



**ACCREDITATION CANADA**



*Driving Quality Health Services*

## Accreditation Report

Prepared for:  
**Western Regional Integrated Health Authority**

Corner Brook, NL

**On-site Survey Dates:**  
November 28, 2010 - December 3, 2010

December 17, 2010



**ACCREDITATION CANADA**  
**AGRÉMENT CANADA**

Accredited by ISQua

# Accreditation Report

## About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Western Regional Integrated Health Authority.

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

## Confidentiality

This Report is confidential and is provided by Accreditation Canada to Western Regional Integrated Health Authority only. Accreditation Canada does not release the Report to any other parties.

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

Table of Contents

About the Accreditation Report..... ii

Accreditation Summary..... 1

Surveyor’s Commentary..... 3

Organization’s Commentary..... 5

Overview by Quality Dimension..... 6

Overview by Standard Section..... 7

Overview by Required Organizational Practices (ROPs)..... 8

Detailed Accreditation Results..... 10

Performance Measure Results..... 71

*Instrument Results*..... 71

*Indicator Results*..... 82

Next Steps..... 90






Appendix A - Accreditation Decision Guidelines..... 91

## About the Accreditation Report

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

### Legend

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

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



# Accreditation Report

|    |                                                     |
|----|-----------------------------------------------------|
| 4  | Emergency Department                                |
| 5  | Emergency Medical Services                          |
| 6  | Intensive Care Unit/Critical Care                   |
| 7  | Laboratory                                          |
| 8  | Long Term Care                                      |
| 9  | Maternal/Perinatal                                  |
| 10 | Medicine                                            |
| 11 | Mental Health                                       |
| 12 | Operating Room                                      |
| 13 | Sterilization and Reprocessing of Medical Equipment |
| 14 | Surgical Care                                       |

## Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Western Regional Integrated Health Authority or "Western Health" is applauded for the commitment to the accreditation process; the process is understood and welcomed. Staff have been tremendously accommodating during the surveyor team visit. They have openly shared information, including the successes and challenges and have confirmed a commitment to excellence despite the many changes and challenges that have come about since the organization's previous survey.

Many positive achievements, programs and services have been observed across the region. These include: the national award for excellence in facilities management related to environmental initiatives; the heart, stroke, diabetes and cervical cancer initiatives; the assertive community treatment team (ACTT) program; and Safer Healthcare Now! initiatives such as the integrated approach to myocardial infarction, to name just a few. Also, Laboratory Services has made significant progress in the development of a quality management system. It will be important to monitor progress of these initiatives and ensure that sustainability plans are designed. Medication reconciliation is an example of an important initiative that needs to be further addressed. As well, it is encouraged that a methodical approach to developing services based on population health influence strategic planning.

Another strength noted is the excellent link to Memorial University and particularly, the integration of the nursing program. The accommodation of many students and commitment to teaching was evident in many programs. Also evident is an atmosphere of learning. This was especially noticeable at the Western Memorial Regional Hospital (WMRH).

The relationships established with affiliate organizations are commendable. In particular, the partnership approach with the other provincial health regions and reflected by most departments is evidently producing mutual benefits. The relationship between Western Health and its many community partners has continued to develop, and again, mutual benefits have been realized toward improving the health of the communities. There is evidence of overall satisfaction with all services from patients, physicians and even between departments.

As noted, many opportunities, challenges, and changes have or will soon occur including the new long term care (LTC) facility in Corner Brook, renovations and program changes at WMRH, and commissioning of some key capital equipment. Others include the Cameron Inquiry, and the impending changes due to the new provincial Department of Child, Youth and Family services. Because of these and other concerns, there is an increased need for ongoing monitoring and evaluation of their impacts on clinical services planning and implementation. This monitoring and evaluation needs to include a review of bed, program and space utilization, patient flow, risk management and resource allocation across the broad system of care. For example, the number of near misses reported is very low at this time, and it is important this evolve and that the vehicle used will further the work on incident reporting and encouragement of a safe supportive culture.

There is evidence of strong communication taking place at all levels of the organization. As changes occur, this strength will be valuable in enabling a culture of caring and inclusion to ensure that the valuable lessons of integration are not lost as relationships change. Ensuring that front line managers are aware of decision making processes needs to occur. Change can be expected to be an ongoing and dynamic occurrence in health care. While change is essential, it is also important to balance the number of initiatives underway at any one time.

# Accreditation Report

The laboratory services has made significant progress in their development of a quality management system. The service is well organized, with an enthusiastic, highly competent, committed group of staff, managers, and pathologists all of whom are 'on board' with the new requirements. Facilities and equipment are generally adequate and up to date, and supplies are well managed. Safety is a high priority and much work has been done to improve patient and staff safety. There is evidence of overall satisfaction with the service from patients, physicians and other departments. The laboratory information system is a very useful tool and is well maintained. Challenges will be to complete the implementation of a document control system, enhance the process for investigation of non conformities including near misses, develop process controls and then audit the processes. Point of care testing will likely bring a new set of challenges in the future, which affects not only the laboratory but clinical areas as well.

The effective management of information technology across the continuum, including increased use of telehealth, can be an enabling tool if planned in a coordinated and strategic manner and leveraged further by collaboration with provincial and federal initiatives. This coupled with continued cohesive governance and leadership, meaningful staff and community engagement and effective communication strategies will continue to assist Western Health in realizing its vision. An exceptional communication strategy is the web site, which is impressive and easily accessed.

A very important strength of Western Health, which underpins many of the successes and will provide the strength on the quality journey, is the staff, and they are duly commended.

## Organization's Commentary

The organization has no comment at this time.

## Overview by Quality Dimension

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

| Quality Dimension                                                          | Met         | Unmet      | N/A        | Total       |
|----------------------------------------------------------------------------|-------------|------------|------------|-------------|
| Population Focus (Working with communities to anticipate and meet needs)   | 85          | 6          | 1          | 92          |
| Accessibility (Providing timely and equitable services)                    | 106         | 7          | 0          | 113         |
| Safety (Keeping people safe)                                               | 510         | 52         | 68         | 630         |
| Worklife (Supporting wellness in the work environment)                     | 140         | 6          | 2          | 148         |
| Client-centred Services (Putting clients and families first)               | 147         | 4          | 6          | 157         |
| Continuity of Services (Experiencing coordinated and seamless services)    | 56          | 1          | 2          | 59          |
| Effectiveness (Doing the right thing to achieve the best possible results) | 794         | 57         | 54         | 905         |
| Efficiency (Making the best use of resources)                              | 73          | 3          | 1          | 77          |
| <b>Total</b>                                                               | <b>1911</b> | <b>136</b> | <b>134</b> | <b>2181</b> |

## Overview by Standard Section

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

| Standard Section                                           | Met         | Unmet      | N/A        | Total       |
|------------------------------------------------------------|-------------|------------|------------|-------------|
| Sustainable Governance                                     | 80          | 7          | 4          | 91          |
| Effective Organization                                     | 100         | 5          | 0          | 105         |
| Infection Prevention and Control                           | 83          | 15         | 5          | 103         |
| Child and Youth Populations                                | 50          | 1          | 0          | 51          |
| Biomedical Laboratory Services                             | 46          | 6          | 0          | 52          |
| Blood Bank and Transfusion Services                        | 64          | 7          | 93         | 164         |
| Community Health Services                                  | 67          | 1          | 0          | 68          |
| Critical Care                                              | 94          | 14         | 1          | 109         |
| Diagnostic Imaging Services                                | 99          | 1          | 4          | 104         |
| Emergency Department                                       | 94          | 13         | 0          | 107         |
| Emergency Medical Services                                 | 151         | 2          | 7          | 160         |
| Laboratory and Blood Services                              | 159         | 14         | 3          | 176         |
| Long Term Care Services                                    | 119         | 0          | 2          | 121         |
| Managing Medications                                       | 110         | 23         | 2          | 135         |
| Medicine Services                                          | 93          | 10         | 1          | 104         |
| Mental Health Services                                     | 109         | 0          | 2          | 111         |
| Obstetrics/Perinatal Care Services                         | 110         | 5          | 4          | 119         |
| Operating Rooms                                            | 97          | 2          | 2          | 101         |
| Reprocessing and Sterilization of Reusable Medical Devices | 89          | 7          | 3          | 99          |
| Surgical Care Services                                     | 97          | 3          | 1          | 101         |
| <b>Total</b>                                               | <b>1911</b> | <b>136</b> | <b>134</b> | <b>2181</b> |

## Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

| Criteria                                | Required Organizational Practices                                                                                                                                                                                                                                                                |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Effective Organization 6.6              | The organization reconciles clients' medications at admission and discharge, transfer, or end of service.                                                                                                                                                                                        |
| Effective Organization 10.5             | The organization's leaders implement an effective preventive maintenance program for medical devices, equipment, and technology.                                                                                                                                                                 |
| Critical Care 7.6                       | The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.                                                                                                                                                        |
| Critical Care 12.5                      | The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. |
| Critical Care 12.6                      | The team transfers information effectively among service providers at transition points.                                                                                                                                                                                                         |
| Critical Care 16.6                      | The team implements verification processes and other checking systems for high-risk activities.                                                                                                                                                                                                  |
| Emergency Department 8.3                | The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.                                                                                                                                                                   |
| Emergency Department 11.5               | The team reconciles medications with the client at referral or transfer and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.  |
| Managing Medications 10.2               | The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.                                                                                                                                             |
| Managing Medications 18.3               | The team uses at least two client identifiers before administering medications.                                                                                                                                                                                                                  |
| Medicine Services 7.5                   | The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.                                                                                                                                                        |
| Medicine Services 11.3                  | The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. |
| Obstetrics/Perinatal Care Services 7.12 | The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.                                                                                                                                                        |
| Obstetrics/Perinatal Care Services 11.3 | The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. |

| Criteria                    | Required Organizational Practices                                                                                                                                                                                                                                                                |
|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Surgical Care Services 11.4 | The team reconciles medications with the client at referral or transfer, and communicates information about the client’s medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. |

## Detailed Accreditation Results

### System-Wide Processes and Infrastructure

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

### Findings

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

#### Planning and Service Design

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

##### *Surveyor Comments*

Provincial legislation requires the board to have a three year strategic plan, as well as to produce an annual report. The board is currently in the process of developing its third strategic plan. A regular review of the mission, vision, values, as well as goals and objectives takes place. All board meetings include input from the strategic planning committee.

For the board to fully assess risk, it is important the board members receive ample information about near misses, as well as strategies to achieve this type of information.

The board operates under a modified Carver model. Modification includes the existence of committees. Board members receive extensive orientation via the Provincial Health Board Association. Most board meetings include an education session on an overview or update of a regional program or service. New members also receive an overview of the organization from the chief executive officer (CEO) and each of the vice presidents (VPs) meets with new trustees for one hour regarding their respective branch and related issues. There are ten mandatory modules from government for board orientation. Training for board members is ongoing and they are encouraged to attend the annual Canadian Health Service Executive, Canadian Hospital Association (CHSE/CHA) leadership forum.

Individual board member evaluation is in place as well as an evaluation after every board meeting and annually. There is a board self assessment tool that was developed by the region to look at how the board as a whole functions. The board conducts a CEO evaluation annually.

Monitoring occurs via balanced score card and specific reports such as on critical incidents. The board recognizes that a higher reporting of incidents may be a positive sign of developing a just culture. The board has a risk management policy, which identifies, assesses and manages risk. The current strategic plan includes areas devoted to the safety of patients and staff.

The board members named a number of accomplishments they are proud of, and these include: having a regional view rather than a focus specifically on their home communities; a focus on learning and growth; a balanced budget over several years; the new facilities; the positive culture in the organization; the quality of the services; and, the organization's relationship with the community.

All indications suggest this board functions well, its members are clear of their role, relationship with CEO and senior management and have timely responsiveness to urgent issues.

No Unmet Criteria for this Priority Process.

## Resource Management

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

### *Surveyor Comments*

Organizational financial policies and procedures are guided by provincial policy. All health boards in the province follow the same requirements and hence, have similar systems. Western Health has enjoyed several years of non deficit financial success. There has been a substantial repayment of debt from years when deficits were realized.

Each division of the organization develops work plans to operationalize the direction of the board's approved strategic plan on an annual basis.

Board policies do not deal with operations and usually apply to the whole organization.

Board policy is drafted by staff in consultation with stakeholders including the Department of Health and Community Services. Draft policies come to the board policy and governance committee and then are submitted and approved by the board as a whole, and may be referred back to committee and staff as necessary.

There is a process in place to monitor policies at every board meeting. This process is part of every regular board meeting and is part of the board's commitment to quality improvement.

The organization's values and code of conduct guide board decision making. Board members acknowledge that they may not recognize an issue as specifically an ethics issue (for example staff performance or resource allocation) but see the value in doing so for the future.

No Unmet Criteria for this Priority Process.

## Human Capital

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

### *Surveyor Comments*

Input to the planning process includes an annual environmental scan prepared by staff. Tri annual community consultation includes meetings with community members and groups, where Western Health reports on progress and receives feedback and suggestions. As well, on an annual basis the CEO visits every site to give staff an opportunity to provide feedback and suggestions.

A great deal of work has been completed in having up-to-date position descriptions for all employees. Much of this is being done in partnership with the other regions and the Department as well as the Treasury Board.

The board stated that one of its responsibilities is that of holding senior staff accountable for providing the safest possible care.

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

| Criteria                                                                                                                                                                                          | Location | Priority for Action |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Sustainable Governance</b>                                                                                                                                                                     |          |                     |
| Each member of the governing body signs a statement or charter that defines his or her role and responsibilities, including legal duties, and expectations for the position.                      | 6.7      |                     |
| The governing body oversees the recruitment and selection of the organization’s clinical leaders, e.g. Chief Medical Officer, Chief Nursing Officer, leaders in infection prevention and control. | 9.2      |                     |

**Integrated Quality Management**

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

*Surveyor Comments*

Western Health has laid the foundation for integrated quality management. Many initiatives appear to be at early stages of development and implementation. Much work needs to be done to fully implement these plans across the region. Further development of quality management will require the focus and commitment of the board, senior leadership team, management and physician leaders, as well as engagement of front line care providers. Encouragement is offered to build on the good work already done, while learning from high performance health systems, best practice evidence, and organizations. For example, the organization may wish to explore the Eden philosophy in LTC, in whole or in part, to enhance the quality of life for LTC residents.

The current strategic plan for 2008 to 2011, and the draft plan for 2011 to 2014 both identify patient safety as a strategic priority. A patient safety work plan has been developed and progress is monitored. There is evidence of senior leadership commitment to, and involvement in patient safety initiatives such as safety walk rounds. Particular focus has been placed on improving compliance with Required Organizational Practices (ROPs). Many of the practice changes (for example medication reconciliation) have been very recently introduced and are not fully rolled out or penetrated across the organization.

