3%)	0	137 (96.5%)	5 (3.5%)	0
Obstetrics Services	72 (98.6%)	1 (1.4%)	0	87 (98.9%)	1 (1.1%)	0	159 (98.8%)	2 (1.2%)	0
Perioperative Services and Invasive Procedures	105 (91.3%)	10 (8.7%)	0	101 (92.7%)	8 (7.3%)	0	206 (92.0%)	18 (8.0%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Public Health Services	45 (95.7%)	2 (4.3%)	0	69 (100.0%)	0 (0.0%)	0	114 (98.3%)	2 (1.7%)	0
Reprocessing of Reusable Medical Devices	81 (94.2%)	5 (5.8%)	2	39 (97.5%)	1 (2.5%)	0	120 (95.2%)	6 (4.8%)	2
Telehealth	52 (100.0%)	0 (0.0%)	0	89 (100.0%)	0 (0.0%)	0	141 (100.0%)	0 (0.0%)	0
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	138 (100.0%)	0 (0.0%)	6
Total	**1179 (95.9%)**	51 (4.1%)	25	1506 (95.9%)	64 (4.1%)	13	2685 (95.9%)	115 (4.1%)	38

* 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).

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: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics 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: Communication			
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Case Management)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (EMS and Interfacility Transport)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Unmet	4 of 4	0 of 1
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Case Management)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Unmet	4 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (EMS and Interfacility Transport)	Met	5 of 5	3 of 3
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (EMS and Interfacility Transport)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (EMS and Interfacility Transport)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (EMS and Interfacility Transport)	Met	1 of 1	2 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Critical 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 (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Inpatient 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 (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics 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			
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Home Safety Risk Assessment (Case Management)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

This survey conducted with Central Health is focused on Clinical Services, Person, and Family Centered Care with the next survey to address corporate areas. The organization's goals of this survey were to receive feedback and recommendations on program standards, PFCC integration, telehealth improvements, medication reconciliation and the patient safety culture that this report will address.

The commitment of the executive leadership that we saw at the overview presentation is palpable. Despite the governance external review they are staying focused on moving the organization forward through action plans addressing the recommendations, have developed leader standard work to enhance visibility, and are utilizing lean tools to enhance their management system. They have strong partnerships with their Community Advisory Committees. This enables a structure and process to have grass root involvement addressing local stakeholder needs in planning and implementation.

Staff feedback that we received was positive and staff are committed and proud to be working in Central Health. The organization is encouraged to look at how they can increase provincial integration specifically around reducing variation and increasing quality and safety, which will in turn drive costs down. Aligning service delivery to health status in an upstream primary health network approach will continue to provide options and improved access for the population of Central Health that will align with the vision.

Central Health has been in operation since 2005 and further standardization and collaboration with internal and external partners will be needed to realize full regional integration of services across the continuum with the patients and families at the centre. The team has lead the Provincial Health Supply chain transformation and have the change management skills required. Patients and family feedback on the delivery of care and services was generally positive but they would like to be involved more, are excited about the vision for PFCC in Central Health, and want that to continue forward with them.

Central Health is committed to the accreditation process, has made significant improvement since the last survey, and have many innovations to share. Despite the vast geographical challenges, some of these innovations have been acknowledged as leading practices including: adopting a National Standard on psychological safety and achieving Level II Guarding Minds certification, enhancing partnerships with patients and families in PFCC, implemented the learning management system, adopting lean, chronic disease strategy, and a healthy aging strategy to mention a few.

The organization is commended for staying focused and moving forward in the right direction on their priorities which are being implemented in the strategic plan, responding to the external review and building the foundation for a better tomorrow through a shift in culture.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Inpatient Services 10.16 · Perioperative Services and Invasive Procedures 12.11 · Critical Care Services 9.23
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Perioperative Services and Invasive Procedures 11.6 · Critical Care Services 8.6 · Inpatient Services 9.7

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: EMS and Interfacility Transport		
11.3	Annual checks of the driving or operating records of team members' who operate transport vehicles are performed and documented.	!
11.5	Vehicle operators participate in regular training on how to operate transport vehicles.	!

Surveyor comments on the priority process(es)

There has been some significant investment in infrastructure with Central Health. The organization should, obviously, continue to look for opportunities to enhance infrastructure and space utilization.

Overall the cleanliness of all areas observed was excellent. It is obvious that this is important to the organization. Preventative maintenance initiatives were also very good.

There is an opportunity to expand existing wayfinding initiatives across the entire region as there appeared to be some variability in this practice.

The Operating Room areas were very well designed and maintained. There are no concerns with the physical layout or with the equipment used by this team.

EMS also has well maintained equipment and the ambulances are kept in good working order and were consistently clean. There are good processes for maintaining EMS assets.

One concern that the organization should consider is the fact that EMS ambulances are always kept outside. While the team has taken steps to ensure that shorelines are available to maintain heat inside, this is still sub-optimal. In the event of a power or heater failure there is no sure way of knowing the perishable drugs and IV solutions in the units were maintained at a level that is not damaging as per

manufacturer specifications. As such all temperature sensitive items would have to be discarded. Given the winter environment in Newfoundland this is a concern.

Given that driving is the major component of pre-hospital service, the EMS Team would be well served to ensure that employees have current driving qualifications and receive regular driving instruction to mitigate any organizational risk associated with this activity.

Priority Process: Emergency Preparedness

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

Unmet Criteria	High Priority Criteria
Standards Set: Infection Prevention and Control Standards	
13.7 Policies and procedures are regularly reviewed and improvements are made as needed following each outbreak.	

Surveyor comments on the priority process(es)

Central Health has a regional emergency management plan that provides a framework for various emergency situations including pandemic planning and an all hazards disaster and emergency response plan. The focus of this survey was only on the standards related to EMS and Interfacility Transport, Infection Prevention and Control, and Public Health Services in relation to emergency preparedness.

The organization has policies and procedures that identify the team, the identification and response to outbreaks and pandemics. The policy and procedures are available throughout the organization to all team members. With exception to the Health Emergency Management Framework that was updated in June 2018, it would appear that all of the policies and procedures related to emergency preparedness have not be reviewed or revised since 2011. The organization is encouraged to review the policies and procedures related to health emergency management and ensure that they are up-to-date and applicable to the current environment, staff, and resource levels within the organization.

It will also be important for the organization to regularly test their health emergency management planning in relation to an all-hazards response, pandemic and outbreak planning. Involvement of the Infection Prevention and Control teams as well as the Public Health teams will be essential in the testing of the plans.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Ambulatory Care Services		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Case Management		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Critical Care Services		
2.6	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Inpatient Services		
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	

16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Mental Health Services		
1.10	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
3.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Obstetrics Services		
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Standards Set: Perioperative Services and Invasive Procedures		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Public Health Services		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

The organization is commended for identifying PFCC as a key strategic direction in the Strategic plan 2017-2020 stating that by centering care on the patient and the family, we will achieve better care for individuals, better health of the population, and better value for improvement. The organization is in early stages of development and implementation of PFCC across the organization and it is recommended that they co-design with their patients and families in a proactive approach which speaks volumes to the philosophy and enabling a culture shift further towards PFCC across the region. The education modules on the Learning management system are good and implementation of this learning and uptake on this has been impressive. Continue to focus on the entire care team including physicians to lead and be the change you want to see. The organization is on the right track and needs to continue to monitor and propel this important work forward co-designing with PFCC on a regular basis.

Continue to use your patient and family voices and stories to tell the why PFCC is so important including to start off leadership and board meetings. Continue to grow your recruitment of PFCC advisers to assist you in the journey.

There are many examples that we saw going throughout the region of direct care engagement and you are strongly encouraged to work on the proactive integration of clients and families into what you are doing including implementing the draft family presence policy and evaluating signage in your region through the lens of PFCC. PFCC's could also play and active role on all of your quality improvement team. All LTC sites need to have resident/family councils set up. There are currently 9/11 set up and the organization is strongly encouraged to get those up and running.

Patients appreciate the white boards and rounding at the bedside where it is occurring and stated this changes made them feel more like partners in their care more than they did 5 years ago.

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)

Central Health performs many activities related to patient flow and capacity concerns, some are formal and others informal. Like many things in Central Health, it is the people who have local knowledge of resources and "know who to call" that make decisions on the fly. Many key positions informally wear multiple hats to fill in for multiple needs. Process mapping these activities would be difficult as it seems that there are so many variables and the response is different based on the situation at that moment in time and it will change rapidly.

Initiatives such as the 'Home First' strategy, improvements in home care and the Alternate Levels of Care strategy are examples of innovative actions to improve flow.

Opportunities to further enhance patient flow should include looking at regional bed management, proactive management enhancements to access to primary care in order to relieve pressures on the ED and EMS.

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: Diagnostic Imaging Services		
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
8.12	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization oversees the team's compliance with the organization's policies and procedures on cleaning and reprocessing.	
Standards Set: Reprocessing of Reusable Medical Devices		
1.3	If services for reprocessing of reusable medical devices are contracted to external providers, a written agreement is maintained with each provider that outlines requirements and respective roles and responsibilities.	!
1.4	Written agreements with external providers are regularly evaluated to verify that the requirements are being met.	!
2.4	A designated individual is accountable for quality oversight and for coordinating all reprocessing services across the organization, including those performed outside the MDR department.	!
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
8.4	Access is provided to hand hygiene supplies, including properly functioning soap and towel dispensers and alcohol-based hand rub stations in the working environment.	!
8.5	Hand hygiene is performed before beginning and after completing work activities, as well as at other key points, to prevent infection.	!

Surveyor comments on the priority process(es)

Reprocessing works closely with its internal partners, such as the Perioperative team. They do not have any responsibility for any reprocessing that is done in the Diagnostic Imaging program. The organization may want to review this separation.

The organization continues to use an in-house certification course for all of its MDR staff. There is a movement across Canada to move to a Canadian national level standard, and the health region is encouraged to move to this standard as well.

With the implementation of a new device tracking system, maintenance record, age and suggested life span can be easily monitored. There is a close relationship with the MDR department, the Maintenance Department, and the biomedical engineers responsible for preventative maintenance. The team has a Purchasing Committee which brings the entire team together to discuss feasibility of the device, and any issues with cleaning or maintenance prior to purchase.

In the James Paton site, there is sufficient space to have clear separation of clean and dirty space. There is a well-defined process for bringing in soiled items in bins, and then placing them in bins again, to send out to the various sites, and units within the site.

There is swift review of any unusual occurrences with a robust investigational process that consists of multidisciplinary team. The review is documented in the CCRS system, which does not provide an adequate space for making recommendations or the dissemination of kthe recommendations. The team is also encouraged to undertake these investigations under the auspices of a Quality Committee.

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, and innovation.

Standards Set: Population Health and Wellness - Horizontal Integration of Care

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

The Population Health program at Central Health utilizes a number of strategies to identify the needs of priority populations. The organization collects information about the service needs of the population that are high users of acute care services as one method of identifying priority populations. As well, through the community advisory committees and consultations with community groups Central Health is able to identify service needs for populations that may be high-risk or hard-to-reach.

Central Health's regional Diabetes care program was assessed in relation to the Population Health standards. This program is focused on promoting better health and improving health outcomes for individuals living with Type I, II, Gestational, and Pediatric diabetes. The comprehensive program located at the James Paton Memorial Regional Health Centre was reviewed. The quality improvement team has developed a robust work plan focusing on quality improvement activities for the program. These activities focused on the Accreditation Canada required organizational practices, as well as key opportunities for the diabetes program to promote its service to patients and families requiring care.

The team has developed a standard diabetes care program orientation which as been implemented within Central Health. There are good collaborations with Diabetes Canada through a local chapter which allows patients, clients and families access to educational materials. There is also a good linkage between the diabetes program and the home and community care team. Central Health is encouraged to continue with this work to ensure that there is integration of services across the continuum of care. Telehealth is well utilized with the priority patient population and allows clients to access services remotely. The is a

truly family and client centred approach given the geography of the region and the challenges for patients and families to travel to the sites where the services may be offered.

As the organization continues with its quality improvement work for the population health portfolio, and specifically the Diabetes Program, Central Health is encouraged to continue the good work of engaging patients, clients and families in their endeavours. The continued identification of priority populations through community engagement and data analytics is encouraged. Central Health is also encouraged to continue with the important work of assessing the impact of programs associated with priority populations to ensure that resources allocated to these activities are achieving the desired outcomes. A more robust population health program evaluation model may assist in this assessment.

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:

Point-of-care Testing Services

- Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

- Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.

Infection Prevention and Control

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

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

Public Health

- Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
6.3	When scheduling services, same-day scheduling of multiple services for individual clients is coordinated with other service areas in the organization in partnership with the client and family.	
6.5	The number of clients who fail to present at scheduled appointments is monitored and strategies to improve attendance are implemented with input from clients and families.	
6.6	The length of time clients wait for services beyond the time the appointment was scheduled to begin is monitored and work is done to reduce that time as much as possible.	
7.7	Translation and interpretation services are available for clients and families as needed.	
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

The Ambulatory Program has a wide geographical referral area for the clinics and includes multiple services under their program area. The diversity of services creates a challenge but many regionalization initiatives have been successfully implemented which has resulted in standardization of and access to care at Central Health.

There is a significant amount of information and data collected through clients and families that have helped inform the service design and support quality improvement initiatives regionally.

Priority Process: Competency

The program has a good process for orienting new staff members, and provides ongoing education to maintain certification and competency.

There is some integration across programs and more of this could assist with recruitment and retention. There are some identified areas where this is being considered.

Priority Process: Episode of Care

Excellent care planning involving clients is evident in the action plans developed for clients. There is significant client involvement in their day to day care and a thorough understanding of their treatment in the Renal Program and Cardiopulmonary Programs. Excellent education is provided in various setting including rounds and clinic appointments with meaningful involvement of the clients.

The COPD Outreach Program is an excellent example of the program identifying a need in the community, analyzing baseline data and getting approval based on positive results from a pilot program showing reduction in Emergency Room visits, admissions and length of stay.

Medication Reconciliation is well done in the Renal Program at Central Newfoundland Regional Health Centre (CNRHC). The Cardiopulmonary program at James Paton Memorial Regional Health Centre (JPMRHC) have not started implementation and presents an opportunity to complete this process for the Region.

Falls Prevention is well done in the Renal Program at CHRHC but is just in the preparation stages in the Cardiopulmonary programs at JPMRHC. Continued priority on this for the rest of the year is encouraged.

Priority Process: Decision Support

The program areas use technology to its fullest capacity with the equipment and software available. Innovative practices are encouraged and supported and have resulted in improved access for areas like Cardiopulmonary Services. The use Epiphany software is an excellent example of using technology to its fullest to provide real time ECG results to providers through Meditech. There is excellent use of data on access and wait times to assist with lean initiatives to reduce Holter Monitor and Echocardiogram wait times.

Priority Process: Impact on Outcomes

Across the program areas there has been work done to reduce variation in care by developing standardized protocols and procedures through order sets and guidelines. An example of reducing variation across the region has been in standardization of appointment letters for all ambulatory services. This has resulted in clients receiving consistent information on their appointment letters.

There are indicators for the program's quality improvement objectives and these and the results are utilized to make improvements and determine the effectiveness of these improvements.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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 at the James Paton Memorial Regional Health Centre was surveyed. Given that the laboratory in Central Health was assessed by the IQMH/OLA accreditation recently, the focus of this survey was only on the standards not already assessed by the IQMH/OLA accreditation.

The Laboratory is to be commended for their commitment, enthusiasm, and proactive approach to delivering quality diagnostic services to Central Health. The Laboratory team is very well organized with clear lines of responsibilities. There are resources focused on quality and safety to guide the quality improvement work across the region. The team collects activity data to optimize their services. Turn around times and wait time are monitored and reported. This information is being used to build indicators, provide feedback to teams and enhance quality.

Point of Care testing (POCT) is utilized in areas where rapid laboratory testing is required. Appropriate controls are in place to ensure the quality control of POCT.

Standards Set: Case Management - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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

This is a very broad program that encompasses everything from children with disabilities, personal care homes, long term care, seniors, foster care and a multitude of other programs. The program has recently undergone significant reductions in management staff resulting in large geographical areas to cover. They remain a committed team that is spread throughout the region. A great deal of work is done via videoconferencing, however the managers and directors continue to make the effort to be visible in each of the location.

Priority Process: Competency

There are orientation programs for all of the Community Support services. It is a cohesive team that is high functioning. There are opportunities for staff to access educational opportunities such as palliative care training.