The board receives an annual balanced scorecard report that includes quality and other performance indicators. The organization is encouraged to further develop the scorecard to ensure that the board monitors a more limited number of performance metrics, appropriate for the governance level, and that these reports are provided more frequently, at least quarterly.

Current leading governance practice is for health boards to establish a quality and safety committee, which Western Health may wish to consider. The work of board quality committees needs to involve a "deeper dive" than boards have traditionally done, especially those such as Western Health, which currently operates under a modified Carver governance model.

These performance metrics need to flow to various operational levels, with increasing degrees of specificity, with metrics relative to the branch, department and unit levels. In many areas, performance measures such as for infection rates are gathered and reported but do not appear to be communicated to staff, or used to inform practice changes to the degree they could. Considerable work is needed to further develop program specific performance measures relative to clinical outcomes. There is very little evidence of benchmarking for comparing infection control rates with international standards.

The disclosure policy is based on the CPSI disclosure guidelines. Staff education on the policy is done and documented. There is an electronic occurrence reporting system. This approach is still unfolding across the organization. While at least fifty education sessions have occurred with staff, it will take time and focus to ensure staff awareness and buy in to this process. The board receives reports on actual occurrences but not on near misses (close calls) even though there is provision for these to also be reported via the on line occurrence reporting system. At this time, the numbers of reported near misses are very small, although the organization expects that this will increase as staff become more familiar and comfortable with occurrence reporting.

The board receives quarterly patient safety reports. Indicators which are monitored include infections, reported occurrences, medication occurrences, falls, 30 Day AMI in-hospital mortality, 30 day stroke in hospital mortality and HSMR.

Good work has been done in introducing medication reconciliation, and a lot more work is needed to fully implement this across the region. Implementation of the plan for spread appears to be considerably behind schedule and will require ongoing effort and engagement of many staff, including region pharmacists and other clinical staff. Awareness and compliance appears to be very variable across the region. Staff across the region that are involved in medication management are aware of quality improvement priorities aimed at reducing medication errors. There is a clear understanding that these initiatives align with the overall strategic direction of patient safety. Nursing staff and pharmacy staff identified recent changes such as the introduction of automated dispensers.

The current strategic plan and draft strategic plan for 2011 to 2014 do not appear to specifically address the need to develop a positive work place culture across the region.

Although Western Health participated in the Patient Safety Culture survey, a low response rate made the data not statistically significant. They are working with the raw data and are encouraged to repeat the survey to achieve a sufficient number of responses to provide useful information to inform strategy.

The strategic plan does not make explicit reference to developing a quality work life for Western Health staff, physicians and volunteers. The organization should re examine, given the importance of staff recruitment, retention and engagement.

In response to a previous Accreditation Canada recommendation, Western Health has developed a framework for contract management. There does not appear to be explicit policies regarding financial thresholds for signing authorities, nor does there appear to be evidence of evaluation of contract performance.

# Accreditation Report

The organization has not yet included Lean as part of its quality improvement methodology. It may wish to learn from health systems that have seen success with this approach. Surveyors observed many instances where Lean could be of help in eliminating waste and optimizing resources, including space. The Lean approach might be useful in designing the new hospital, ensuring a new facility reflects and supports future service delivery.

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

| Criteria                                                                                                                                   | Location | Priority for Action |
|--------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Effective Organization</b>                                                                                                              |          |                     |
| The organization reconciles clients' medications at admission and discharge, transfer, or end of service.                                  | 6.6      | ↑                   |
| Medication reconciliation is implemented in one client service area at transfer, discharge, or end of service.                             | 6.6.2    |                     |
| The organization monitors its client safety culture by using the Patient Safety Culture Instrument.                                        | 6.8      |                     |
| The organization administers the Patient Safety Culture Instrument at least once every three years.                                        | 6.8.1    |                     |
| The organization does not have any unaddressed priority for action flags based on their most recent Patient Safety Culture survey results. | 6.8.2    |                     |
| The organization has a positive worklife culture as a strategic priority.                                                                  | 8.1      |                     |
| <b>Sustainable Governance</b>                                                                                                              |          |                     |
| The governing body oversees the management of contracts and the evaluation of contracted services.                                         | 15.2     | ↑                   |
| The governing body regularly reviews the frequency and severity of near misses and adverse events.                                         | 15.3     | ↑                   |

## Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

### Surveyor Comments

The organization has clearly defined its core values and a related code of conduct. These are reviewed every six years as part of the region's strategic planning process. Recently, staff consultation resulted in modification to the descriptions of values for respect and excellence.

There is an ethics framework, which addresses roles and processes relative to ethics consultation, policy review and capacity building for ethical care and decision making.

Western Health has a research ethics board (REB), which follows Tri-Council guidelines and links to the human investigations committee based in St. John's. Approximately 22 research proposals were reviewed last year. The organization is involved in discussions regarding development of a provincial REB.

An ethics committee is made up of a good cross section of Western Health providers and a lay representative. The committee meets regularly and has been involved in a number of organizational ethics issues such as a smoking policy, fund raising and solicitation, and pandemic planning. Approximately thirty staff education sessions have been conducted regarding ethics process and polices. Orientation for new employees includes discussion of the organization's approach to ethics. Information is also available on the Intranet.

An ethics consultation service is in place, in coordination with Eastern Health, which coordinates access to ethicists based at Memorial University. Discussions are underway regarding a more coordinated provincial approach to ethics. Access to an ethicist and ethics consultation service after hours is limited because of these arrangements.

Discussions with a patient family member and staff involved in a recent ethics consultation indicated a high level of satisfaction with the process.

The organization is encouraged to continue with the good work already underway, including increasing staff awareness of ethics policies and the ethics consultation service. Members of the ethics committee identified a high level of 'moral distress', owing to the many ethics issues that staff confront every day, including end of life issues. Although there is some evidence of an ethical lens being applied to important administrative decisions, this is rarely an explicit part of the decision making process for example, resource allocation.

Organizational values and code of conduct guide board decision making. Board members do not explicitly use an ethics framework or lens to guide decision making. Board members acknowledge that they may not recognize an issue as specifically an ethics issue (for example staff performance or resource allocation) but see the value in doing so for the future. The board could benefit from further education regarding the organization's ethical framework and its role in ensuring ethical decision making in the boardroom, as well as at the bedside. An enhanced ethical framework that includes a decision making algorithm for ethical decisions should be explored.

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

| Criteria                                                                                                                                                               | Location | Priority for Action |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Sustainable Governance</b>                                                                                                                                          |          |                     |
| The governing body promotes access to research and evidence, and the value of evidence-informed decision-making and benchmarking in improving the quality of services. |          | 15.6                |

## Communication

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

### *Surveyor Comments*

Western Health has done a good job in developing its Intranet as an effective means of communicating with staff. Plans are being developed to further develop the Intranet and Internet to make them more user friendly. The Internet was especially effective in communicating with the public during last year's H1N1 pandemic. Staff kiosks are being introduced to assist staff with access to email.

Other communication methods include staff newsletters, town halls, and meetings between senior staff and front line staff across the Region. The CEO visits each of the sites annually for open dialogue with staff regarding the organization's progress on achieving its strategic plan and other issues. There does not appear to be evidence of the board communicating regularly with staff and the organization, as this appears to be delegated to senior staff.

There appears to be a respectful relationship between the board and CEO, with clarity of roles.

The board rarely holds in camera sessions other than for matters related to special circumstances such as CEO evaluation. Leading governance practices now include regular in camera sessions, which the organization's board may wish to consider.

As Western Health further develops its performance monitoring processes, it should examine mechanisms other than the annual report and posting of wait times on the Internet, to increase communication, transparency and accountability to the public.

The organization is planning to enhance its Meditech application to include clinical documentation and other applications. The PACS is widely available, which provides tremendous advantages for patients and care providers, especially those in remote communities. Speech recognition is being implemented in radiology.

The health records department in WMRH is very crowded and many processes are very cumbersome and labour intensive, despite existence of an EHR. The organization may wish to explore use of Lean methodology to redesign these and other information management (IM) processes.

The province has recently funded a change management professional who is introducing standardized change management methodology to assist planning and implementation of IM technology and processes. This will be helpful in supporting practitioners to accept new processes and elimination of old, redundant processes such as printing of laboratory reports that are available on line.

Two staff provide expertise and advice related to privacy, including guidance for new privacy legislation. Work is underway to further develop related policies such as an email policy, which is still in draft form.

A small but very enthusiastic communications team provides guidance on graphics standards and support for effective communications across the region, including crisis communications. Staff consultation has informed the region's communications plan and confirmed the importance of face to face communications between managers and front line staff. Media relations appear to be handled effectively, with an emphasis on responsiveness and transparency, within the limits of privacy legislation and patient confidentiality.

A strengths, weaknesses, opportunities and threats (SWOT) analysis has been done to examine using social networking sites such as Facebook, Twitter, Utube, although these are not currently used by the region.

A partnership exists with the Bay St. George Literacy Council to assist in developing communications at appropriate literacy levels.

Staff have access to research and best practice information via a variety of mechanisms including the health sciences library and its very enthusiastic staff.

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

| Criteria                                                                                                                   | Location | Priority for Action |
|----------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Sustainable Governance</b>                                                                                              |          |                     |
| The governing body holds regular in-camera sessions without the presence of the CEO, senior managers, or clinical leaders. | 9.5      |                     |
| The governing body, with the CEO, communicates with staff and the rest of the organization.                                | 9.6      |                     |

## Physical Environment

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

### *Surveyor Comments*

Recently, the organization won the 'Wayne McLellan Award Of Excellence' for facilities management related to environmental initiatives, awarded by the Canadian Healthcare Engineering Society.

Safety cafes and executive walk rounds are commitments carried out on a regular basis. Education on disclosure, newsletter articles regarding staff roles for safety, promoting a learning environment, staff health and other issues pertinent to staff are provided regularly. Many previous security concerns have been addressed such as the maternity unit at WMRH.

The renovations on patient floors has hugely improved safety for both patients and staff and has reduced hallway congestion, while wheelchairs, lifts, housekeeping carts and so on are not uncommon sights in hallways. In DCLLHC for instance, wheelchairs and EKG for the OR are stored in a narrow hallway at the ambulance entrance, potentially blocking access for stretchers. Storage was raised as an issue in several sites however, in most facilities some space is marginally used. A space and use review process and regular audit system for all facilities would be advisable.

With the planning for the replacement of WMRH, decisions with regard to limiting the scope of renovations is at issue and there is evidence of decisions in this regard being considered using appropriate processes.

The failed flooring at Sir Thomas Roddick Hospital (STRH) should be given priority attention, as it is to the point of being unsafe both from a tripping hazard and an infection control standpoint.

Signage is an issue in some facilities, most notably at WMRH, while for others such as STRH, signage is very good. Two other issues with signage were noted: Although facilities and grounds are smoke free, there are No Smoking signs in designating areas near door ways, which give a confusing message. In many facilities, temporary signage, posters, and notices are abundant, resulting in losing sight of the more important information. Consideration of control procedures/processes in this matter is encouraged.

Facility cleanliness was found to vary. The Calder Heath Centre (CHC) and Rufus Guinchard Health Centre (RGHC) were among those that stood out as being exceptionally clean. A very good understanding of the need and process of terminal cleaning was gleaned from environmental cleaning staff at Sir Thomas Roddick Hospital, while a less satisfactory understanding came from WMRH and RGHC staff, among others. As well, WMRH environmental services staff are perhaps more taxed in keeping up with the demands part of which may be attributed to an aging facility.

No Unmet Criteria for this Priority Process.

### Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

#### Surveyor Comments

Evacuation drills and disaster exercises have lapsed since the H1N1 work. The organization is encouraged to return to a schedule for these exercises in the near future. Having said that it must be noted there have been more than the average share of real emergencies, which have tested the plans and abilities. This was most evident in Stephenville, where floods, aircraft diversions and other compounding situations contributed to a great learning opportunity. Having said this, the code orange policy and procedure, although recently revised, is exceptionally large and complex and would be very difficult to make operational by anyone not intimately involved. Thought might be given to the basic procedure being separated from other parts, appendices, et cetera.

At WMRH, the new fire alarm system has contributed to a high number of false alarms, causing disruption and taxing the Fire Department resources. It has however, greatly improved internal processes and procedures.

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

| Criteria                                                                                                             | Location | Priority for Action |
|----------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Effective Organization</b>                                                                                        |          |                     |
| The organization’s leaders regularly test the organization’s disaster and emergency plans with drills and exercises. | 11.8     | ↑                   |

Emergency Medical Services

The team conducts regular disaster exercises at least once per year. 2.3

**Patient Flow**

Smooth and timely movement of clients and their families through appropriate service and care settings.

*Surveyor Comments*

Overall, there is an effective system for transfer and flow of patients between facilities within Western Health. Patients move smoothly to higher levels of care, based on established referral patterns, and not on a formal system of no refusal policies between facilities. Critical care beds are managed as a single facility resource, although there is discussion of participation in a provincial critical care bed management system.

At individual facilities such as WMRH, there is a significant problem with alternate level of care (ALC) patients. This is tracked regularly and the organization is aware of the issues leading to such a high ALC rate. There is active engagement of community partners and other organizations to increase community capacity to provide care to patients after discharge and supportive living. However, there does not appear to be an equivalent approach to understanding the population that is in hospital and a strategy to keep them out of hospital in the first place.

Within the organization, emergency (ER) wait times are tracked but not benchmarked against expected performance standards. There is a three level “trigger” system, based on bed occupancy. WMRH is often a Trigger 3, which is the highest level, and for prolonged periods. This does not appear to be an effective process for managing periodic surges in ER activity. The trigger levels lead to activities based on monitoring appropriateness of admission and encouraging prompt discharge planning. There is a history of using a formal system to assess appropriateness of admission (MCAP) but this was discontinued on a provincial basis and there has not been any replacement system instituted.

There does not appear to be any strategy to manage periodic surges using over capacity protocols or other flow initiatives. The staff could not describe any planning approaches to understand and eliminate bottlenecks in the system, such as with Lean, other than to increase capacity to discharge into the community. There also does not appear to be a strategy to streamline patient flow between services for typical clinical conditions such as breast cancer. Patient navigator roles are being discussed to assist patients to move along the system more effectively. However, there is no strategy to address waste, duplication and bottlenecks that patients experience in a journey through an episode of care by redesigning the flow between services.