Priority Process: Episode of Care

There are high percentages of ALC clients in acute beds, in both the urban and the rural centres. The Long Term Care group will move clients out of the urban sites to the rural sites to improve flow within the urban centres. There are a number of new LTC beds opening which should assist in decreasing the ALC rates.

The staff are particularly proud of a new program that has been implemented, Home First. This program is a type of rapid response to the Emergency room when an elderly client comes in for care. In the past three months this program has averted 38 admissions to acute care. This program is definitely a success.

The program continues to find efficiencies by reviewing the communities needs and tailoring the programming and skill mix necessary to deliver the programs in the communities. An example is a staff member who had capacity was willing and volunteered to add additional work that has streamlined the intake process for community health services.

Priority Process: Decision Support

Staff are challenged by having to use three different electronic systems plus a paper system in the community setting. It creates a lot of duplication in the information that needs to be inputted with the side effect of possibly not having consistent information throughout the different systems, or information that is truncated.

Priority Process: Impact on Outcomes

Home Safety assessments are consistently performed. The program could develop an outcomes focused QI project by focusing on the intake process and determining both client and staff satisfaction with the new process.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.10	There is a surge capacity plan for critical care units to manage a high number of clients during times of increased volume, as well as during pandemics, mass-causalities or other large-scale emergencies.	
Priority Process: Competency		
3.4	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.7	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
6.1	There is a process to screen potential clients against admission criteria for critical care.	
7.2	Family presence is promoted within the critical care environment based on the wishes of the client and family.	
8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.6.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.23	Information relevant to the care of the client is communicated effectively during care transitions.	ROP

9.23.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
13.5	Information is documented in the client's record in partnership with the client and family.	
Priority Process: Impact on Outcomes		
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
Priority Process: Organ and Tissue Donation		
12.3	There is a policy on donation after cardiovascular death (DCD).	
12.4	There is a policy on neurological determination of death (NDD).	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Critical Care program at James Paton is struggling with recruitment of internal medicine specialists which has adversely affected the ability of the team to work on quality projects. The interdisciplinary team also struggles with recruitment of trained professionals. The team has a good understanding of the population they serve and the chronic diseases prevalent, plus the type of conditions that present to the Critical Care unit.

Priority Process: Competency

Staff have the ability to access advanced courses such as ACLS. The Critical Care Unit will hire and provide an orientation and buddy program, then send the RNs off to a Critical Care course when an opening is

available. The smaller sites are prioritized to ensure highly competent staff are working in the smaller centers.

Priority Process: Episode of Care

There is a sense of comradery in the team, and because of the small size of the team, things seem to get done faster – such as changing standing orders and other forms. However, this is site specific, rather than a regional standing orders.

The team at James Paton is very proud of the interdisciplinary rounds done at the bedside with the participation of the patient and family. This new process has generated positive feedback from the patients. Handover between shifts are done at the bedside using a consistent tool. The Critical Care Unit in James Paton is spacious and well set up with good flow.

Family engagement is encouraged, although at both Critical Care sites there are still signs with visiting hours posted. The team should consider implementing open visiting hours based on discussions with the client and families.

Priority Process: Decision Support

The electronic health record is used consistently in James Paton. The system allows for timely access to information such as compliance with pressure ulcer review and falls risk assessments. Staff have a clear understanding of privacy and confidentiality and have responses ready when visitors are asking about other patients. The staff are commended on this, in such small community's privacy becomes very important.

Priority Process: Impact on Outcomes

The Critical Care team should think about developing a set of Critical Care admission criteria. While the Internal Medicine group in James Paton cannot as of yet take on 24/7 call, they could be consulted prior to each admission regarding best bed allocation

Priority Process: Organ and Tissue Donation

There is a provincial program for Organ and Tissue donation, and staff know the number to call. However, they state they do not usually keep those types of patients, they are transferred out prior to brain death. The program should monitor the number of missed opportunities for organ donation and plan a quality improvement project.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
6.7 The team annually reviews and updates the Policy and Procedure Manual.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Imaging	

Central Health has a very efficient and professional group of people working in the Diagnostic Imaging area. Given the recent upheaval with leadership changes it is a bit surprising to find the team well organized and functioning at a very high level. The Team is very well connected regionally, provincially and nationally. There is strong leadership with an eye toward excellence and quality improvement. Data is used to inform the team of system performance and opportunities for improvement without sacrificing patient safety. The organization would be served to continue to enhance data analytics in all areas in order to guide future improvements and system performance.

The only real concern noted was that the current policies and procedures are more than 20 years old. The good news is that there is a robust suite of policies and procedures ready in draft form. A communication plan has been developed and activities have already started that involve face to face meetings with Team members to "socialize" the idea that new policies are on the way.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
7.1	Entrance(s) to the emergency department are clearly marked and accessible.	!
8.2	The Pediatric-CTAS is used to conduct the triage assessment of pediatric clients.	
8.4	A triage assessment for each pediatric client is conducted within P-CTAS timelines, and in partnership with the client and family.	!
8.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.	
12.3	Client privacy is respected during registration.	
12.9	Clients who have received sedatives or narcotics are monitored.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.5	Ambulance offload response times are measured and used to set target times for clients brought to the emergency department by EMS.	
18.6	Data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen is tracked and benchmarked.	
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 organization has strong clinical leadership that clearly understands quality and patient safety tenets.

The major challenges facing the organization will continue to revolve around physical space and resources. While the organization functions effectively with multiple informal 'work arounds', this is not sustainable.

With several imminent retirements coming to key positions, Central Health will be facing the attrition of a significant amount of local knowledge that is vital to keeping the wheels turning and being responsive to changing system pressures. Recruitment, retention and succession planning will be vital moving forward. Resource allocation and workloads must also be examined in order to optimize patient safety and overall system performance.

Priority Process: Competency

There is a very collaborative culture in Central Health EDs where multiple people take on additional roles out of necessity. The willingness of staff to help other areas was very noticeable. The clinical competency and pride in the services being provided was obvious. while this is admirable, this informal approach of doing more with less is likely not sustainable.

There was some tension noted between key referral sites but this did not appear to impact services but was rather a by product of an older cultural situation.

There were several instances where linkages to other regions was obvious but the opportunity to leverage services both regionally and provincially could be explored further.

Priority Process: Episode of Care

The quality of care provided within Central Health is excellent. Many initiatives to enhance safety were noted. Screening at registration concern areas is an excellent, proactive step to enhancing patient safety. Anticoagulant use, suicide prevention and sepsis screening are examples of this. Client satisfaction with services was high with all who we spoke with. Clients were appreciative of the quality of the people and the care they received.

The majority of concerns continue to revolve around aging infrastructure and space limitations which is an issue universally in healthcare. Thoughtful and deliberate attention to the infrastructure will help to alleviate many concerns.

Again, improved access to primary care resources would go a long way to enhancing the overall system performance and, by extension, the quality of care by reducing the system pressures on ED and EMS resources.

Priority Process: Decision Support

Data analytics to support decision making is an area where great strides can be made. While there is data analytic support available, the majority of this is done by unit management personnel who are already performing many different roles. A common theme was the overwhelming expectations of all staff but especially middle management. Developing analytics capacity with trained and dedicated staff would enhance the quality of the analytics and remove the burden from management to allow them to focus on frontline care. They would be free to examine quality data in order to guide QI initiatives in a proactive rather than reactive way.

Priority Process: Impact on Outcomes

The EDs in Central Health have implemented many initiatives already. The implementation of a Fast Track component and the Best Possible Medication History initiative are shining examples of innovations in care.

The development of QI Teams across the organization coupled with the commitment to participate in a third party accreditation process clearly demonstration of the organizational commitment to excellence, safety and improvement. Data analytics will be imperative to decision making moving forward. Quality data points and strong analytics provides robust information that ultimately guides decision makers and enhances care. Increase in client demand with limited resources will only magnify this need moving forward.

Priority Process: Organ and Tissue Donation

The organization has taken the proactive step to gather information on organ donation practices from the provincial program and making it available to the Central Health practitioners. Well done.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	There is a written response and deployment plan consistent with the organization's mission, resources, and service demands.	
1.3	The written response and deployment plan includes strategies to manage the demands of emergency medical services and interfacility transport.	!
Priority Process: Competency		
5.20	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
15.3	The dispatch team has ongoing education and training on the dispatch protocol.	
Priority Process: Episode of Care		
14.2	In the event of an equipment or power failure, the communication centre has a contingency plan to restore communications if services are disrupted.	
14.3	The communication centre tests its contingency plan a minimum of two times per year.	
14.4	The communication centre uses standardized processes and tools to identify and track infectious events at calls, and communicates this information to partners and other organizations.	
14.6	Pre-arrival instructions are provided to callers who are at the scene or sending site, and the information provided is documented.	!
14.7	Resources are deployed based on the organization's deployment plan, and the team follows a standardized process to request assistance from other community or emergency services when required.	
14.9	The transport team's safety and movement are monitored throughout transport and updates are provided as required.	
14.11	In the event of a loss of communication, the communication centre has a procedure to restore it throughout the transfer.	
15.2	EMS only: There is an up-to-date emergency medical dispatch protocol for responding to service requests.	!

15.4	EMS only: The emergency medical dispatch protocol is used to assign the degree of urgency for each call and prioritize service.	!
18.1	The communication centre is notified when the team arrives at the sending site or incident scene and documents its travel time.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
17.1	Performance targets are set and tracked for handling requests for service.	!
17.2	The communication centre monitors and documents critical time points for each mission.	
17.3	Response time standards for each mission are tracked in accordance to established standards.	
17.4	Random case reviews are completed for each member of the dispatch team to measure compliance with its dispatch protocol, identify strengths, and target areas for improvement.	
Priority Process: Medication Management		
	The organization has met all criteria for this priority process.	
Priority Process: Infection Prevention and Control		
13.12	Sterile supplies are appropriately stored to maintain the integrity of packaging, and damaged or opened packages are discarded.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Medical oversight is managed provincially by the Provincial Medical Oversight (PMO) Team in St John's.

The Central Health EMS Team is well connected regionally and provincially. They have sought out collaborative opportunities with other regions and entities in order to improve their service delivery model.

Central Health may consider developing a partnership with other first responder agencies to enhance medical first response in the region. Limited budgets and a large geographic area of responsibility combine to make timely response to emergency medical situations difficult at the best of times. Partnerships with existing emergency response agencies, such as fire departments, can provide a system that is more responsive to identified time dependent medical emergencies and can positively impact patient outcomes.

Priority Process: Competency

The organization has taken steps to enhance the scope of available pre-hospital service by introducing Advanced Care Paramedics to their operations and should be commended for this.

There is opportunity for Central Health to enhance their dispatch services to be more comprehensive and deliberate and to be provincial leaders in this regard. A dedicated dispatch system with trained dispatchers would enhance patient and practitioner safety as well as improve the overall efficiency and effectiveness of the system.

Priority Process: Episode of Care

The care being provided by the Central Health EMS Team is excellent. It is commendable that the organization embraces full scope of practice for Primary Care Paramedics (PCPs) and has taken the next step by introducing Advanced Care Paramedics (ACPs). This provides significant opportunities for the organization to develop an enhanced community presence by leveraging the paramedic scope through innovative initiatives such as Community Paramedicine.

A major gap in the EMS Episode of Care revolves around the lack of a formal and dedicated EMS dispatch centre. There are multiple ambulance areas that appear to have different processes for answering calls for service through multiple call answering points. The only coordination of resources occurs at the local level with discussions between Emergency Room Managers and the EMS crews in real time for emergency situations.

May want to consider developing a regional EMS emergency and IFT dispatch system that will help Central Health manage EMS resources. The lack of a coordinated dispatch system is a risk to the organization.

An existing plus is the Ambulance Dispatch and Management System (ADAMS). This is a coordination centre that screens Inter-facility Transfer (IFT) requests and streamlines the use of resources to optimize safety and performance. Acting as a filter for requests, ADAMS personnel review IFT requests to determine priority and the optimal response while filtering routine vs. urgent requests to limit night time driving whenever possible and feasible. The ADAMS concept would be a good foundation on which to build a more comprehensive dispatch centre.

The development and implementation of a more formal communications and dispatch system will afford the following benefits:

o Improved safety for patients. Trained call evaluators can use validated tools to evaluate calls for priority. Proprietary tools already exist and are in broad use globally. An integral part of such systems is the ability for the call taker to immediately begin to assist callers with “Pre-Arrival Instructions”. The initial call for help is the earliest and best opportunity to have an immediate impact on outcomes by

employing these simple over-the-phone directions in life threatening situations. Examples of PAIs include such interventions as CPR in cardiac arrest or chest compressions for unconscious choking victims to name a couple.

o Practitioner safety. Properly evaluated calls help to reduce the number of lights and siren responses which are inherently risky. Additionally, a dispatch centre can track the EMS response throughout the duration of the call and act as an immediate resource to frontline crews when unexpected and dangerous situations arise. Other first responder agencies (i.e. police, fire) can be quickly summoned by the dispatch centre which frees crews to focus on managing their situation with the knowledge that help is on the way.

o System performance. Coordination of the system enhances overall performance efficiency thus improving effectiveness. Response times can be improved by the coordinated deployment of resources from a central location that is able to fully comprehend and be responsive to the regional big picture in real time. The benefits of gathering data from a central location is crucial in understanding system performance and for planning regional response plans.

Priority Process: Decision Support

The EMS Team in Central Health complete a Patient Care Record for every patient encounter. The processes for record retention, storage and privacy appears sound. As the organization continues to develop electronic options will continue to emerge and energy will need to be applied to updating policies and processes in order to keep pace.

An electronic charting option for EMS will be the way of the future and will afford many opportunities to further exploit data for better understanding of system performance and opportunities for improvement.

Priority Process: Impact on Outcomes

Coordination of system resources enhances overall performance efficiency thus improving effectiveness. Central Health has an opportunity to enhance their data collection of critical time points in order to better understand overall performance in order to optimize response.

A dedicated dispatch and call evaluation process would aid this tremendously.

Priority Process: Medication Management

Overall medication management by Central Health EMS is very good. The organization should consider ensuring that all High Alert Medications are managed and labelled in accordance with corporate policy and in accordance with ROP standards.

Priority Process: Infection Prevention and Control

Central Health EMS is supported by the organizations IP&C program. They do a good job of maintaining equipment and are well aware of IP&C philosophies and the importance of it.

There is an opportunity for EMS to become more integrated with the IP&C community moving forward.

Some time and attention should be paid to ensuring proper packaging of invasive devices and ensuring all units are equipped with readily accessible alcohol based hand sanitizer.

Standards Set: Infection Prevention and Control Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.3	There is access to a qualified IPC physician to provide input to the IPC team.	
2.6	The IPC team is consulted when planning and designing the physical environment, including planning for construction and renovations.	!
2.7	Input is gathered from the IPC, and the OHS teams to maintain optimal environmental conditions within the organization.	
4.2	There are policies and procedures that are in line with applicable regulations, evidence and best practices, and organizational priorities.	!
4.7	IPC policies and procedures are updated regularly based on changes to applicable regulations, evidence, and best practices.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Central Health has a very engaged team focusing on Infection Prevention and Control (IPAC) within the region. The IPAC team is made up of a regional lead and a number of infection control practitioners who work with numerous infection control liaisons located within each of the rural sites who are responsible for monitoring the QI indicators and infection rates as well as promoting awareness of IPAC. Given the broad geography of the region and the availability of resources, this appears to be a well functioning model. Unfortunately, the infection control team does not have a qualified IPAC physician (and have not had one for over 3 years) as part of the team. It is strongly recommended that Central Health identify a medical leader for IPAC to support this work in the region.

The quality improvement program for IPAC within Central Health is made up of a multidisciplinary team comprised of 12-15 active members made up of IPAC representatives, pharmacy, medical device reprocessing, surgical services, wound care, employee wellness, respiratory, public health, food services, and nursing from various sites. The team focuses on providing safe and quality care in the prevention of infections, minimizing outbreaks, and regularly reviews hand hygiene compliance and vaccination (influenza and pneumococcal) rates. Hand hygiene rates are available at the unit level. While the rates are available at the unit level, hand hygiene compliance appears to be an ongoing challenge within the organization. Central Health is encouraged to continue monitoring and implementing strategies to enhance hand hygiene compliance. One possible strategy might be to publish hand hygiene compliance by professional group (physicians, nursing, support services, etc.). This might further highlight groups that

need to focus on hand hygiene compliance process and engage patients and families in requesting care providers wash their hands prior to contact.

IPAC has targeted surveillance within acute care and long-term care focusing on healthcare associated infections. The organization is encouraged to utilize this targeted surveillance to continue to support quality improvement efforts to achieve zero preventable harm associated with hospital acquired conditions. Some of the successes that the IPAC team shared resulting from this work include reductions in ventilator associated pneumonia, reduction in overall UTI rates in long term care, and an overall reduction in MRSA.