There is very effective management of individual patient flow within the hospitals, but the approach is based on managing critical flow issues rather than a systematic understanding of overall patient flow and a plan for system redesign. Wait times for a number of services including diagnostic imaging and surgery are tracked, and this seems to be a new process. There are no formal goals or benchmarks established for performance accountability. Patients can access retrospective wait time reporting data only, and not current wait time data.

Surgical wait times for priority procedures are reported to be within externally set benchmarks, and cataracts, and joint replacements meet federal commitments. There is a single locally developed surgical wait list managed in the organization but patients are prioritized and booked, based on individual surgeon’s criteria and decisions, rather than by formal triage criteria.

# Accreditation Report

There are specific areas of improvement noted. Based on concerns raised by referring family physicians, the surgical referral process was redesigned and bottlenecks were addressed for each of the surgical disciplines and service. This is reported to have reduced surgical referral wait times. However, there is no data available to support this.

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

| Criteria                                                                                                                                      | Location | Priority for Action |
|-----------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Emergency Department</b>                                                                                                                   |          |                     |
| The team has strategies in place to effectively manage overcrowding and surges in the Emergency Department.                                   | 2.3      | ↑                   |
| The team’s strategies to manage overcrowding include plans to manage clients when in-patient beds are unavailable.                            | 2.4      |                     |
| The team quickly recognizes overcrowding in the Emergency Department and follows protocols to move clients elsewhere within the organization. | 6.3      | ↑                   |
| <b>Surgical Care Services</b>                                                                                                                 |          |                     |
| The team uses a standardized process to prioritize and schedule elective procedures.                                                          | 6.7      |                     |

## Medical Devices and Equipment

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

### Surveyor Comments

The organization follows a collaborative process for input to the purchase of capital equipment, including medical equipment. Staff and physicians report that this is an inclusive process, which allows for priority setting and best decisions for limited capital dollars. The RMAC membership expressed concern that they continue to be included in the review process.

Staff across the organization express appreciation for the timely and skilled work done by the bio medical team. They feel that equipment in the organization is in good repair and that their needs are met. They are well aware of programs intended to update their equipment. Training provided is good when new equipment arrives.

At this time, there is no evidence of a process to evaluate the effectiveness of the organization's preventive maintenance (PM) program.

The procurement process for medical devices is rigorous and involves careful selection, based on criteria with Canadian licensed suppliers.

The emergency medical services (EMS) vehicles and equipment are kept in top condition. Checks are done daily and repairs are carried out as a high priority.

It is not clear whether there is a more extensive cleaning procedure applied to EMS vehicles after carrying a person with a suspected communicable disease. The EMS staff should collaborate with infection control and housekeeping to agree upon a cleaning protocol for this situation.

The various sterile processing departments (SPDs) continually review the needs of the organization and work to make improvements. Good examples of this include their work with OR staff to reduce the need for flash sterilization, with the purchase of more instruments and by standardizing trays. Flash sterilization is monitored closely and occurrence reports are prepared every time it is used in order for the organization to discuss why it was necessary and to look for ways to reduce the need.

The SPD staff at WMRH and infection control staff have worked closely together to audit the quality of services and to ensure national standards are in place. This same rigorous audit needs to be conducted in all locations that are providing SPD services. There are a few inconsistencies in practices between sites, especially at the Dr. Charles L. Legrow Health Centre (DCLLHC) site, which is missing steps in the cleaning process and does not have an appropriate storage device to hang clean endoscopes.

Ongoing in-services are offered to staff. In addition, when new equipment or devices are introduced, there is special training provided - often through company representatives. The competency of staff members is reviewed regularly.

There was no evidence provided that the organization conducts annual competency evaluations of staff who are involved in reprocessing functions. Some regular refreshers and audits would be useful to ensure Regional services are all provided to the same standard. There was no evidence that education, qualification, competencies and training requirements are clearly set out for all staff involved in reprocessing endoscopy devices. It is recommended that these be reviewed and standardized.

It is not clear if all Regional SPDs produce an annual report which is provided to the senior leadership.

Contaminated articles are moving to the SPD in three locations via public elevators and corridors. While this is not an absolute requirement, more organizations are now using hard-covered bins versus soft cloth covers when moving contaminated items through public areas. The organization has an opportunity to purchase inexpensive plastic bins with hard covers for transportation for contaminated materials.

The SPD staff have no process to screen incoming contaminated supplies for sharps. The staff report that there are too many sharps returned from the OR amongst contaminated supplies. The SPD staff may be at increased risk.

At DCLLHC, there seemed to be unmarked access to both the contaminated and clean areas of this department.

# Accreditation Report

At WMRH, a common elevator, which appeared to be quite dirty, is used to transport clean stores up to the ORs. Hand washing stations and alcohol hand sanitizers are difficult to access in the SPD at WMRH and there are none just outside of the contaminated area. At the time of survey, there were no washing stations at the entrance and exits that do not require hand operation in any regional SPD departments.

There is currently no clear dress code in place in the SPD departments of the region. There are notable differences in dress and standards between sites, with some staff in full greens and others in street clothes. The wearing of home clothing that will bring contamination into and out of the department is discouraged.

Cidex being used across the organization is not kept in containers, which would offer protection for staff involved in its use. Specifically, it is being used in various locations without ventilation. When Cidex is used as a disinfectant and the solution is tested daily, there are no logs kept.

The team is encouraged to adopt the attitude that if it is not recorded, it did not happen.

There are no consistent cart washing protocols. Inappropriate or harmful solutions may be in use at DCLLHC. This should be reviewed by an infection prevention and control (IPC) expert.

There was some evidence that at the Sir Thomas Roddick Hospital (STRH) in Stephenville the SPD is not thoroughly cleaned by housekeeping, based on a set schedule and according to clear guidelines. The staff could not report when ventilation systems and upper shelves and walls had last been cleaned. There was also evidence of inappropriate storage on upper shelves in clean areas. These extra stores may increase the risk of dust and moisture in these areas.

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

| Criteria                                                                                                                                                                              | Location | Priority for Action |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Effective Organization</b>                                                                                                                                                         |          |                     |
| The organization’s leaders implement an effective preventive maintenance program for medical devices, equipment, and technology.                                                      | 10.5     | ↑                   |
| The organization’s leaders have a process to evaluate the effectiveness of the organization’s PM program.                                                                             | 10.5.3   |                     |
| <b>Emergency Medical Services</b>                                                                                                                                                     |          |                     |
| The team follows specific procedures for additional cleaning and disinfection of EMS vehicles after transporting patients with a known suspected communicable disease or contaminant. | 11.6     |                     |

| Infection Prevention and Control                                                                                                                                                                                   |      |   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---|
| For each disinfectant, the organization follows manufacturers' recommendations for use, contact time, shelf life, storage, appropriate dilution, and required PPE.                                                 | 12.6 | ↑ |
| The organization has written requirements for education, qualification, and competency of staff involved in the reprocessing of endoscopy devices.                                                                 | 13.1 | ↑ |
| Operating Rooms                                                                                                                                                                                                    |      |   |
| For each disinfectant, the team follows manufacturers' recommendations for use, contact time, shelf life, storage, appropriate dilution, and required PPE.                                                         | 12.4 | ↑ |
| Reprocessing and Sterilization of Reusable Medical Devices                                                                                                                                                         |      |   |
| The organization reviews its operational plan and the information it collects about service volumes and equipment use to decide which reprocessing and sterilization services are offered within the organization. | 1.2  |   |
| The organization conducts baseline and annual competency evaluations of staff members involved in reprocessing and sterilization.                                                                                  | 2.5  |   |
| The organization limits access to the medical device reprocessing department to appropriate team members, and posts clear signage limiting access to all entry points.                                             | 3.2  | ↑ |
| The team works with others in the organization to properly clean the sterilization unit or area.                                                                                                                   | 3.7  | ↑ |
| The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.                                    | 5.2  | ↑ |
| The team follows a detailed dress code while in the clean reprocessing area that addresses clothing, hair, jewelry, artificial fingernails of any form, and covered footwear.                                      | 5.7  | ↑ |
| As part of the quality management system, the team engages in an annual review of reprocessing and sterilization activities, with formal reports provided to the organization's senior management.                 | 12.2 |   |

## Horizontal Integration of Care

### Findings

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

### Population Health and Wellness

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

#### *Surveyor Comments*

Western Health has made a strong commitment to integration and coordination of services for youth and children. In response to Strategic Issue #2 in the current strategic plan, staff have established a pregnancy, birth and early parenting work plan, which includes review and revision of policies to support service integration, enhancement of staff competencies, and enhanced education and support to expectant families within the region who are referred to Community Health Nursing.

Child and youth services cover the period from prenatal care to age 18 years. Community needs are assessed through a variety of mechanisms, including a primary health care needs assessment, regional environmental scan, and school health needs assessment. This information is used to identify populations at highest risk. The region partnered with schools and students to identify their needs e.g. housing, addictions supports, supports for single mothers, individuals with low income and/or education. Multiple partners and social isolation have also been identified as significant risk factors for this population.

Client risk assessment for every child and family considers developmental, disability and social interaction risks, with programming coordinated by regional staff and partner organizations working collaboratively to meet client needs. The region and its partners provide a wide range of child and youth programs, some of which are mandated by the province and some of which are partially funded by Health Canada e.g. Family Resource Centres. Some services such as most pediatric physiotherapy and occupational therapy are provided and funded by Eastern Health.

Community partners expressed a high level of satisfaction in working with Western Health. A social work position in one school is cost shared by the region and the school. There is some degree of uncertainty around this arrangement because funding is year to year. The region may wish to formalize this and other partnerships and should ensure there are more formal processes to evaluate these partnerships.

The region has a standard of providing an in-home visit for every newborn within 24-48 hours of discharge. In January, all newborns will receive hearing testing within 24-48 hours of birth.

Timely access to psychology services is provided through a single point of entry and prioritization of client risk. Crisis intervention and short term interventions are available.

Staff have access to leading practice through a variety of mechanisms, including a librarian from the health sciences library who is valued by other team members as an integral part of the team. This arrangement illustrates their commitment to continuous learning and improvement. Use of evidence based practice guidelines and protocols include diabetes education, prenatal standards and guidelines, immunization standards and the MORE OB program.

The region advocates for healthy public policy and provides public education related to issues such as a smoke free environment, use of car seats and breast feeding. Many staff volunteer on related community agency boards.

Staff use a variety of performance measures including number of people being followed on the diabetes registry, smoking rates, and immunization rates. There has been some program evaluation. The team is encouraged to enhance its work in both of these areas.

Coordination of services is supported through periodic ISSPs. Observation of this process confirmed a team approach centred around the client, with family an integral part of the care team. Staff were observed to have very professional and compassionate interactions with clients. Professional staff are encouraged to consistently ensure they use plain language when communicating with families and to use examples to illustrate complex treatment concepts.

Staff competency is promoted through e-learning and other staff development programs.

Clients who were interviewed indicated a high level of satisfaction with current services although availability and consistency of privately contracted home therapists is an issue beyond the control of Western Health.

There is considerable concern and anxiety related to government's plan to transfer some Western Health child and youth services to a new provincial government department. Staff are anxious to retain the program enhancements they have made and the strong relationships they have established. Work is underway to develop memoranda of agreement which hopefully will enable ongoing coordination and enhancement of services.

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

| Criteria                                                                                                                                                                       | Location | Priority for Action |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Child and Youth Populations</b>                                                                                                                                             |          |                     |
| When developing partnerships with other organizations in the community, the organization has a process to assess the quality of services provided by the partner organization. | 3.2      |                     |

## Direct Service Provision

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

## Findings

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

### *Biomedical Laboratory Services*

#### **Diagnostic Services - Laboratory**

Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

##### *Surveyor Comments*

The laboratory has developed and is in the process of implementing a quality management system, consistent with Accreditation and other best practice standards. It is recognized that significant progress has been made and most importantly, that staff know their roles and responsibilities and requirements specific to their jobs and are enthusiastic about the changes. It is also noted that safety is a high priority and much work has been done to meet staff and patient safety requirements.

The laboratory has a regional LIS system which includes an order entry function. Laboratory and nursing staff have access to specimen collection requirements via the LIS for most routine procedures. At STRH, nurses have created their own specimen collection 'references', which shows the need for the information. Nevertheless, this must be more controlled to ensure the information is current. The sample collection information available to nursing at all sites should be reviewed.

Glucometer use by nursing is monitored by a designated staff member. This is the only point of care (POC) testing being monitored in the organization however, urinalysis dip sticks are in use in the ER at Bonne Bay Health Centre (BBHC) and STRH, as well as occult blood tests in the ER at WMRH. There is a need to become proactive and do a thorough review of what might be occurring elsewhere in the organization which the laboratory is not aware of, as well as develop hospital wide policies and processes around POC testing up front. As technology changes, there are more and more 'attractive' simple POC tests that physicians may want to implement and there may be very valid reasons for the requests. Simple POC tests can often result in significant process improvements on the clinical side and can be successfully managed to ensure quality if processes and proper training are in place.

There is a comprehensive process for dealing with irreplaceable or 'precious' specimens such as tissue specimens including documentation on the report and notification to the requesting physician. There is also an excellent tracking process for surgical specimens with a sign off for every specimen at 'hand over' points.

Results are not released to patients or unauthorized individuals. Some INR patients have been authorized to receive results, and this list is maintained and the patients may call the laboratory directly.

Clients interviewed are quite satisfied overall with turn around time (TAT) and support of the laboratory. It was noted that clients, namely the ER team at WMRH, are not always notified when equipment is down and delays in results are imminent. As these occurrences do occur from time to time, communication of these situations is important so that affected departments can adjust their processes to deal with delays accordingly, and it also helps to reduce frustration.

The request form, which is a paper form and used by external clients is under review and/or revision. The current form does not provide for the provision of pertinent information required by microbiology as it is a 'general' laboratory form. A new separate form for microbiology is under development.

Standard operating procedures (SOPs) are in various stages of review and revision and the organization is working towards a full document control system, which is a lengthy process. In the meantime, staff generally have access to the information they need. In some cases, staff at all sites were aware of the processes but could not find the SOP. The use of 'read and sign' sheets ensures that staff are made aware of changes in a timely manner.

The relocation of the out patient blood collection centre at WMRH has been successful for out patient (OP) clients. A review of the impact on hospital clinic patients, specifically pre anesthesia, and staff on duty who may be requiring blood work due to a needle stick injury, should be reviewed.

A review of the process for blood collections by MLA's should be reviewed. Currently, the MLA is running around all over the hospital to obtain samples, and in between routine patients, and is running up and down stairs to respond to stat requests as well as to get stat samples to the laboratory in a timely manner. Consideration should be given to use well established and successful process review and improvement strategies such as 'Lean' or 'Six Sigma' to improve efficiency and further reduce turn around times.