Patient and family involvement in IPAC is achieved through a variety of activities that include: educational webinars, involvement in facility redevelopment, engagement in the development of educational materials, participation of IPAC in family counsel meetings, etc. The organization is encouraged to continue the promotion of IPAC with patients and family members. While a number of patients and family members indicated that they understood the importance of infection prevention and control, many could not articulate strategies that they could utilize to reduce infections. Ongoing education and support for all patients, clients and residents receiving care in Central Health is recommended.

Many of the facilities in Central Health that were visited have aging infrastructure and are undergoing construction and renovation projects. IPAC staff are involved in the planning of construction and renovation projects but stated that they were unable to continuously monitor the status of IPAC requirements associated with various projects. It was also reported that it was not uncommon that construction projects could be initiated without IPAC involvement or awareness. Hoarding is a very important process in ensuring that the clinical environment is not compromised during construction. IPAC should play a very active role in ensuring that the built environment is protected from potential hazards associated with renovation. It was observed at the James Patton site in the emergency room that the hoarding associated with a construction project was sub-optimal. Duct tape that is intended to ensure separation between the construction area and clinical area had separated from the wall and was not providing air flow protection. It is recommended that Central Health formalize a standard operating procedure to ensure that no construction projects are initiated without IPAC involvement in the planning, construction, and close-out phases of the work.

The IPAC policies and procedures are available to staff on the intranet site. Throughout the visit, staff could identify where to access the IPAC manual, policies and procedures. Based on a review of the IPAC policy and procedure section on the intranet, it would appear that many of the policies and procedures have not be reviewed or revised since 2011. The organization is encouraged to review all policies and procedures on a more frequent basis, eliminate those policies that are no longer relevant, and ensure that remaining policies represent current evidence informed practice.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
8.6	The team verifies that the client and family understand information provided about their care.	
9.7	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
9.7.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.18	Where appropriate, clinical care pathways are consistently followed when providing care to clients to achieve the same standard of care in all settings to all clients.	!
10.9	A process to monitor the use of restraints is established by the team, and this information is used to make improvements.	
10.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
10.16.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**

11.8	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.	!
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	

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

The Medical Quality Improvement team is a strong, focused team with strong clinical leadership. The team anticipates the addition of a physican lead in the imminent future. The team is providing strong leadership across the the region. The medical quality improvement team is working to expand its scope to include all inpatient services, including Pediatrics, surgery inpatient care and obstetrics, to become a regional inpatient care QI team.

Patient involvement in the medical inpatient quality improvement team is in development but the team Terms of Reference are being amended to include patient involvement in the near future. Patients have been involved in the development of the acute cardiac syndrome (acute myocardial infarction / AMI) bundle under the medical QI team.

There is a pressing need to coordinate cardiac services with the other regional health authorities and, in particular with Eastern Health, to streamline access to interventional cardiology services (angiography and coronary revascularization). This is provided as a provincial service but is not organized or coordinated as such and consequently, Central Health has a significant patient flow issue with patients waiting for transfer to St. John's for cardiac angiography occupying beds with excessive lengths of stay. This is not consistent with the principles of patient centred care and is an opportunity for leadership in developing program partnerships.

Priority Process: Competency

The inpatient units surveyed are staffed by competent, skilled, and professional staff from a variety of disciplines. While most staff have had contemporary performance evaluations, this is not consistent across the region. At some sites surveyed, performance evaluations are not done regularly due and this is attributed to the large spans of control that the managers have.

While the inpatient unit teams are high functioning and manage patients with a variety of complex

conditions, the organization is encouraged to regularly evaluate team functioning and focus on team dynamics. Regular critical incident drills (Code Blue, for example) on all units and in all sites, can help to both evaluate team functioning and act as learning experiences for l care teams. Individuals may be highly qualified and skilled, but high functioning teams can both achieve more than a group of skilled individuals can and mitigate the impact of one or more individuals who may not perform at their peak due to a variety of circumstances (fatigue, distraction, etc). The organization is encouraged to focus on team competency.

Priority Process: Episode of Care

There is a considerable amount of information available to patients during an admission to hospital. The patient information booklet is a rich source of pertinent information. However, it is important that staff are consistent in ensuring that patients and families understand the information about the care they are receiving and ongoing care plans. From discussion with patient's it did not appear that this was done consistently at all sites surveyed and patients interviewed were not aware of the material in the booklet.

Although there is information available to clients and families that describes the process for filing a complaint, patients interviewed indicated that they had not received this information and were not aware of the process. The organization should ensure that clients and families are proactively informed of these processes and not assumed to have accessed the information on their own through reading the booklet. A standardized orientation for patients that highlights key information may assist with this.

Central Health has implemented a standardized medication reconciliation process with corresponding documents and forms to be used as part of the patients active medical record. Not all sites use the documents in the same way and for the same purpose, such as generating admission orders or discharge prescriptions, and not all physicians within a single site use the discharge reconciliation form in particular in the same way. In particular, medication reconciliation has not been implemented at points of transfer in at least one site.

Clinical care pathways are not in use for common diagnostic groups or presenting conditions, although standardized order sets provide the framework on which clinical care pathways could be developed for common conditions or interventions. Clinical care pathways, or care maps, can standardize most aspects of client care and provide a means to manage lengths of stay while ensuring consistently good clinical outcomes by embedding leading evidence based practices in all aspects of a patient's care.

It is important that staff consistently use 2 patient identifiers before any treatment or intervention. While this is identified by all staff as a required practice, not all staff were observed to be consistently doing so, particularly at smaller sites. It is important that the organization emphasize to all staff that while they may be personally acquainted or familiar with a specific patient or client, in order to maintain a high level of safety throughout the system, they must adhere to the 2 patient identifier policy.

There has not been a formal evaluation of the effectiveness of communication tools and standardized communication formats. Staff report using various communication tools and formats for information

transfer and communication at different transfer and 'hand over' points in the patient care journey.

Although staff report individually doing informal assessments of the likelihood of readmission, and there are well developed discharge planning processes, there is no formal and objective assessment of the risk of readmission. The organization is being proactive in assessing the likelihood of admission for emergency patients in Gander through the "ER Connect" program.

Priority Process: Decision Support

Staff have access to a variety of standing orders and decision support tools to assist them in their assessment of admitted clients (nursing) and the generation of patient treatment orders (physicians).

The Meditech electronic health record does not, however, have clinical decision support for order entry of medications. There are no drug interaction, frequency or dose limit or adjustment alerts built into the ordering system. This is a safety concern as medication ordering is a high risk activity and electronic alerts enhance safe prescribing. The lack of these alerts in an electronic system may also lead a prescriber to assume that a dose is appropriate simply due the lack of alerts. This is particularly true for locum physicians who may be coming from other jurisdictions where such alerts are built into the system.

Priority Process: Impact on Outcomes

The Quality Improvement team has a series of initiatives that it is implementing in inpatient units across the organization. Each of these initiatives has an indicator or indicators associated with it. Not all of these indicators are specific or have clear timelines associated with them. The organization is encouraged to promote the use of SMART goals (specific, measurable, attainable, relevant, and time-based) in its quality improvement initiatives.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.16	Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
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

There is input that is gathered from the residents and families on many fronts. Central Health is in early days of formalizing PFCC and it would be helpful to develop a regional philosophy that is understood and applied consistently in an proactive way with principles and a framework that is developed with your service population in a proactive way.

There is strong clinical leadership and the team is working on decreasing variation and increasing quality and safety using indicators and data to determine next steps. The team is using the 5S methodology as a lean tool and have realized organization and hard green dollars and this approach to CQI is encouraged.

Priority Process: Competency

Excellent education video on hand washing in LTC for staff and residents that is a valuable resource that could be shared with any LTC program across the country that highlights the importance and gives all the key messages.

Establishing the need and implementing Nurse Practitioners at 8/11 of your sites is laudable and demonstrated the value of using everyone to the full scope of their practice. There are still opportunities to explore this further in this service line with the paramedics that are on site in health centres that could be used in clinical areas.

Performance reviews have not been done consistently in all areas of the organization.

Priority Process: Episode of Care

The team is commended for the ALC work they did in a cross-functional and integrated manner across the continuum which increased access and flow including decreasing transfer time to LTC from 8 days to 24 hours. Nineteen residents form this service line have been discharged back into the community which speaks volumes to the type of collaborative integrated care that is provided.