Opportunities exist to review utilization patterns and some standard orders such as pre operative routine blood work in an effort to reduce unnecessary testing, as well as reduce costs.

At STRH, nursing clients and physicians noted recent significant improvements in laboratory services, with the addition of round the clock staffing and efforts to have blood work available to meet the 1100 hours discharge targets.

At the off site blood collection centre, 'receipt time' in the LISA does not reflect the time received at the main laboratory site. Sample tracking capabilities may be compromised and should be reviewed.

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

| Criteria                                                                                                                                                       | Location | Priority for Action |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The laboratory makes available standardized operating procedures (SOPs) for processing samples and specimens.<br>CSA Reference: Z15189-03, 5.4.2, 5.5.1, 5.5.3 | 4.1      |                     |

|                                                                                                                                                |     |   |
|------------------------------------------------------------------------------------------------------------------------------------------------|-----|---|
| If tests are performed outside the laboratory, the appropriate individual applies the same processes and procedures as used in the laboratory. | 4.7 | ↑ |
| The laboratory verifies the trueness of results using appropriate quality control methods.<br>CSA Reference: Z15189-03, 5.6.3                  | 5.2 |   |
| The organization has defined those situations in which testing and analysis may occur outside the laboratory.                                  | 6.1 | ↑ |
| When monitoring point-of-care testing, the laboratory performs quality control checks on each analysis.                                        | 6.3 | ↑ |
| The laboratory informs individual requesters of analyses of their utilization patterns.                                                        | 8.2 |   |

## ***Blood Bank and Transfusion Services***

### **Blood Services**

Safe processes to handle blood and blood components, from donor selection and blood collection through to providing transfusions.

#### *Surveyor Comments*

Laboratory staff are very keen and eager to learn, and participation in continuing education and professional development activities should be strongly encouraged.

Western Health's inter hospital transfer of blood products is a very good program. However, in the process of transfer of cross matched units in CBS containers, there is not always documentation of receiving time and visual check of product with this type of transfer. A standard operating procedure (SOP) is written for use of the CBS box to include a log record however, it is not followed and needs reinforcing.

The practice of collecting an extra tube for Transfusion Medicine, which is then re labelled by Meditech bar code does occur. This process poses a risk.

WMRH and DCLLHC do not have a consistent format for obtaining consent for transfusion of blood and blood products.

A strength of the Transfusion Medicine laboratory is the position of a transfusion safety officer (TSO), which enables implementation and education. Also, the communication within the provincial level, assisted by the provincial blood coordinating program, helps to develop the necessary tools for easier implementation and standardizing.

The provincial blood coordinating program is working on the development of pamphlets for distribution to clients receiving transfusion on the risk, benefits and alternatives, signs of adverse events and notification of blood product transfusion. The TSO plans to integrate these within Western Health.

Communication within Western Health to sites for the transfusion medicine laboratory is very good.

Autologous donor units are on a separate shelf but the basket is not clearly labelled. At the DCLLHC laboratory, the storage of blood products are not separate from specimens and reagents. The receipt of a reagent shipment log should indicate a visual check of the quality. The discard of specimen policy is not consistent and should ensure that a specimen is retained at least five days post transfusion.

A focus on the transfusion process outside the laboratory such as obtaining consent for transfusion and clerical registration identification of clients are needed. An internal audit program for the transfusion medicine laboratory would help to monitor this, also a more formal laboratory quality management system would improve the document and process control in the region.

A challenge at the WMRH blood bank laboratory is that the staffing is shared between transfusion laboratory and core laboratory schedules and the expertise for problem solving may not be available, given the age categories, and new technologist need to learn the problem solving techniques of transfusion medicine. The projected retirements of laboratory staff could pose a loss of discipline expertise in the laboratory and planning should be considered.

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

| Criteria                                                                                                                                                                     | Location | Priority for Action |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The team keeps blood and blood components separate from donor and recipient samples, tissues for transplantation, or blood centre reagents.<br>CSA Reference: Z902-04, 9.4.3 | 11.6     | ↑                   |
| Each shipment of whole blood or blood component is accompanied by a standardized, comprehensive release voucher.<br>CSA Reference: Z902-04, 9.5.2.6                          | 15.4     |                     |
| The organization has a standard operating procedure (SOP) for the release of blood and blood components for use.<br>CSA Reference: Z902-04, 9.1                              | 16.1     | ↑                   |
| The organization follows a standard operating procedure (SOP) to obtain the recipient's informed consent prior to transfusion.<br>CSA Reference: Z902-04, 11.2.1             | 18.1     | ↑                   |

|                                                                                                                                                                                                                                                                                    |      |   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---|
| The organization provides the recipient with information that includes a description of the whole blood or blood component, the risks and benefits associated with transfusion, and any alternatives including their risks and benefits.<br>CSA Reference: Z902-04, 11.2.1, 11.2.2 | 18.2 | ↑ |
| The organization provides its staff with the most recent information about the risks associated with transfusion.<br>CSA Reference: Z902-04, 11.2.3                                                                                                                                | 18.3 | ↑ |
| The team provides all recipients with written information about the blood or blood product they receive.<br>CSA Reference: Z902-04, 11.2.2                                                                                                                                         | 18.4 | ↑ |

## Community Health Services

### Clinical Leadership

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

#### Surveyor Comments

There is abundant evidence that the Western Health's strategic plan and resource allocations encourage and support an upstream approach to community based care in a collaborative and integrated model. Almost without exception staff described their roles in relation to an interdisciplinary and inter agency team. There is a focus on early intervention, diagnosis, and access to services that promote optimal independence and healthy living by providing the most appropriate intervention in the right place at the right time.

Community health is grouped with community support services, mental health, addictions, child and youth services, primary health care, and health promotion under the umbrella of population health. Some programs are co located in Corner brook and Deer Lake, with certain team members located in smaller rural communities outside of these two centres. There is some deliberate co location of professionals to further the objectives of integrated primary care. Planning is underway to be more deliberate in this effort as the primary health care model is further developed and defined.

In Corner brook, there are good examples of collaboration with the historically high risk and hard to serve low income housing development area(s). Community Health has collaborated closely with the Board of a neighbourhood community centre, the public housing authority, a local tenants' association and others to design and deliver programming that promotes healthy living and encourages new parents, children, and youth to identify initiatives that will lead to a brighter future. The community health staff have created resources and delivered programs that reach out to youth on issues that they have identified the need to know more about. Healthy sexuality, HIV/AIDS prevention, anti bullying, good nutrition, and parenting skills are just a few of the examples mentioned. Staff acknowledge that the key to the success of these programs is community partnership, being accessible, and ensuring that the program priorities are identified by clients that recognize their "need to know". There are some logistics to be worked out, but plans are underway to establish a primary care clinic in the neighbourhood, initially staffed by two community health nursing positions.

Traditional modes of public health teaching and promotion are currently used, although the topics are contemporary and a lot of effort is put into developing materials based on best practice and consistent with what potential participants have identified as topics of interest. There is recognition that social marketing methodologies are changing all the time, with the advent of new technologies, and there is some early discussion about how Western Health can get on board with the way that young people communicate today. Using a hockey analogy, one staff person noted that: "if you want to play, you have to skate where the puck is going".

It is very notable that Western Health staff consistently reported that there has been great benefit to the amalgamation of services across the continuum and to alignment with provincial priorities. The "Go Healthy" initiative of the Ministry of Health and Community Services was cited as a good example of how provincial, regional, and local alignment can get all levels of government working to promote activity in line with the determinants of health and based on what available data say about the health status of the population.

Western Health has noted its concern about a new Ministry of Child, Youth and Family Services. The new ministry will devolve responsibility for programs that have been under the organization's umbrella for the past five years. The approach has been to prepare for the new organizational structure by reviewing practices that have worked well and looking at protocols that can potentially survive the reorganization and to identify, if there is a benefit to the care of clients who access services from multiple points of care in the health and social services continuum.

Client interviews were conducted in home care and with clients receiving early child care services via community health. There was a high level of satisfaction expressed by all of the clients interviewed. Most notable was the common expression of how much clients appreciated being able to get in touch with a primary contact person and without any hassle, gain access to a full range of services within a very short time. From the clients' perspective, there exists a single point of entry and a system that is well enough coordinated to respond with the most appropriate mode of service delivery. This perception extended to clients that are receiving services such as pre and post natal support in community based settings not operated by Western Health. To the client, services are seen to be seamless.

No Unmet Criteria for this Priority Process.

## Competency

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

### *Surveyor Comments*

In community health, multidisciplinary teams identify specific roles for each of the disciplines, which in turn, strengthen the team. It is noteworthy that para professional and professional staff work closely together and identify the added value that each one brings to clients with varying degrees of complexity in their care plans.

Staff have specific job descriptions and related qualifications identified. Professional development needs are identified specific to the orientation and performance planning objectives of individual staff. In most cases, individual staff stated that there are abundant opportunities for self learning modules, or participation in region sponsored educational events, but perhaps not enough time because of work load demands.

Staff are very much involved in the development of work plans in their program areas that are designed to support the strategic directions. The system of making operational, the strategic directions into divisional and unit specific work plans is complex and said to be quite time consuming. However, staff and middle management agree that participation is worthwhile from the perspective of planning, measuring progress, and identifying resource needs. There is some talk of re working the planning process to more deliberately support primary health care reform, or to cluster activity around the needs and objectives of primary health care teams that are strategically located across the communities and region.

Many staff commented that they see the value in planning for the variable needs of the clients and communities served so that clients can remain independent and receive services as close to home as possible. Nevertheless, there was a kind of consensus that there is "no one size fits all" when it comes to the development of a primary health care model. Some staff expressed concern that whatever structure is developed, it must take into account that some components may have adequate resources to be housed across the region, while others are only available on a consultative basis, and may be stretched to meet expectations.

There is evidence that Western Health has a robust human resource (HR) support system. There is an in house employee assistance program (EAP) that staff can access.

Senior team members do facilitate ongoing discussions with staff to adjust resource allocation, based on demand. Decisions are supported by data collected in client surveys and focus groups, or from information collected by programs or the province. Staff are regularly involved in work plan development and review so that priorities can be adjusted, based on shifting priorities and risks. It was noted that the H1N1 response resulted in an organization that is a lot more prepared to shift gears and adjust priorities on short notice.

No Unmet Criteria for this Priority Process.

## Episode of Care

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

### *Surveyor Comments*

Community health operates on a model that delivers services where these will be most accessible to clients. There is well established access to home based assessment and care from a variety of disciplines including nursing, social work, occupational therapy, behaviour management, and others.

The very high immunization rates in the 90 plus percentile are indicative of an organization that meets its clients where access is made easy. Increasing uptake on the HPV vaccination program over the initial three years, in the face of initial opposition from some client groups, provides another illustration of a service delivery model that is responsive to its community.

In the community health nursing program, nurses have assigned responsibilities to schools in the areas they cover. Staff are encouraged to develop tailor made programs, based on what their clients are telling them about their needs for information and supporting health status information.

On line charting is used (CRMS) and this is an evolving system that was not originally designed for multidisciplinary charting, or integrated care planning. Western Health has the opportunity to give input to the development of this custom made provincial system. Paper charts are maintained for back up and ease of care plan monitoring and maintenance by individual disciplines. There is work to be done, particularly around educating people to use common definitions when entering data so that management reports that are eventually produced are reliable.

The predominant feedback from clients is that a primary care provider is identified and referrals for allied service are via a single point of entry and are effective. Care needs are met in a respectful and effective way.

No Unmet Criteria for this Priority Process.

## Decision Support

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

### *Surveyor Comments*

Staff feedback indicates that people have ample opportunity to participate in mandatory education and professional development experiences that encourage best practice in their fields.

Staff articulate an awareness of the organization's strategic planning process, environmental scan, and how priorities of individual service areas need to be aligned with organizational priorities.

Providers use standardized assessment tools to assess potential risks and longer term intervention needs.

No Unmet Criteria for this Priority Process.

## Impact on Outcomes

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

### *Surveyor Comments*

Staff were able to identify measures that the organization supports to ensure a safe work environment, including use of cell phones, documentation of staff whereabouts when on home visits, training in non violent crisis intervention, and other things. Staff feel confident that when servicing outlying communities, there is flexibility in their travel schedules to accommodate for hazardous driving conditions.

Western Health's new school health policy was highlighted as a deliberate effort to coordinate the organization's activities in schools. There are essential services that are standard in all schools, and then "priorities for action" are developed as part of Western Health's strategic directions depending on the availability of resources. Community services staff describe these priorities for action as exciting opportunities to connect with youth and to find creative ways to do health promotion and prevention.

# Accreditation Report

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

| Criteria                                                                                                                                                                                | Location | Priority for Action |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service. | 11.2     | ↑                   |

## Critical Care

### Clinical Leadership

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

#### Surveyor Comments

The intensive care unit (ICU) at WMRH provides critical care beds for the region, with limited ICU and CCU beds operating at other sites. While there is not a strong regional oversight for ICU operations, all ICU locations have strong administrative and clinical leadership, appropriate policies and procedures, dedicated and competent staff and clinicians, and well resourced beds.

The various ICU teams use relatively informal approaches for collecting information and planning for services. Adjustments to the number of beds and the services provided in the unit are done as demands change. Planning for the flu pandemic is an example of this team's expertise at planning for a possible surge in demand for critically ill patients.

The various ICU teams are knowledgeable about the capital procurement program and they feel that the organization supports them in the acquisition of new technology. New equipment was needed to support the recent introduction of the ventilator associated pneumonia (VAP) protocols and the organization moved on this quickly. The team reports that good equipment life cycle management is in place.

Although there are ICU beds at a number of locations in the region, there is no evidence that there is any significant collaboration amongst these teams. It appears that they are functioning as single entities rather than as a group. There may be missed opportunities, especially in advocating to the region for resources.

No Unmet Criteria for this Priority Process.

### Competency

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

#### Surveyor Comments

Team members are active in mentoring students. Nursing staff participate in the nursing school program. Retired nurses are hired back as part time staff whenever possible.

The ICU team members at WMRH are multidisciplinary and work closely together. They have significant support from respiratory therapists, social work services and other disciplines. The notable exception is clinical pharmacy, which was noted by a number of the ICU staff locations as needed and noticeably absent.

Team members regularly participate in code drills and provide code teams for other areas of the hospital. Although the admissions criteria restrict the admission of pediatric patients admitted, the team maintains currency in pediatric advanced life support (PALS). Team members in both ICU and ER cross train in order to maintain capacity in both areas, as part of contingency planning.