Priority Process: Decision Support

The team identified the need for one consistent client record for the organization.

Priority Process: Impact on Outcomes

Carmelite House is a bright, modern, homelike and well equipped facility. Having proximity to the acute care site provides the advantages of having nearby access to those acute care services. The team has a significant number of disciplines who collaborate together to coordinate and provide care. The addition of the Nurse Practitioner who is present full time 5 days a week has made the coordination and provision of care for the residents timely and he is readily accessible to the other disciplines. The team has made significant progress on a number of initiatives including reduction of the use of antipsychotics and reduced time to placement of residents from acute care.

There are strong ties with many community organizations such as Meals on Wheels, church groups, the Lions Club and the movie theatre to name a few. There are also linkages with such groups as the Alzheimer's Society and Parkinson's Society.
Residents and their families are active participants in the resident's care and are given opportunities for choices and input in many aspects of their lives and their surroundings. As an example when the siding needed to be changed on the building, the residents had input into the color chosen. The family council is active and provides improvement opportunities to the team which is acted upon and communicated back to the residents and families.

Medication orders are entered into the computer system and printed for the chart by the nurse practitioner which avoids transcription errors. The medication distribution system using 7 day multidose packaging has been an improvement for nursing.

The team is using data to tell there story and implemented needed changes including the expansion of LTC beds to meet the demand.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
12.3	Conditions appropriate to protect medication stability are maintained in medication storage areas.	
13.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies.	!
14.5	Steps are taken to reduce distractions, interruptions, and noise when team members are prescribing, writing, and verifying medication orders.	
14.8	There is a process to ensure that medication orders are transcribed accurately.	!
14.9	Compliance with the policies and procedures regarding medication orders is regularly monitored, and improvements are made as needed.	!
15.1	The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose.	!
18.3	Emergency, urgent, and routine medications are dispensed within the timelines set by the organization.	
18.5	Automated dispensing cabinets are equipped with a profiling system.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The pharmacy department services both acute care and long term care sites and the 2 main referral hospitals also service the rural health care centers and hospital sites.

There are 3 Committees (Antimicrobial Stewardship, Medication Management QI and Medication Reconciliation) that provide direction and have accountability for different medication management areas and there is accountability through Pharmacy and Therapeutics Committee and Medical Advisory Committees. These appear to be active and working effectively. The significant number of quality initiatives implemented attests to this.
Consideration is being given to adding a patient advisor on 2 of the Committees and this should be encouraged.

There have been improvements made to the drug distribution and medication management processes

over the past few years. There is a good solid unit dose drug distribution system with many quality processes in place. It has a very good system to separate look alike, sound alike drugs in both the pharmacy and the units that have automated dispensing cabinets. There is wide disseminated use of Tallman font in all areas.

In the rural areas such as Baie Verte there is evidence of some high alert drugs not having proper high alert labelling or kept in proper storage areas.

Clinical pharmacists where they are available provide valuable support to the program areas and this could be expanded. Rural areas could use this type of support and some availability would be worthwhile to consider.

Further improvements to consider include a full centralized IV admixture program and further rollout of automated dispensing cabinets. The current automated dispensing cabinets should include patient profiles. In the absence of automated dispensing cabinets, 24 hour patient specific strips of oral medications should be considered for acute care patients.

The Antimicrobial Stewardship Program has been formalized and now includes a number of expanded interventions to optimize antimicrobial use. There is good use of restrictions and best practice guidelines appropriate for the patient population. It has not been able to expand as successfully to rural areas due to limited geography and pharmacy resources.

There are excellent auditing practices in many areas of medication management and feedback on results and improvement practices have resulted.

The pharmacy has implemented a novel system to prevent alert fatigue by changing the coding of overrides on a regular basis so that a different code must be entered by the pharmacist to override an alert.

Medication storage on the patient care areas for refrigerated medications is not temperature controlled or monitored and this should be addressed.

There is significant development of patient order sets which contributes to standardization of ordering according to best practice guidelines. Apart from order sets, medication ordering is undertaken in one of two processes, one on carbon copy paper or written electronically and a copy sent to pharmacy. There is potential for transcription and other errors with this hybrid system. Entry directly into Meditech as the only method of order entry should be considered. Medication administration records are handwritten in acute care and can be an area of risk for transcription errors. Computer generated medication administration records should be considered.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.6 Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care	
2.7 The physical environment is safe, comfortable, and promotes client recovery.	
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	

Engaged passionate team focused on the Recovery model.The team has good multidisciplinary communication at transition points and they are creative to meeting the needs and working together to do the right thing for the people they serve. They have a laudable mission statement that they have recently renewed to align with their philosophy, which is to provide opportunity for individuals and families and communities to participate in recovery orientated services that promote wellness and foster hope, resilience, collaboration and empowerment which is posted and lived at all 3 sites. They have done a good job of centralizing intake and have reduced wait lists for the population they serve secondary to these projects and their philosophy on the recovery model. The TAO - therapy assistance online approach through telehealth is an innovative approach and enhancing presence of the team in a virtual way that enables access and capacity in hard to reach areas as well as to the correction's community. This approach is laudable and needs to be expanded to assist with your vast geographical challenges.

To align further with their mission the team is encouraged to explore outreach reach programs in conjunction with primary health care providers to bring services to their vulnerable population. The drop in centers are an excellent example of how the team has used community engagement and client and family centered input to listen to what the needs are. The Naloxone tent that was set up to deliver

education and naloxone kits to the those that were interested is another example of reaching out and bringing services to the population continue to explore how all areas in primary care do this in a collaborative flexible manner to suit he needs of the population versus a diagnosis approach to intervention. The inpatient unit infrastructure meets the security standards that said, a plan to explore future needs in this site would be of benefit to help address the mixed population that is being cared for specifically adolescents with different needs and different levels of care.It would further be of benefit for flow and client needs to have a therapeutic quiet room in the emergency department in Grand Falls.

There is an opportunity to provide formal ethics training to all staff, many staff are aware of how to address an ethical issue and they know who to call however that is not consistent with all staff members in terms of awareness and what the ethical decision making tool is. The team is encouraged to move forward with their FACT(Flexible assertive Community Treatment teams) to enhance their team based model. The team is encouraged to continue to implement their action plans including securing the space for the Opiod dependency program and look at opportunities for further integration and full scope of practice across their service line.

The team is commended for their education session for the elderly called learning the ropes and looking and listening to the future population to identify needs and create understanding on early onset dementia. Client and family feedback is generally positive and they state that the staff and the teams care about them and they can feel that and makes them feel empowered to take steps forward. There are certainly pockets of engagement with clients and families and it would be of benefit to formalize your structures and processes around PFCC that align with all of your service lines to enhance your services and fully integrate and co-design the future state with your clients and families. A fully integrated electronic health record would enable even better communication between providers and across service lines. Ensuring recreational activities are consistently available for clients was cited as an opportunity by staff and clients which is supported.

Hope Valley is an integrated approach to Youth detox and a therapeutic home like environment focused on the recovery model. The entire model is commendable and the staff and client feed back is consistently positive noting the opportunity to ensuring access to psychology service when they need it at times it has not been available and they value that service. The team at Hope Valley is encouraged to work on an evaluation framework to demonstrate how this model is delivering what the clients and families need and put it forward for a leading practice it is a model to replicate across the country! The emergency suicide intervention kit was also approved as a leading practice and the STARS(stand tall and rid stigma) an art contest to display messages and pictures and posters to this end to raise awareness during mental health awareness week has been going on for 5 years.

Priority Process: Competency

There is no formal training for all staff on ethics or ethical decision making that was documented this was also confirmed with staff on tracers.

Priority Process: Episode of Care

At 2E the 20 bed inpatient unit there is an opportunity to explore the physical layout and space to align with the services that are provided there to the mixed population to enhance their model of care and reflect the needs of the population.

Priority Process: Decision Support

There are different clinical systems that are used including medi tech and CRMS that do not talk to each other which is a communication gap for providers and does not enable information flow and increases rework for providers.

Priority Process: Impact on Outcomes

There is further opportunity to share best practices and refresh and update regional policies across the service line. Quality improvement plans are in large part action items and a renewed focus on outcome indicators to focus your work and to evaluate would be a step further towards your future state and making these indicators visible to track your status at a glance with your teams at huddles and rounds would be of benefit.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.12 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
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

The obstetrics service is designed as a 'two campus' program with intrapartum and delivery care to be provided in both Grand Falls - Windsor and Gander. Unfortunately, a shortage of physicians, both family physicians with obstetrical privileges and obstetricians in Gander has resulted in the diversion of expectant mothers from Gander to Grand Falls - Windsor for the past 8 months.