There is a comprehensive orientation program for the ICU. Infusion pump training has been done with all nursing staff and is being refreshed with recent upgrades to the pumps.

No Unmet Criteria for this Priority Process.

**Episode of Care**

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

*Surveyor Comments*

The region's ICUs have clear admission and discharge criteria, as well as clear roles and responsibilities for staff in the ICU area. The team uses a sequential organ failure assessment (SOFA) score to initially assess the overall patient status and this is updated as the patient's condition changes.

Where the team cannot offer ICU services, for instance for pediatric patients, they coordinate with other facilities in cities such as St.John's and Halifax to transfer the patient.

The ICU patients and families report that they are given good, clear information and choices are offered and their decisions respected. There is evidence that properly received and signed consents are in place for ICU patients.

The team is inconsistently completing advance directives. Where they are in place, there is no standard way to place them for easy view by staff.

Medication reconciliation is not in place for ICU patients at this time. There is no medication reconciliation at transfer or discharge at this time.

There is no longer an organ procurement person on staff in the region. It was not clear to the ICU team if a policy was still in place or up to date. There is a strong sense that without a dedicated person who is well versed in organ donation protocols, that many opportunities for organ harvesting are missed.

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

| Criteria                                                                                                                      | Location | Priority for Action |
|-------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| During the assessment, the team determines whether the client has an advance directive and records this in the client record. | 7.3      |                     |

|                                                                                                                                                                                                                                                                                                  |        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| The team reconciles the client’s medications upon admission to the organization, with the involvement of the client, family or caregiver.                                                                                                                                                        | 7.6    |
| There is a demonstrated, formal process to reconcile client medications upon admission.                                                                                                                                                                                                          | 7.6.1  |
| The team generates a Best Possible Medication History (BPMH) for the client upon admission.                                                                                                                                                                                                      | 7.6.2  |
| Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).                                                                                | 7.6.3  |
| The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.                                                                                                                              | 7.6.4  |
| The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.                                                                                            | 7.6.5  |
| Medication Reconciliation at Admission                                                                                                                                                                                                                                                           | 7.7    |
| The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation at admission.                                                                                                                                                          | 7.7.1  |
| The team meets Accreditation Canada’s recommended target for medication reconciliation at admission.                                                                                                                                                                                             | 7.7.2  |
| The team follows a protocol that meets legal requirements when approaching clients and families about organ donation.                                                                                                                                                                            | 9.9    |
| The team uses standardized clinical measures to evaluate the client’s pain on a continuous basis.                                                                                                                                                                                                | 10.5   |
| The team reconciles medications with the client at referral or transfer, and communicates information about the client’s medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. | 12.5   |
| There is a demonstrated, formal process to reconcile client medications at referral or transfer.                                                                                                                                                                                                 | 12.5.1 |
| The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.                                                                                                                                                                | 12.5.2 |
| The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.                                                                                                                         | 12.5.3 |

|                                                                                                                                                                                                                                          |        |   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---|
| The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.                                | 12.5.4 |   |
| The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.                                                                 | 12.5.5 |   |
| The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.                                                 | 12.5.6 |   |
| The team transfers information effectively among service providers at transition points.                                                                                                                                                 | 12.6   | ↑ |
| The team uses mechanisms for timely transfer of information at transition points (e.g. transfer forms, checklists) that result in proper information transfer.                                                                           | 12.6.1 |   |
| Staff is aware of the organizational mechanisms used to transfer information.                                                                                                                                                            | 12.6.2 |   |
| There is documented evidence that timely transfer of information occurs.                                                                                                                                                                 | 12.6.3 |   |
| Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning. | 12.7   | ↑ |

**Decision Support**

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

*Surveyor Comments*

The team at WMRH develops goals based on Safer HealthCare Now recommendations, which align well with the organization's strategic goals. The team has recently introduced the bundle to reduce ventilator acquired pneumonia (VAP) and is in the process of introducing the bundle for central lines. These examples demonstrate the team's focus on patient safety and ensuring it is providing care in accordance with best practice information.

It was not clear if other sites are also pursuing these same goals.

No Unmet Criteria for this Priority Process.

**Impact on Outcomes**

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

*Surveyor Comments*

Team members receive appropriate training and support to reduce risk to them in the delivery of care. There are regular occupational health and safety (OHS) reviews of the work area. All team members have WHMIS training, as appropriate.

# Accreditation Report

The team has considerable training in reducing patient risks. These include training on monitoring patients for adverse events related to medications, ventilators and other interventions.

There is an opportunity for the teams at all locations to seek input from patients and families about ways that the services can be improved.

While there are limited measurements in place in ICU, the team has an opportunity to move more towards outcome measurements based on national guidelines.

There is evidence that the teams at various ICU locations do not report near misses. They also state that there is little feedback on occurrences that are reported. The physicians do not feel connected to this process.

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

| Criteria                                                                                                                                                                                | Location | Priority for Action |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The team shares benchmark and best practice information with its partners and other organizations.                                                                                      | 15.4     |                     |
| Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service. | 16.2     | ↑                   |
| The team implements verification processes and other checking systems for high-risk activities.                                                                                         | 16.6     | ↑                   |
| The team evaluates the verification processes and uses information to make improvements.                                                                                                | 16.6.3   |                     |
| The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.                                                                   | 16.7     | ↑                   |
| The team monitors clients' perspectives on the quality of its critical care services.                                                                                                   | 17.2     |                     |
| The team shares evaluation results with staff, clients, and families.                                                                                                                   | 17.5     |                     |

## Diagnostic Imaging Services

### Impact on Outcomes

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

*Surveyor Comments*

Services have an impressive array of up to date equipment and processes of care.

No Unmet Criteria for this Priority Process.

**Diagnostic Services - Diagnostic Imaging**

Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

*Surveyor Comments*

All policies and procedures are being updated and posted on the intranet. Staff are readily able to produce and use procedure manuals.

The quality assurance (QA) program for diagnostic imaging (DI) is region wide. This program is working in a systematic way to do both QA and quality improvement. Some of the components are well underway and others are in varying stages of development, implementation and use.

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

| Criteria                                                                                                             | Location | Priority for Action |
|----------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The team regularly surveys referring medical professionals about their needs related to diagnostic imaging services. | 1.2      |                     |

***Emergency Department***

**Clinical Leadership**

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

*Surveyor Comments*

There has been a recent focus on equipment replacement. At WMRH, there is an addition of an USS, following a patient outcome review and a request by the medical leadership.

The ER space at WMRH has been recently renovated and enlarged. The telemetry and resuscitation patients are now in direct view of the nurse at the nursing station. There is a negative pressure room and a safe room.

# Accreditation Report

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

| Criteria                                                                                                                                                                             | Location | Priority for Action |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The team’s goals and objectives are linked to benchmarking of bed availability in the Emergency Department, time to admission, client diversion to other facilities, and wait times. | 2.2      |                     |

### Competency

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

*Surveyor Comments*

There is a recent addition of a nurse practitioner at WMRH ER that focuses on assessment, treatment and disposition of Canadian triage acuity scale (CTAS 4 and 5) patients. The role description is in place and the scope of practice of the primary health nurse practitioner is sufficient to meet the needs of the population served.

There is a 10 week orientation plan for new RNs on staff at WMRH. A regional educator is accountable for the broad education of advanced cardiac life support (ACLS) and locally, the PCC manages the education needs.

There is a substantive orientation program at both WMRH and Calder Health Centre (CHC) to ensure knowledge, skill and judgement meets standards prior to working on the unit. At CHC experienced nurses voluntarily back up a new 'orientee' that may be working for the first night as the sole RN on duty.

The team is very serious about review and follow up of any work place violence issue and takes the necessary action.

All staff receive a performance review every two years and at the end of the probationary period.

At WMRH, the ER may call in additional staff as required when census or acuity peaks. At CHC, bringing in an extra nurse is usually very difficult because of the small number of nurses on staff.

No Unmet Criteria for this Priority Process.

### Episode of Care

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

*Surveyor Comments*

At WMRH, input from other providers comes in the form of hand overs for EMS, transfer forms completed by sending centre, and communication directly with family physicians.

There is 24 hour on site access to diagnostic imaging at WMRH, which involves X ray. A radiologist is on call and can be accessed to visualise PACS images at home, or in another work place.

The standardised process for inter facility transfer is a physician to physician discussion, with assistance from the tertiary centre for air ambulance if required.

At Calder Health Centre (CHC), there is a call button for patients to push after hours, which is directly opposite the nursing station. There is closed circuit television so the person can be identified before being allowed in. Most patients call before coming to the ER.

At CHC, off load is not an issue.

At CHC, the formal process for medication reconciliation is rolled out to all patient areas namely, ambulatory, pre admit, ER, in patient and LTC. At WMRH, ER medication reconciliation has not been rolled out.

Several clients and families that had previously experienced a transfer of care to another facility expressed satisfaction with the process. The staff and physician explained the whole process from start to finish and the receiving facility is well prepared for accepting the patient on arrival.

There is nurse to nurse transfer of information from ER to the floor care area.

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

| Criteria                                                                                                                                                                                                          | Location | Priority for Action |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The team measures ambulance offload response times, and sets and achieves target times for clients brought to the Emergency Department by EMS.                                                                    | 6.7      |                     |
| The team monitors ambulance offload response times and uses this information to improve its services.                                                                                                             | 6.8      |                     |
| The team sets, tracks, and benchmarks data related to waiting times for services and information, and the length of stay (LOS) in the Emergency Department.                                                       | 6.11     |                     |
| The team reconciles medications for clients with a decision to admit, with the involvement of the client, family or caregiver.                                                                                    | 8.3      |                     |
| There is a demonstrated, formal process to reconcile client medications for clients with a decision to admit.                                                                                                     | 8.3.1    |                     |
| Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive). | 8.3.3    |                     |
| The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.                                               | 8.3.4    |                     |

|                                                                                                                                                                                                                                                                                                 |        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.                                                                                           | 8.3.5  |
| Medication reconciliation for clients with a decision to admit.                                                                                                                                                                                                                                 | 8.4    |
| The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation.                                                                                                                                                                      | 8.4.1  |
| The team does not have any unaddressed priority for action flags based on their medication reconciliation indicator results.                                                                                                                                                                    | 8.4.2  |
| The team reconciles medications with the client at referral or transfer and communicates information about the client’s medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. | 11.5   |
| There is a demonstrated, formal process to reconcile client medications at referral or transfer.                                                                                                                                                                                                | 11.5.1 |
| The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.                                                                                                                                                               | 11.5.2 |
| The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.                                                                                                                        | 11.5.3 |
| The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.                                                                                              | 11.5.4 |
| The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.                                                                                                                        | 11.5.5 |

**Decision Support**

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

*Surveyor Comments*

At WMRH, there are ER issues surrounding privacy and confidentiality, which have been resolved with the renovation and reorganization of the clinical space and also in the triage process.

At WMRH ER, although there is not a standardized process for selecting evidence based guidelines, any guidelines in place are regularly reviewed and updated.

The staff and physicians make frequent use of the hospital's well developed web site to access information. As well, staff can keep connected to the manager or PCC via Meditech MOX. Diagnostic images are available remotely via PACs.

The process for selecting guidelines is not formal. There is use of literature searches, and professional associations.

No Unmet Criteria for this Priority Process.

**Impact on Outcomes**

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

*Surveyor Comments*

The ER in WMRH has a safe room to use with mental health patients where least restraint has proven ineffective. There is a code white button in triage and at the nursing station. The staff and physicians do not wear code white buttons but call in the code through locating. There is a code white response team.

There has not been a critical incident noted but the team is well aware of the organization's policy and procedure in the event of a critical incident.

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

| Criteria                                                                                             | Location | Priority for Action |
|------------------------------------------------------------------------------------------------------|----------|---------------------|
| The team shares benchmark and best practice information with its partners and other organizations.   | 14.5     |                     |
| The team identifies and monitors process and outcome measures for its Emergency Department services. | 16.1     | ↑                   |
| The team compares its results with other similar interventions, programs, or organizations.          | 16.3     | ↑                   |

**Emergency Medical Services**

**Clinical Leadership**

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

*Surveyor Comments*

Education regarding injury prevention and health promotion is delivered by the Western Injury Prevention Coalition of which Western Health EMS is a member.

No Unmet Criteria for this Priority Process.

**Competency**

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

## *Surveyor Comments*

All paramedics in the region are primary care paramedics and so are required to have certification in basic cardiac life support (BCLS), pediatric advanced life support (PALS), and neonatal resuscitation (NRP).

Paramedics stationed at Corner Brook participate in the care of patients when not out on a call. For example, they may assist in the resuscitation room with intubation, assist with reduction of a fracture and application of a cast. The ER physicians and nurses appreciate the additional resources when they are available.

The paramedics have access to all resources available to any other employee of Western Health. No Unmet Criteria for this Priority Process.

## **Episode of Care**

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

## *Surveyor Comments*

Although there is 24/7 call answering for emergency calls, at times they are answered by a clerk in ER. The standardised tool for taking call information is not always adequate. The paramedics do not always receive the information they need to safely care for a patient. At times, there is no probing for additional information owing to the fact that the ER clerk has other demanding concurrent tasks.

There are a couple of dispatchers/unit clerks that speak French, but generally language is not an issue, as almost all patients speak English.

The dispatch centre can track the actual location of a given vehicle.

The dispatch call receiver conducts an influenza like illness screening tool and communicates any concerns to the team responding to the call.

The team benchmarks from the time of call received to wheels rolling, which is referred to as: "chute times" and it is two minutes. The actual chute time is one minute.

In the event that there is time to obtain informed consent, the paramedic will consult with the patient and/or the family member and explain the situation and rationale for intervention. If the advance directive is readily available and is related to the reason of the ambulance call out, the paramedic will inform the medical oversight physician. There is implied consent where the patient or family has accepted care by the paramedic in an emergency. In the meantime, basic assessments and interventions are begun until the paramedic is confident that the advance directive is in effect in that particular situation.

If a team is called out to a patient and the patient refuses treatment or refuses transfer to hospital, the paramedic follows procedure to consult with the medical oversight physician to ensure it is safe to follow the patient's request.

Where possible, the crew calls ahead to the hospital with expected time of arrival (ETA) and condition of patient.

The EMS ambulances have two providers: one is a paramedic and one is the emergency medical responder (EMR). The EMR is not trained in medication administration so cannot provide the independent double check. In lieu of the independent double check, the paramedic alone checks drug dose, concentration and rate at least twice before administering. If unsure at all, the paramedic accesses the medical overseer on duty.

No Unmet Criteria for this Priority Process.

## Decision Support

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

### *Surveyor Comments*

The members of the team have a book that references all protocols and guidelines that many keep in their pocket when in the field.