There is planning underway, through an interdisciplinary committe, with plans to include ongoing patient representation, and utilizing the expertise of a consultant, to introduce a midwifery model of delivery care in Gander. This exciting initiative is an excellent example of patient centred care with its emphasis on delivery closer to home, choice of delivery provider (and potentially delivery location), and enhanced team work between midwives, nurses, family physicians and obstetricians. The health authority is encouraged to look at models of integrated midwifery care in other jurisdictions to understand not only the necessary steps to introduce a new clinical service, and category of clinical service provider, but also to understand the impact and disruptive effects on other services.

Priority Process: Competency

The health authority has participated in the Managing Obstetrical Risk Efficiently (MORE OB) program for within the full scope of their roles, better communication in both routine and emergency care situations, and a more sustainable obstetrical workforce.

The health authority is encouraged to leverage the team based learning and critical incident drills embedded in the MORE OB program to introduce similar team concepts to other clinical areas within the organization.

With the diversion of all deliveries to Grand Falls - Windsor, there is a sense of workload stress and fatigue amongst the front line obstetrical staff. The organization is encouraged to pay close attention to its nursing staffing model in order to prevent burn out and disengagement arising from unsustainable workloads, or from the disruptive effect of the introduction of a new model of obstetrical care as midwives join the team.

The organization is encouraged to focus attention on ensuring that all staff are knowledgeable about the Ethical Framework and ethics resources available to them.

Priority Process: Episode of Care

The organization is to be commended for seeking World Health Organization 'Baby Friendly' status in 2019. The focus on best practices in maternity care is producing measurable changes in indicators such as 'skin to skin' rates, low risk and primary Caesarean section rates and rates of 'trial of labor after C/section". The focus on achieving a tangible quality goal has energized the quality team.

Priority Process: Decision Support

There is a good sharing of patient prenatal information between the different care providers and venues involved in the delivery of antenatal and peri-partum care. The organization is encouraged to optimize the flow of information through the integration of the prenatal record into the electronic medical record.

Priority Process: Impact on Outcomes

The obstetrical quality improvement team is taking a focused approach to the use of indicators to drive quality. By benchmarking indicators such as C/section rates (primary and repeat), 'skin to skin' rates, breastfeeding initiation rates, and rates of 'trial of labour after C/section' to other facilities and venues within the province and nationally, the team has been able to develop practice improvements through standardization of evidence based practices. This is an excellent example within the health authority of using data and indicators to drive quality improvement. As part of the provincial Perinatal Program, the team has both support and access to quality resources to achieve these improvements.

Standards Set: Perioperative Services and Invasive Procedures - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.3 Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency	
6.4 Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
7.5 The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
8.1 The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	
Priority Process: Episode of Care	
11.6 FOR INPATIENTS ONLY: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions. 11.6.4 The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	ROP **MAJOR**
12.11 Information relevant to the care of the client is communicated effectively during care transitions. 12.11.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP **MINOR**
20.16 There is a process to follow up with discharged day surgery clients.	

20.17	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
Priority Process: Medication Management		
15.3	Every medication and solution on the sterile field is labeled.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This Regional program has management staff that are over both sites (Gander and Great Falls) with the Medical Director having also worked in both sites. This allows the program to have consistent information from both sites, and allows for better standardization.

Priority Process: Competency

The organization has a robust educational program with dedicated educators. This has allowed the team members to be up-to-date on their clinical skills, and mandatory educational components

Priority Process: Episode of Care

Patients have high praise for the service and the staff, wait times meet or more than meet the provincial standards.
The service has a hip and knee assessment clinic, which assesses all hips and knees who are referred by

their family physician to an Orthopedic surgeon. This multidisciplinary team has managed to divert a number of clients who are not appropriate for joint replacement, thus decreasing the wait time for the others waiting to see the surgeon. The program is encouraged to review and evaluate its program. Anecdotally, patients appear to do better after attending this clinic, they have a better understanding of the process, type of pain, and expected recovery time

Priority Process: Decision Support

The organization has implemented a system that allows for almost complete documentation electronically. The system allows for easy retrieval of data to support monitoring and improvement activities.

Priority Process: Impact on Outcomes

CNRHC has implemented a change in time of blood draws for potential discharges. The blood draw is times for 0630 which allows the results to be in the charts by the times the physicians are rounding. The James Paton Hospital expressed interest and is encouraged to follow through on this project. Moving people through the system faster allows for better patient flow.

The program should consider adding client and family representatives to the QI team and the Action-planning team. A formal process to collect input from clients and families is needed.

Priority Process: Medication Management

The surgical services areas are waiting for Automated Drug Cabinets. The OR has just received new anaesthetic carts and all are set up the same, same as the medication carts in each room.

Standards Set: Point-of-Care Testing - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Point-of-care Testing Services

The Point of Care Testing (POCT) Program in Central Health is well established and managed centrally by a single operational leader. The POCT coordinator is well informed and committed to quality improvement. This individual oversees a very robust quality control program for POCT within Central Health. The focus of this survey was on the standards not already assessed by the IQMH/OLA accreditation that was already conducted.

The program has a well-established process for the orientation, education, and training of staff who will be performing POCT. Individuals are unable to log into the POCT equipment until they have gone through the appropriate training and certification. There is an annual recertification process that is computerized and managed centrally. All staff who are authorized to perform POCT must complete ongoing education / certification in order to be able to continue to use the POCT equipment.

POCT testing is performance for Glucose and Troponin testing, with a plan to deploy urinalysis testing once acceptance testing has been completed. Numerous sites across the region are utilizing POCT testing and the laboratory team anticipates that there will be continued growth in the use of POCT.

The POCT documentation process represents a potential risk for the organization. The POCT team shared that clinical staff are required to manually transcribe POCT results from the POCT equipment into the clinical information system. This represents an opportunity for manual data entry errors. Central Health has identified a plan to create an electronic interface to the ADT system and results reporting system which would eliminate the need for transcription and the associated risk. Given the projected growth in the use of POCT, the organization is encouraged to rapidly implement this solution to minimize the risk to patients and clients.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
4.3 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Public Health	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Public health uses a number of approaches to garner input from clients, families, staff and community partners on work and job design, and roles and responsibilities. The community is actively involved in the design of public health services through the community advisory committees, community consultation processes and various documentation that is released including an annual report and community profile.

Priority Process: Competency

Public Health Services is delivered by a highly skilled multi-disciplinary team. There is good connection between the public health teams and other interdisciplinary teams working in primary care and home and community care. The team has access to continuing education and professional development through team-based learning activities as well as the learning management system within Central Health. Staff also indicated that they take opportunities to personally develop themselves through online courses and conferences that are offered outside of Central Health.

The staff orientation process includes relevant public health legislation related to respective roles. Ongoing performance evaluations do not appear to be regularly conducted. Numerous staff indicated that they had not had a performance review for many years. In some instances, staff could not recall the last time that they had a performance review. The organization is encouraged to ensure that team member performance is regularly evaluated and documented.

Priority Process: Impact on Outcomes

Through the QI team action plans, the team was able to share a number of examples where they utilized data in the planning, service delivery, evaluation and quality improvement strategies related to five specific goals:

1) Improve Public Health Nursing services in the area of Prenatal Education and Support
2) Enhance Public Health Nursing services in the area of Parenting Education and Support
3) Improve Public Health Nursing services in the area of School Health Services
4) Enhance Public Health Nursing services in client service delivery to the 0 to 5-year aged population and their parents
5) Adhere to Central Health policies and PHIA legislation regarding personal health information during service delivery.

The quality improvement goals are designed to meet specific objectives. Many of these goals had performance indicators that identified process and outcome measures. The team is encouraged to continue its work on the refinement of the performance indicators and in particular identifying the key indicators that would support the achievement of specific outcomes.

There may also be opportunity for the team to identify indicators that would allow Central Health to benchmark its performance against other public health programs and services across the country. The team referenced that some of this work is underway and they are encouraged to continue this great work.

Priority Process: Public Health

The public health team is a committed group of individuals focused on a variety of health promotion and protection services across the region. They work in collaboration with a variety of stakeholder across sectors to influence and promote improvement of social support networks, the built environment employment and working conditions, education, food security, etc. The understanding of staff of the interplay between their services and the social determinants of health was strongly evident in all discussions with the leadership team. Numerous examples were provided of cross-sector partnerships that focused on improving the health of the population. Clients and partners spoke highly of Central Health and the public health team as a partner in health promotion.

Population assessment data is used to inform public health services at a regional and local level. The information is used to identify populations who are at risk as a result of social or environmental factors.

Clients spoke highly of their experiences in receiving services from Public Health. It is clear that the public health staff play an instrumental role in delivering services and building relationships with the clients in a patient and family centred manner. Examples of work related to immunization, pre-natal and post-natal care were shared and clients articulated thanks for the services being offered.

Standards Set: Telehealth - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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

Telehealth is a provincial program with overall program governance and coordination taking place at the provincial level rather than within the health authority. Telehealth service delivery is organized by dedicated staff within the health authority. Designated staff at ach site are responsible for local coordination of telehealth services, and operation of telehealth equipment.

Telehealth is used for three main purposes: clinical consultations, business operations (meetings), and education. The organization is encouraged to develop a strategic approach to the use of telehealth that looks at the impact of telehealth enabled services on local and regional models of service delivery as well evaluating telehealth enabled services with respect to effectiveness and efficiency of service delivery and optimization of the experience of clients and providers.

Priority Process: Competency

The organization is encouraged to approach telehealth services from a 'needs based' perspective, where telehealth is viewed as an opportunity to enhance access to services or connections between people and services, rather than as a distinct clinical service delivery model.

Priority Process: Episode of Care

The health authority is encouraged to optimize the use of telehealth enabled clinical services. Minimizing travel and expense while optimizing clinical access and effectiveness of service delivery is an excellent example of patient centric care. Given the geography that the health authority covers, optimizing telehealth enabled service delivery and busines and education applications is also a staff and client safety and risk reduction issue.

Priority Process: Decision Support

Since telehealth enabled clinical encounters do not integrate with either the electronic and paper based health record, the health authority is encouraged to work with its provinical partners to develop standardized encounter reporting and information transfer protocols. It is important to ensure that clinical information arising from telehealth enabled encounters is consistently recorded and included in the client's composite health record and is accessible by other practitioners along with other health information.

Priority Process: Impact on Outcomes

Telehealth is still a relatively new modality of clinical service delivery. While there is a high degree of client, family and provider acceptance of telehealth enabled clinical services, not all clinical services can be optimally provided remotely and the nature of client - provider interactions may be altered.

The health authority is encouraged to systematically evaluate the impact, effectiveness and acceptability of telehealth enabled clinical services as well as the potential impacts on other services.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

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

The main blood supplies are kept in the two Regional Hospital sites and some supply is kept at rural sites to meet any critical needs. The transport system is good to rural areas and integrity of product is maintained while in transport.

Good quality control measures are in place to ensure blood product is kept in date. There are processes in place to deal with shortages and a plan in place to deal with needs should the supply reach critical levels.

Quality indicators are in use and the team identifies areas where access can be improved. They have added extra panels to be done in-house in order that better turnaround times could be achieved.

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.

Governance Functioning Tool (2016)

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: January 9, 2017 to February 8, 2017**
- **Number of responses: 7**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	14	0	86	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	N/A
3. Subcommittees need better defined roles and responsibilities.	100	0	0	N/A
4. As a governing body, we do not become directly involved in management issues.	0	0	100	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	57	0	43	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	N/A
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	N/A
12. Our ongoing education and professional development is encouraged.	0	0	100	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	0	100	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	N/A
17. Contributions of individual members are reviewed regularly.	60	0	40	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	14	0	86	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	40	0	60	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	14	0	86	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	33	17	50	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	33	33	33	N/A
27. We lack explicit criteria to recruit and select new members.	40	20	40	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	N/A
31. We review our own structure, including size and subcommittee structure.	0	0	100	N/A
32. We have a process to elect or appoint our chair.	50	0	50	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	100	N/A
34. Quality of care	0	0	100	N/A

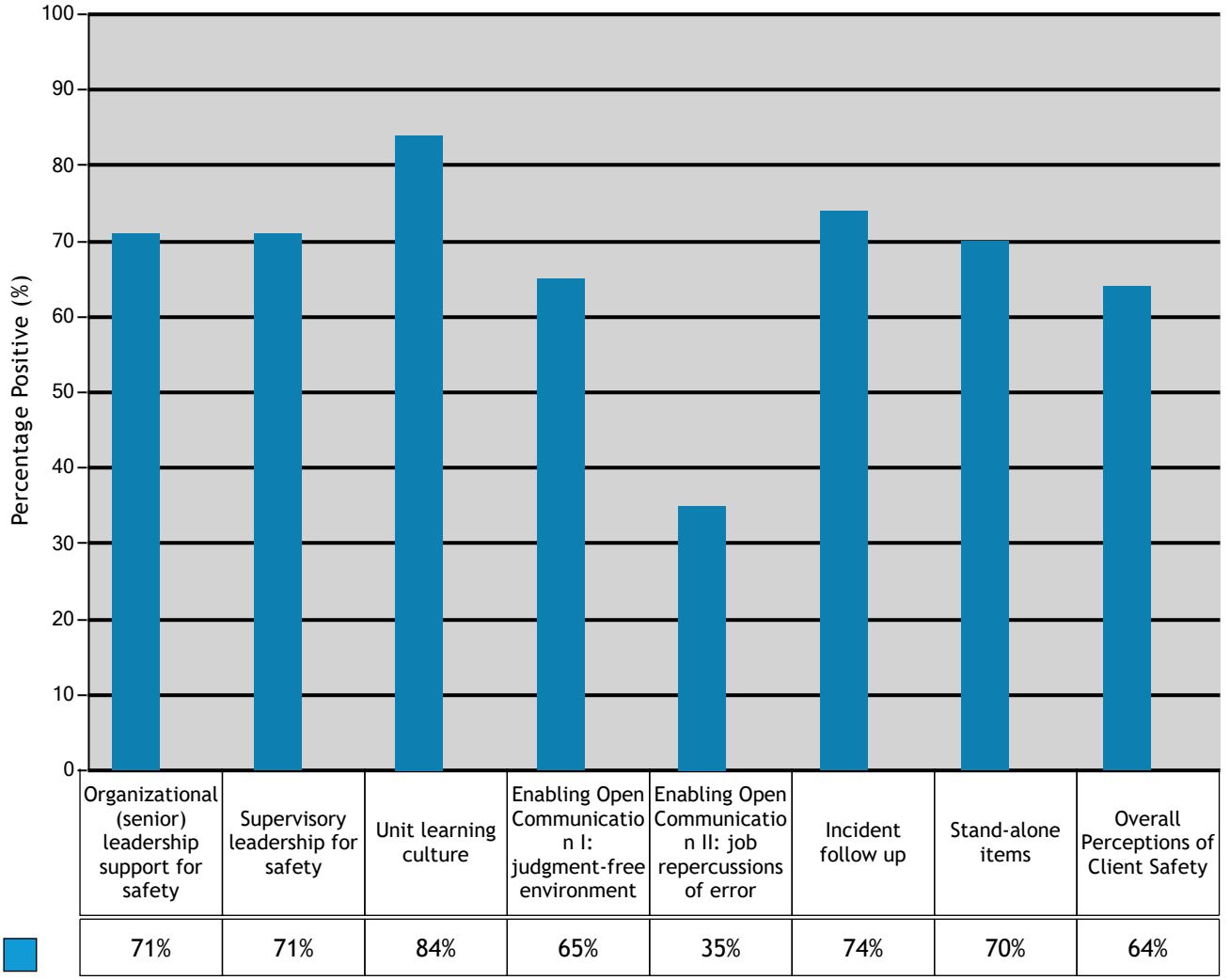
Canadian Patient Safety Culture Survey Tool

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 20, 2015 to November 25, 2015**
- **Minimum responses rate (based on the number of eligible employees): 330**
- **Number of responses: 669**

Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	71%	71%	84%	65%	35%	74%	70%	64%

Legend

Central Regional Integrated Health Authority

Worklife Pulse

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

Organizations can use results from the Worklife Pulse Tool to identify strengths and gaps in the quality of worklife, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals. By taking action to improve the determinants of worklife measured in the Worklife Pulse tool, organizations can improve outcomes.

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 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.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
People-Centred Care	Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.