The team explains particular procedures and what a client can expect. For example, in a run to the airport with a cardiac patient being transferred to St. John's for angio catheterization, the paramedic had a conversation with the patient on what to expect when they reach the helicopter and what to expect on arrival.

No Unmet Criteria for this Priority Process.

## Impact on Outcomes

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

### *Surveyor Comments*

Paramedics must write an exam and participate in a set number of continuing medical education (CME) orders to continue to be licensed by the province.

The team enters any incidents into the occurrence software.

The organization does an environmental scan for the entire region.

There is some reluctance by paramedics to identify systems issues that may effect colleagues who are also friends.

The team compares its performance to national standards. There is not a level of understanding among the front line staff interviewed regarding the alignment of emergency medical services with the overall corporate strategic plan.

No Unmet Criteria for this Priority Process.

## Infection Prevention and Control

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

## *Surveyor Comments*

All sharps are kept in a sharps container on board the ambulance and then disposed of at the hospital in appropriate sharps containers.

Dirty linen is separated from clean linen and handed off at the hospital according to hospital policies.

Hand hygiene practices are not evident other than for wearing rubber gloves.

No Unmet Criteria for this Priority Process.

## ***Infection Prevention and Control***

### **Infection Prevention and Control**

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

#### *Surveyor Comments*

The organization's response to the 2009 H1N1 pandemic was commendable. There appeared to be excellent communications across the region. Staff were well versed on the outbreak plan and their individual responsibilities. Work done by rural staff to ensure maximum immunization rates were noteworthy. Great job!

There is evidence that the organization is aware of current issues in infection control. The infection prevention and control (IPAC) team's ongoing work to reduce the rate of catheter caused UTIs is an excellent example of the team's efforts to make improvements to patient outcomes, based on national best practice.

The influenza vaccination rate amongst staff is commendable and evidence of the importance this organization places on staff and client safety.

There was no evidence provided by the team that it is currently assessing the IPAC program. There was no evidence that the organization evaluates its partnerships in infection prevention and control. There was no evidence that infection prevention information provided to clients was documented.

There was no evidence that cleaning of the various clinical or administrative areas is monitored. In fact, there were many housekeeping staff in WMRH that were not clear about where protocols were kept and what exactly was required for different potentially hazardous scenarios.

To date, the hand hygiene campaign has been a partial success. It is acknowledged that new IPAC staff have made a considerable effort on this front. While most staff and patients report that they are well aware of the importance of hand hygiene, many staff and most notably, physicians and students continue to fail to comply. The hand hygiene products are available but frequently, they do not seem to be placed in the most obvious places for patient care personnel and their pump actions are difficult to use. For example, sinks in patient rooms in STRH are placed as far from the door as possible, while the waste bin or used towels is on the opposite side of the room. No one appeared to be using either.

Use of automatic dispensers placed closer to the bedside should be considered by the organization. In addition, the IPAC team and physician community must work together to determine how physician compliance with hand hygiene can be improved and to support changes suggested by this group. In the SPDs, there are few easy to use sink areas and none is foot/ elbow operated. However, the hardworking IPAC team are commended for the improvement in hand hygiene rates and is encourage to continue to monitor and work on this issue.

Regular audits have been completed in key IPAC areas such as the SPD at WMRH. It is recommended that audits of all SPD areas in the region be completed. The region may benefit from using an external SPD expert to conduct these reviews, as this is a very specialized area.

At DCLLHC, endoscopes are not stored in a hanging closet. Other areas have very good storage devices that should also be provided to this site. In addition, the strips coming off the STERIS machine are not annotated with the name of the patient.

Although the organization's rates are reported to Accreditation Canada and appear on the portal, they are all flagged RED, even though the infection rates of the organization, as reported to the survey team appear acceptable. The IPAC team and QM should work with Accreditation Canada to change these priority for action flags to GREEN.

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

| Criteria                                                                                                                                                                                       | Location | Priority for Action |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The organization collects information about its infection prevention and control activities and uses it to plan, implement, and evaluate those activities.                                     | 1.7      |                     |
| The organization regularly evaluates its partnerships and develops new partnerships based on gaps, community needs, and emerging trends.                                                       | 2.3      |                     |
| The organization shares IPAC research and best practice information with staff and service providers involved directly in client service, senior management, partners, and peer organizations. | 3.2      |                     |
| Staff, service providers, and volunteers attend the IPAC education program at orientation and regularly thereafter.                                                                            | 5.4      | ↑                   |
| Information provided to clients and families is documented in the client record.                                                                                                               | 7.3      |                     |
| The organization properly cleans and disinfects client and staff areas.                                                                                                                        | 10.2     | ↑                   |

# Accreditation Report

|                                                                                                                                                                                                                                                                                                                                                                                       |       |   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|---|
| The organization regularly monitors the quality of its cleaning and disinfection of the physical environment, and uses the information to make changes to policies and procedures.                                                                                                                                                                                                    | 10.6  |   |
| The organization uses safety engineered devices for sharps and other high-risk materials.                                                                                                                                                                                                                                                                                             | 11.6  | ↑ |
| The organization verifies the qualifications and competencies of staff involved in reprocessing reusable medical devices.                                                                                                                                                                                                                                                             | 12.1  |   |
| The organization reviews and verifies the education, qualification, and competency of staff involved in reprocessing of endoscopy devices.                                                                                                                                                                                                                                            | 13.2  | ↑ |
| Following disinfection or reprocessing, a qualified staff member flushes all channels with 70% isopropyl alcohol followed by forced medical grade air to facilitate drying.                                                                                                                                                                                                           | 13.9  |   |
| The organization stores endoscopy devices in a manner that minimizes contamination or damage.                                                                                                                                                                                                                                                                                         | 13.11 | ↑ |
| The record of endoscopy device reprocessing includes the identification number and type of endoscope, the identification of the automated endoscope reprocessor (AED) if applicable, date and time of the clinical procedure, the name or unique identifier of the client, results of the individual inspection and leak test, and the name of the person reprocessing the endoscope. | 13.13 |   |

## Laboratory and Blood Services

### Diagnostic Services - Laboratory

Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

#### Surveyor Comments

The laboratory staff and pathologists are commended for the great deal of work and progress made in recent months. Staff are friendly dedicated professionals and proud of their work, with a desire to achieve high standards. There is still much work to be done now and on an ongoing basis as the 'quality bar' keeps rising.

Volumes and workload indicators are being collected and monitored in the laboratory and some are used for budget purposes, but no formal reporting of performance indicators to senior leaders is evident. Some performance indicators are under development. A client satisfaction survey undertaken by the region included a section on laboratory services. A separate laboratory client satisfaction survey is planned. The survey should include patients, physicians and other clinical departments. It is noted that the WMRH did respond to public input and made a permanent change to the blood collection centre.

Contracts for referred out services such as couriers are managed via purchasing, and the laboratory controls the contracts for referral laboratories. The laboratory does require accreditation status, licensing information and so on from its referral laboratories.

Although there are external quality assurance (QA) programs in place, no inter laboratory comparisons are currently performed and if done, these will enhance the QA programs.

Clients have indicated overall satisfaction with turn around times, availability of staff and pathologists for consultation and laboratory services in general. Clients interviewed identified a significant improvement in turn around times since the implementation of new chemistry equipment with front end automation.

Currently, staff do not regularly participate in continuing education (CE) and budget for this is minimal. Upcoming changes to regulate MLT's and MLA's will dictate CE requirements and will require maintenance of professional portfolios. Web based CE programs that provide for a wide variety of on line courses specifically for laboratory staff are available at reasonable costs including group rates. These group rates would provide equal access for all staff to educational programs and where some topics can be 'assigned' and used to evaluate competencies, as well a wide variety of courses that anyone can voluntarily take which provide CE credits.

Western Health has supported educational opportunities for staff to develop in areas of need, for example the pathology assistant, which is commendable. There is a laboratory technologist dedicated to work with IT to support the LIS. Succession planning for continued support for this position is encouraged as it is a vital component in a computer based environment.

Competency evaluations have begun but the process is in the early stages and not across sites.

Incidents are reported however, staff are encouraged to report near misses in order to identify problems before they occur.

Safety is a high priority and the program is well developed and implemented. Regular audits and an annual program review will help ensure the program is maintained. The histology laboratory has been adversely affected on more than one occasion where a toilet above the laboratory has overflowed. The risks associated with such incidents are significant and a more permanent solution needs to be found and implemented.

Equipment is sufficient for needs, up to date and well maintained. Space is generally adequate across sites.

Significant improvement and increased awareness of quality control and quality assurance is evident. Staff 'buy in' to the concept of a quality management system (QMS) will take some time to fully implement.

Document control processes are under development as part of the QMS. It is recognized that this is a major project and will take two years or more to fully implement. Exploring the use of commercial software to facilitate the process in a cost effective and efficient manner is suggested. Histology and transfusion medicine manuals have recently been reviewed and rewritten in a standardized format, which meets ISO standards, but have not yet been distributed. Other manual revisions are in progress.

# Accreditation Report

The laboratory is encouraged to continue to improve processes and documentation of regular maintenance and calibration of all laboratory equipment including pipettes, microscopes, centrifuges, thermometers and so on.

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

| Criteria                                                                                                                                                                                                                              | Location | Priority for Action |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The laboratory collects and reviews information at least annually about service volumes, client perspectives on services, and patterns of requests from service providers and other organizations.<br>CSA Reference: Z15189-03, 4.1.2 | 1.1      |                     |
| The laboratory's affiliates engage in regular quality control and quality improvement procedures, including proficiency testing and inter-laboratory comparisons.                                                                     | 4.3      | ↑                   |
| Staff regularly participates in professional development activities.<br>CSA Reference: Z15189-03, 5.1.9; Z902-04, 4.3.2.2                                                                                                             | 7.2      |                     |
| The laboratory has a formal program to assess competence.<br>CSA Reference: Z902-04, 4.3.3.1                                                                                                                                          | 7.4      |                     |
| The laboratory reviews and updates the SOPs annually or more often if needed.<br>CSA Reference: Z902-04, 4.6.1.4                                                                                                                      | 10.5     |                     |
| The laboratory tracks changes to SOPs using a document control procedure.<br>CSA Reference: Z15189-03, 4.3.1, 4.3.2; Z902-04, 4.2.2.4, 4.2.3, 4.2.4                                                                                   | 10.6     |                     |
| The laboratory monitors and controls utilities and environmental conditions.<br>CSA Reference: Z15189-03, 5.2.4, 5.2.5                                                                                                                | 13.7     |                     |
| The laboratory uses a standardized and consistent format to label supplies, reagents, and media.                                                                                                                                      | 18.4     |                     |
| The laboratory's processes include testing new methods on consenting clients, as appropriate.                                                                                                                                         | 24.6     | ↑                   |

|                                                                                                                                                                                                                                                                 |      |   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---|
| The laboratory has a formal quality management system.<br>CSA Reference: Z15189-03, 4.1.5, 4.12.4, 4.15.1, 4.15.3, 4.15.4                                                                                                                                       | 25.1 | ↑ |
| As part of the quality management system, the laboratory evaluates outcomes using formal internal audits, proficiency testing, and inter-laboratory comparisons.<br>CSA Reference: Z15189-03, 4.2.2, 4.14.1, 4.14.2, 4.14.3; Z902-04, 4.3.3.2, 4.3.3.3, 4.3.3.4 | 25.4 | ↑ |
| The laboratory identifies potential sources of nonconformities and their root causes, and implements and monitors action plans to prevent nonconformities.<br>CSA Reference: Z15189-03, 4.9, 4.9.1, 4.9.2, 4.10.1, 4.10.2, 4.10.3, 4.11.1, 4.11.2               | 25.5 | ↑ |
| The laboratory implements and monitors quality indicators to evaluate its contribution to patient service and shares the results with staff and other programs, services, or organizations.<br>CSA Reference: Z15189-03, 4.9                                    | 25.6 | ↑ |
| The laboratory's senior managers use indicator and evaluation information to guide decision-making and to make ongoing and timely improvements to its procedures and quality management system.<br>CSA Reference: Z15189-03, 4.12, 4.14.3                       | 25.7 | ↑ |

**Long Term Care Services**

**Clinical Leadership**

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

*Surveyor Comments*

Site visits were conducted at the Corner Brook LTC facility (CBLTCH) and Bay St. George Long Term Care Centre (BSGLTCC). Almost all staff had some level of awareness about Western Health's strategic planning process and the expectation that all programs would participate in the development of work plans supporting the strategic direction of the organization.

The CBLTCH is new. Residents and staff moved into the facility on June 21, 2010, with the majority coming from three pre existing facilities in the city. Staff and management at the facility have experienced significant transition issues associated with the move. In hindsight, the leadership team recognizes that formal efforts at preparing staff for the change could have begun much sooner than they did. The new facility has design features that are intended to lead to more "resident and family focused" care than was possible in the older buildings. New routines for dining and bathing are examples of opportunities to offer more choice to residents however, initiatives to incorporate new ways of doing things have been met with some resistance. The management team is responding to the transition issues by dedicating senior management time and additional resources to address the concerns of staff and family members.

The organization is encouraged to work on the development of a philosophy of care that puts the care needs of residents at the forefront and encourages staff to develop work patterns that support that philosophy in practice. This is a large facility, with private rooms that are spread out along long hallways. Generally, staff are currently orientated to routines that have all residents up and into common dining rooms, and to care procedures on a schedule that accommodates staff work schedules. In this context, there is a perception that work load is an issue however, staffing levels appear to be quite robust when compared to other regions and facilities across the country, with a staff to resident ratio of 1:5.

The BSGLTCC has an older, community based facility that is well integrated into its community. While there are many challenges with an aging facility that lacks adequate storage space and has many semi private spaces for residents, the staff express great pride in their ability to provide quality care at the heavier end of the continuum. They see themselves as "integrated" in the sense that they accommodate respite, adult day programs, palliative care, and specialized dementia care in a community that offers independent seniors' housing and supported living in the immediate vicinity. The facility staff develop work plans that are aligned with the strategic directions of the region and see themselves as having benefited from the greater range of service options and supports gained by 'regionalization'. There are opportunities to take a fresh look at how the needs of residents and their families are met in the Bay St. George facility to enhance the approach to care. For example, resident living areas are identified by names like protective care, chronic care, and the north and south units, which would seem to encourage a medical model of care.

The CBLTCH and BSGLTCC would benefit from sharing their stories about how the residential care system has evolved, then work together to develop a common philosophy of care that would drive program development in the region. There is a high level of enthusiasm and positive discussion about the priority that Western Health places on LTC services, an area that traditionally identifies itself as an underdog when it is directly associated with acute care.

No Unmet Criteria for this Priority Process.

## Competency

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

### *Surveyor Comments*

The LTC facilities identify many benefits of working in an interdisciplinary team environment. There is strong social work, recreation, and rehabilitation presence. The availability of many disciplines puts the service area in a good position to develop a care delivery model that excels at putting the resident first by addressing the needs of the whole person. It is evident that job descriptions exist for all of the players, but it is not clear how responsibilities are delineated around the needs of the resident and family.

There is a mix of dedicated physician resources and services that are provided by family physicians who follow their patients into the facilities. In terms of proactive assessment and care planning for the residents it would be worthwhile giving consideration to the role of the physician in multidisciplinary care in a residential setting. For example, staff noted that when there is concern about the high average number of medications utilized, it may not be considered acceptable by physicians to ask for medications to be reviewed. There is opportunity for pharmacy to review and suggest modifications, and there are some nursing suggestions made to physicians, but there is no concerted effort to adjust medications based on a comprehensive geriatric assessment that considers alternative methodologies to address presenting behaviours and issues.

There are regular care conferences held within the first couple of months of admission and annually thereafter, providing routine opportunities to review and adjust medications, based on a review of progress.

Staff have access to non violent crisis intervention training. Concern for the safety of staff and residents is evident in risk assessment tools and in significant investments that have been made in new equipment and building modifications.

A recent simulation of a code yellow exercise at BSGLTCC resulted in some significant lessons learned for staff of the facility and community partners about potential risks and challenges in searching the surrounding area. Staff were also involved in an evacuation exercise two years ago, when a flood occurred in one of the care units. During the two months that it took to renovate and re claim the unit, many lessons were learned about how to care for residents in alternate makeshift accommodation in the group areas of the facility. BSGLTCC is the evacuation site for patients of the hospital so the exercise proved to be valuable in terms of a mock preparation for such an event.

Use of infusion pumps is minimal in LTC although CBLTCH intends to accommodate more acute procedures to facilitate aging in place. Staff identified that training needs are initially met via supplier training, and then ongoing support is available at the acute care hospital and via on line training modules.

The goal is to provide annual performance reviews and to discuss educational requirements in conjunction with these. Compliance with the goal is said to be at about 65 percent. Staff at BSGLTCC speak very positively about the organization's support for their professional development and interdisciplinary collaboration and practice. The challenges of bringing together a new staff complement in CBLTCH is viewed as an opportunity to concentrate considerable effort on developing strategies and taking actions to advance resident focused care in the facility. The organization is encouraged to continue its efforts to capitalize on the advantages it has with significant new capital investments, good staff to resident ratios, and staff that are engaged and interested in strategic priorities. All of these assets can be used to build a corporate care philosophy and related protocols that demonstrate leading practices in resident focused long term care.

No Unmet Criteria for this Priority Process.

## Episode of Care

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

### *Surveyor Comments*

A medication reconciliation process is in the process of being implemented at admission in LTC. There is evidence that audits of the process are carried out by a risk management/patient safety advisor. Registered nursing staff were quite well versed in the organization's expectations, but identified that additional experience and education will be required to identify the process as something more organized than what they have historically done as part of their normal nursing practice. The process was seen as more of an "accounting" of the current state than as an opportunity to review and discuss best practice around the current care needs of the resident.

There is consultation with the pharmacist and initial and subsequent review with the physician.

Concern was noted about the high number of medications being taken by the average resident. The LPNs stated that they had not received education about medication reconciliation and were not familiar with the terminology.

It is noteworthy that there is a general consensus amongst staff, clients, family members, and community partners that it is a high priority to organize practice in a way that keeps care as close to home as possible and minimizes the need for transfers to acute care.

Issues around food service were a theme in the facilities visited. With BSGLTCC taking on responsibility to provide meals to the acute care site and CBLTCH being so new and large, work load is identified as an issue, even with what appears to be good staffing levels compared to industry standards.

It would be worthwhile to spend some time talking about food policies and practices relative to striking a balance between cultural norms and healthy living, and responsiveness to the daily habits and routines of the resident versus workload issues associated with the staffing model.

No Unmet Criteria for this Priority Process.

## Decision Support

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

### *Surveyor Comments*

Being as resident and family focused as possible is a priority for the leadership of the organization and for all of the staff that participated in the survey process. It was interesting to note how various people's perception of what resident focused care looks like differed. Generally, people aspire to be as collaborative as possible, put safety first, and demonstrate compassionate care. There is a high level of interest in discussing "best practice". With all of the changes happening in this portfolio, the timing is right to harness this interest and enthusiasm of staff to develop common definitions for some of the concepts that would define behaviours and structures that "put the resident first" at Western Health.

No Unmet Criteria for this Priority Process.

## Impact on Outcomes

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

### *Surveyor Comments*

The team provided supporting documentation to discuss its efforts to develop work plans that align with the strategic directions of Western Health. The team gave abundant examples of investments that have been made to support initiatives in those directions. CBLTCH is all new and features modern lift and bathing equipment, among other things. At BSGLTCC, new lift equipment and bath tubs have been installed and there are plans underway to purchase additional ceiling track lifts.

This organization demonstrates significant effort to solicit feedback from clients via surveys, focus groups, and other means. There are plans to review the role of resident and family councils to ensure that the model makes the best use of this valuable partnership and feedback mechanism.

It was pointed out that warming carts used to transport meals between BSGLTCC and the hospital are large and heavy. These are seen as a potential risk for injury to staff that deliver meals between facilities and down long corridors.

There is an automated incident reporting system that staff are aware of and it is described as an on line system into which a staff person can report an occurrence that will be reviewed by corporate staff and sent to the site manager for review and follow up.

No Unmet Criteria for this Priority Process.

## **Managing Medications**

### **Medication Management**

Interdisciplinary provision of medication to clients.

#### *Surveyor Comments*

Western Health is working diligently and systematically to remove unnecessary drug strengths. Where multiple strengths must be available in the same care area, special precautions are being taken. The staff at all sites have labelled items in pharmacy stores and in ward stock areas. Certain high risk medications, including concentrated electrolytes and high potency unfractionated heparins and high potency opioids have been removed from patient care areas. This has required considerable effort on the part of an all pharmacy department staff and commendation is given for making such good progress with the Institute of Safe Medication Practices (ISMP) guidelines.

While there is a region wide pharmacy and therapeutics (P&T) committee in place and has been active in making decisions on key medication policies in the past, the committee seems to meet irregularly and infrequently. This has already caused delays in moving some drug policies and procedure decisions forward. The organization is encouraged to find solutions to the barriers of getting an active P&T committee re established.

The organization is commended for its work in critically reviewing package labelling, with a view to reducing inadvertent medication selection errors.

There are good supports to nursing staff after hours, including on call pharmacy staff in Corner Brook and night cupboards in all locations. Many rural pharmacists are not officially on call but make themselves readily available after hours to answer questions.

There is evidence that the organization has not implemented a finalized, region wide policy on the use of sample medications.

The organization has neither a policy nor a process to guide staff when there are shortages of medications. Given that this has become an increasing reality in Canadian pharmacies, the organization is advised to proceed with a procedure that provides for clinical leaders to authorize therapeutics substitutions or an alternate action when these shortages occur.

The organization does not currently purchase many intravenous (IV) preparations that are available commercially because of the cost and dating problems. These preparations would increase patient safety and reduce risk by decreasing the number of IV solutions that needed to be prepared on the various wards/care areas under less than ideal conditions. Alternatively, pharmacy staff are best positioned to provide 'CIVA' services, with supporting transportation across the region.

There is no evidence that the medication storage areas in the acute care sites separate medication products based on look-alike, sound alike criteria. In fact, medication drawers in the medication carts often had various strengths of high risk medications side by side thereby increasing the likelihood of choosing the wrong strength.

There is evidence that the policy on medications brought from home by patients needs review based on recent incidents where a patient was taking a cytotoxic medication and the nursing staff were not aware of its potential risks. The organization should consider that all medications ordered by physicians and brought in from home be entered by pharmacy and also viewed and labelled with product cautions such as cytotoxic packaging.

Although there are any numbers of pre printed order sets used by the physicians, they have no regular update schedule and no clear office of responsibility for their update. There are a number of examples of pre printed order forms that contain "do not use" abbreviations.

There is no evidence that education is provided to staff when new medications are added to the formulary.

While there is evidence that body surface area (BSA) calculations in chemotherapy and weight based dosing in pediatrics are always done by pharmacy and nursing staff, there are no actual policies in the region to support this.

The organization will need to review the current medication administration records (MARs) and develop a procedure for recording double checks in the case of administering high risk medications.

In the ER at WMRH, it was clear that two identifiers were not used when medication was being administered. In addition, across the region the staff and patients had trouble articulating how this was done so it is likely not being consistently done.

There is evidence that the results of adverse drug event investigations is not sent back to staff in a timely manner. There are no outcome indicators in place relative to medication management in this region.

Pharmacy technicians in the region are not working at full scope of practice. In fact, at WMRH, the technicians spend considerable time portering medications. The team has already identified the need to have pharmacy technicians working at full scope of practice, including a 'tech check tech' process. This should be strongly supported by the organization and the team is encouraged to then release pharmacy staff for much needed clinical roles. The organization should be aware that clinical departments across the region want greater clinical pharmacy support and that this department may need additional staffing resources to make this happen.

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

| Criteria                                                                                                                                                                                                                                         | Location | Priority for Action |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The organization educates staff and service providers about new medications prior to their use.                                                                                                                                                  | 2.6      | ↑                   |
| The organization educates staff and service providers about new uses for existing medications.                                                                                                                                                   | 2.7      | ↑                   |
| The organization purchases commercially-manufactured medications when available to minimize compounding in the pharmacy.                                                                                                                         | 3.1      |                     |
| The organization has a policy and process to manage the availability of sample medications.                                                                                                                                                      | 3.7      |                     |
| The organization separates or isolates look-alike, sound-alike medications; different concentrations of the same medication; high-risk/high-alert medications; and discontinued, expired, damaged, and contaminated medications pending removal. | 6.5      | ↑                   |
| The pharmacy establishes and follows a policy and process to monitor bulk chemicals which includes eliminating those that are not regularly used or that are considered dangerous.                                                               | 8.1      | ↑                   |
| The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.                                                                                             | 10.2     | ↑                   |
| The organization's preprinted forms, related to medication-use, do not include any abbreviations, symbols, and dose designations identified on the Do Not Use List.                                                                              | 10.2.3   |                     |
| The organization provides quiet work areas where medication orders are written, transcribed, and entered into computer systems.                                                                                                                  | 10.12    |                     |
| The pharmacy computer system is used to perform dose range checks and to warn staff and service providers about low and high doses for high alert medications.                                                                                   | 11.4     | ↑                   |
| The organization has a policy for weight-based dosing in pediatrics that includes verification based on milligrams per kilogram.                                                                                                                 | 11.5     | ↑                   |

# Accreditation Report

|                                                                                                                                                                                        |        |   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---|
| The organization has a policy for body surface area prescribing for chemotherapy that includes verification based on milligrams per square meter.                                      | 11.6   | ↑ |
| The pharmacy sets and follows policies for dispensing emergency, urgent, and routine medications.                                                                                      | 13.4   |   |
| The organization has medication delivery turn-around times for emergency, urgent, and routine medications.                                                                             | 15.2   |   |
| At the start of service, service providers educate clients and families about how to take an active role in ensuring medication prescribed for them is administered safely.            | 16.1   | ↑ |
| Service providers record in the client record verbal or written information that is provided to the client.                                                                            | 16.5   |   |
| The team uses at least two client identifiers before administering medications.                                                                                                        | 18.3   | ↑ |
| The team uses at least two client identifiers before administering medications.                                                                                                        | 18.3.1 |   |
| The organization minimizes the use of multi-dose vials in client care areas.                                                                                                           | 19.5   | ↑ |
| The organization has a policy and process about the adverse drug event review process including which staff and service providers to involve in the review.                            | 21.6   |   |
| The organization provides staff and service providers with regular feedback about adverse drug events, hazardous situations, and risk reduction strategies that are being implemented. | 21.9   |   |
| The organization selects and monitors process and outcome indicators for medication use and medication management.                                                                     | 22.1   |   |
| The organization monitors medication use with an ongoing medication utilization review.                                                                                                | 22.2   |   |
| The organization has a quality control program for the pharmacy.                                                                                                                       | 22.3   |   |
| Based on the data collected and analyzed, the organization identifies and addresses areas for improvement.                                                                             | 22.4   |   |

**Medicine Services**

**Clinical Leadership**

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

*Surveyor Comments*

Overall, medical services provide apparently excellent care to individuals. Outcomes are reported as being good, although there is little data collected to support this. There is a range of secondary specialties available with some sub specialties also available.

Planning for medical services appeared to take place almost entirely at the local facility level however, and there was little evidence of region wide planning. One exception to this is the focus on stroke care, as well as the chronic disease management approach which includes diabetes and the health aging strategy.

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

| Criteria                                                                               | Location | Priority for Action |
|----------------------------------------------------------------------------------------|----------|---------------------|
| The team’s goals and objectives for its medicine services are measurable and specific. | 2.2      |                     |

**Competency**

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

*Surveyor Comments*

There are operational team meetings on the patients currently on the unit but team members did not describe a formal, systemic planning process for the service.

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

| Criteria                                                                                                                                          | Location | Priority for Action |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements. | 3.7      |                     |
| Team leaders regularly evaluate and document each team member’s performance in an objective, interactive, and positive way.                       | 4.8      |                     |

### Episode of Care

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

#### Surveyor Comments

Nursing care processes on the medical units at WMRH and DCLLHC are appropriate and meet standards with respect to patient identification. The medication reconciliation process is being introduced in a staged process. This is working well at the Dr. Charles L. Legrow Health Centre.

There are appropriate nursing, safety and other policies available to staff on the units. All staff have been appropriately orientated and specifically orientated to the use of infusion pumps. Narcotics and other medications are safely stored and appropriately tracked and recorded.

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

| Criteria                                                                                                                                                                                                          | Location | Priority for Action |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| The team reconciles the client’s medications upon admission to the organization, with the involvement of the client, family or caregiver.                                                                         | 7.5      |                     |
| There is a demonstrated, formal process to reconcile client medications upon admission.                                                                                                                           | 7.5.1    |                     |
| The team generates a Best Possible Medication History (BPMH) for the client upon admission.                                                                                                                       | 7.5.2    |                     |
| Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive). | 7.5.3    |                     |
| The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.                                               | 7.5.4    |                     |
| The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.             | 7.5.5    |                     |
| Medication Reconciliation at Admission                                                                                                                                                                            | 7.6      |                     |
| The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation at admission.                                                                           | 7.6.1    |                     |
| The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.                                                                         | 7.6.2    |                     |

|                                                                                                                                                                                                                                                                                                  |        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| The team reconciles medications with the client at referral or transfer, and communicates information about the client’s medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. | 11.3   |
| There is a demonstrated, formal process to reconcile client medications at referral or transfer.                                                                                                                                                                                                 | 11.3.1 |
| The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.                                                                                                                                                                | 11.3.2 |
| The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.                                                                                                                         | 11.3.3 |
| The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.                                                                                        | 11.3.4 |
| The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.                                                                                                                         | 11.3.5 |
| The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.                                                                                                         | 11.3.6 |

**Decision Support**

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

*Surveyor Comments*

No Unmet Criteria for this Priority Process.

**Impact on Outcomes**

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

*Surveyor Comments*

It is recommended that the team expand its use of indicators to include outcome measurements and use the data to make improvements.

# Accreditation Report

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

| Criteria                                                                                                                                                                                | Location | Priority for Action |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service. | 15.3     | ↑                   |
| The team compares its results with other similar interventions, programs, or organizations.                                                                                             | 16.3     | ↑                   |
| The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.            | 16.4     | ↑                   |
| The team shares evaluation results with staff, clients, and families.                                                                                                                   | 16.5     |                     |

## Mental Health Services

### Clinical Leadership

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

#### Surveyor Comments

The mental health (MH) team provides input to, and sets direction according to the strategic planning process for Western Health and the province every three years. There is a community needs assessment done every four years, with a random sample survey sent to households across the region. Plans are underway to move to needs assessments that will be done every three years. These will be designed to tailor initiatives to the particular needs identified by individual primary health care teams. The team also relies on the provincial "community accounts" database for information about health status according to the determinants of health. From these sources of information and various inter agency collaborations, an environmental scan is created. The data are used to inform the strategic plan and the work plans of individual services. There are discussions underway about how to develop leading indicators to support upstream program development. Previously, the practice has been to look at what the data tells the organization about conditions that already require more intrusive interventions into peoples lives.

The organization actively seeks out relationships with community partners. Much has been done to develop protocols that allow for "need to know" sharing of information within the circle of care, and with appropriate client consent. There is recognition that clients of mental health are often clients of other public and not for profit agencies. Western Health is working to devolve child, youth and family services(CYFS) to a new ministry, while maintaining the gains that have been made in terms of interdisciplinary practice during the time that CYFS have been provided in house.

Staff working in the "psychiatry" unit for many years comment that the amount of collaboration occurring with colleagues and other programs now far exceeds anything that was done a decade ago. They also comment that the new ways of doing business go a long way to putting the outcomes for the client at the forefront of the service delivery model. Initiatives such as the early psychosis nurse, acute community care team (ACTT) and the MH liaison nurse during peak hours in the emergency unit provide good examples of the organization's efforts to invest in the right service, in the right place, at the right time.

The mental health team is called upon to provide one and three day orientations to staff that work in ER and ICU. There are specific efforts at improving ease of access to timely and appropriate service; reducing wait times and sharing information between professionals that have a part in client care plans.

It is very clear that staff working in various components of the mental health and addiction services at Western Health follow the continuum of care, providing services as and when needed to clients that enter the system at multiple access points. Tracers of client journeys in the hospital based unit and the ACTT supported the notion that workers move between services to ensure that clients are responded to according to their requirements for brief intervention, solid discharge planning, referral across transition points, and multidisciplinary intervention for persistent, chronic mental illness.

No Unmet Criteria for this Priority Process.

## Competency

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

### *Surveyor Comments*

There are a full spectrum of mental health and addiction services available from Western Health, with a concerted effort to have sufficient resources in place to intervene at the right times to keep people living as independently and safely as possible. The roles of the players are clearly defined and there are innovative approaches to staff, as seen with the early psychosis nurse, ACTT team, and emergency room nurse. It is particularly notable that the roles of peer supports, home support services, and community based service organizations are highly valued.

Professional development opportunities are available to all staff, and many of these are encouraged, or even made mandatory when they are associated with strategic priorities of the service area and Western Health. These include training that is designed to arm staff with information and resources that will keep them safe and healthy in the workplace.

Western Health has an in house employee assistance program of which staff are well aware. In the mental health areas, clinical case reviews and professional supervision are key components of a healthy workplace for people that work in professions where workplace stress and other risks are ever present.

Regular performance review and planning is a priority.

No Unmet Criteria for this Priority Process.

## Episode of Care

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

## *Surveyor Comments*

In the acute psychiatry unit there is a designated primary nurse that is known to the client and family. In the ACT team and other community based services, the key contact person is identified to the client. Based on program descriptions, chart reviews, and conversations with staff and clients, it is apparent that every effort is made to streamline access to all services via a single point of entry from the client's perspective, respecting the privacy and confidentiality of client information.

Consents for sharing of information are consistently sought. All of the mental health services, but particularly the ACT team function as highly collaborative and integrated teams with the objectives of providing the right service, at the right place, at the right time to avoid hospital admissions when home based care will best serve the need of the client.

There is a steady flow of services between emergency, acute care, and community programs when clients who are known to the system present, or when a new client is identified that would benefit from a referral to a more appropriate service. The early psychosis nurse is an example of a service that might come into acute care when a young person has been admitted with the initial signs of a mental illness for which the client and care givers will be better able to do self management with additional information. The efforts that Western Health has made to support integration and collaboration in mental health services are evident in the way that staff along the continuum of care establish protocols and take the initiative to connect where the client presents.

There is access to on call service for people with persistent mental illness. The intent is to respond to situations that might result in crisis, or more acute interventions, and to maintain the independent functioning of the client as much as possible. Staff in the ACTT program and others acknowledged that although there is an array of services available from Western Health, the partnerships with private business, not for profit and other community partners are both valued and essential.

Managing wait lists is an area of concern. Access to the ACT team is limited, based on the philosophy of the program. Western Health information suggests that there can be lengthy wait lists for non acute services and there is no clear evidence that caseloads are systematically reviewed to determine if the level of activity on particular cases justifies keeping those open, while other clients wait. There is no clear evidence that people who are wait listed are placed in order of priority for service, although this is on the radar screen in the organization's planning process.

There is access to a range of professionals, including psychiatry and psychology, although there are challenges with recruitment and retention.

Suicide risk assessment is routinely done at intake and in subsequent re assessments. All staff have access to ASSIST training from in house trainers.

No Unmet Criteria for this Priority Process.

## **Decision Support**

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

## *Surveyor Comments*

Client records were reviewed in each of the service areas and then considered in relation to client and staff interviews. Charts were found to be well organized, with consents, multidisciplinary assessments, and progress notes available.

The ACT team has an evaluation component, using a tool called the Fidelity scale, which looks at compliance with this well defined program. Staff feel that a key to this evidence based program's success is adherence to all of the features of the defined model. It will be important to consider this evaluation mechanism relative to how well this component of mental health and addiction services fits with other mental health and addiction services along the continuum of care, so that Western Health can determine how well it is generally responding to demand from the communities it serves.

No Unmet Criteria for this Priority Process.

## **Impact on Outcomes**

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

## *Surveyor Comments*

While there is regular discussion about safe practices, there is room for improvement in terms of overt practices around discussion and debriefing of safety. Staff feel that assessment of risk and the opportunity to travel in twos as required, along with the check in systems while on home and community visits, and so on, contribute to staff safety.

There is increased awareness of the risk of sentinel events in this client population following the suicide of a client in the in patient unit. Follow up to that event has resulted in many improvements to the physical environment, as well as initiatives to improve protocols and practices on the unit. There is a sense that lessons learned will contribute to the development of an improved design for the new hospital that is in the capital plan. The organization is encouraged to continue to look at program based initiatives that can reduce the risk of adverse events in the current unit.

No Unmet Criteria for this Priority Process.

## ***Obstetrics/Perinatal Care Services***

### **Clinical Leadership**

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

## *Surveyor Comments*

The team is embarking on year two of the managing obstetrical risk (MOREob) program, which reflects a significant organizational financial investment.

The equipment maintenance program and PM of equipment is documented and monitored by the bio medical department.

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

| Criteria                                                                                                | Location | Priority for Action |
|---------------------------------------------------------------------------------------------------------|----------|---------------------|
| The team’s goals and objectives for its obstetrics/perinatal care services are measurable and specific. | 2.2      |                     |

**Competency**

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

*Surveyor Comments*

The team enjoys a wonderful family centred environment that provides plenty of space for the provision of care, especially in the labour, birth, recovery, post partum (LBRP).

Obstetrics units at other sites such as STRH and DCLLHC are prepared for emergency births only, but have full service, two labour and delivery and recovery post part (LDRP) spaces where women stay post delivery. This gives the community an assumption that the centre is competent to provide the full scope of service for Level 1 obstetrics.

No Unmet Criteria for this Priority Process.

**Episode of Care**

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

*Surveyor Comments*

The team completes a discharge profile for the mother and baby that is used by the public health nurse.

The perinatal service has a designated scope of service that allows care of women and babies at more than 34 weeks gestation. Any patients with complex issues are referred antenatally to the tertiary centre in St John’s.

Women booked for elected C section attend a pre admit clinic for assessment and teaching.

All permanent full time and part time nurses are cross trained to all three clinical areas: labour and birth, postpartum and nursery. This process enables flexibility and additional peer support within this episodic work environment.

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

| Criteria                                                                                                                                                                                                                                                                                         | Location    | Priority for Action |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------------|
| The team reconciles the client’s medications upon admission to the organization, with the involvement of the client, family or caregiver.                                                                                                                                                        | 7.12        |                     |
| There is a demonstrated formal process to reconcile client medications upon admission.                                                                                                                                                                                                           | 7.12.1      |                     |
| Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).                                                                                | 7.12.3      |                     |
| The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.                                                                                                                              | 7.12.4      |                     |
| The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.                                                                                            | 7.12.5      |                     |
| <b>Medication Reconciliation at Admission.</b>                                                                                                                                                                                                                                                   | <b>7.13</b> |                     |
| The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation at admission.                                                                                                                                                          | 7.13.1      |                     |
| The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.                                                                                                                                                        | 7.13.2      |                     |
| The team reconciles medications with the client at referral or transfer, and communicates information about the client’s medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. | 11.3        |                     |
| There is a demonstrated, formal process to reconcile client medications at referral or transfer.                                                                                                                                                                                                 | 11.3.1      |                     |
| The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.                                                                                               | 11.3.4      |                     |
| The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.                                                                                                                         | 11.3.5      |                     |

## Decision Support

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

# Accreditation Report

### Surveyor Comments

Nursing staff provide excellent patient education and refer women to public health, using a criteria based tool. They are very aware of responsibilities with regard to child and infant protection.

No Unmet Criteria for this Priority Process.

### Impact on Outcomes

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

### Surveyor Comments

The team is just completing year one of the MOREob program. By way of this program, the team's performance will be benchmarked against other like centres in Canada.

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

| Criteria                                                                                           | Location | Priority for Action |
|----------------------------------------------------------------------------------------------------|----------|---------------------|
| The team shares benchmark and best practice information with its partners and other organizations. | 15.5     |                     |

### Surgical Procedures

Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

### Surveyor Comments

Overall, surgical services provide apparently excellent care to individuals. Outcomes are reported as being good although there is little data collected to support this. There is a range of basic surgical specialties available with some sub-specialties also available. Planning for surgical services takes place almost entirely at the local facility level, however there is no evidence of region wide planning. One exception to this is the focus on expanding pre-operative clinics to communities to enhance surgical patient screening and preparation while reducing patient travel. There is also a recent focus on the appropriateness of some of the preoperative testing.

Nursing care processes on the surgical units (WMRH) are appropriate and meet standards with respect to patient identification at medication administration. Medication reconciliation has been introduced at admission. It is not continued through other patient transfer points. It has not yet been started in the surgical unit at STRH.

There are appropriate nursing, safety and other policies available to staff on the unit. All staff have been appropriately oriented and specifically oriented to the use of infusion pumps. Narcotics and other medications are safely stored and appropriately tracked and recorded.

A care map is in use for knee arthroplasty but not for other procedures.

There is a common waitlist data base but it is not managed as a common waitlist. Each surgeon prioritizes patients on their individual wait list so there is no systemic triage to ensure that patients are booked by order of clinical urgency. Despite this, wait times from ‘decision to incision’ are reported as good. Patients have access to retrospective wait time data only.

ALOS for surgical patients is higher than ELOS but the actual ratios for different conditions were not available. While staff had an expectation of ELOS for orthopedic (joint replacement) surgery, there are no external benchmarks in use.

### Operating Room:

In both WMRH and STRH the OR suites are effectively and appropriately designed and stocked. A ‘pre-operative pause’ we observed in the WMRH OR and appropriate use of, and recording of the Surgical Checklist was demonstrated. In STRH, the checklist was available but not consistently used.

In the WMRH OR, vials of concentrated morphine (50 mg/ml) were found in the OR PIXIS system although staff seemed unaware that they were there.

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

| Criteria                                                                                                                                                                                                                                                                                         | Location | Priority for Action |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| <b>Operating Rooms</b>                                                                                                                                                                                                                                                                           |          |                     |
| The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.                                                                                                                                                |          | 1.8                 |
| <b>Surgical Care Services</b>                                                                                                                                                                                                                                                                    |          |                     |
| Medication Reconciliation at Admission                                                                                                                                                                                                                                                           |          | 7.13                |
| The team follows Accreditation Canada’s protocols and definitions to collect and submit data on medication reconciliation at admission.                                                                                                                                                          |          | 7.13.1              |
| The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.                                                                                                                                                        |          | 7.13.2              |
| The team reconciles medications with the client at referral or transfer, and communicates information about the client’s medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization. |          | 11.4                |
| There is a demonstrated, formal process to reconcile client medications at referral or transfer.                                                                                                                                                                                                 |          | 11.4.1              |

|                                                                                                                                                                                                           |        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.                                                                         | 11.4.2 |
| The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.                                  | 11.4.3 |
| The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made. | 11.4.4 |

## Performance Measure Results

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

### Instrument Results

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


# Accreditation Report

## Governance Functioning Tool


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

### Summary of Results

| Governance Structures and Processes                                                                                                                                                         | % Agree      | % Neutral    | % Disagree   | Priority for Action |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------|--------------|---------------------|
|                                                                                                                                                                                             | Organization | Organization | Organization |                     |
| 1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.                                                                | 0            | 0            | 100          |                     |
| 2 We have explicit criteria to recruit and select new members.                                                                                                                              | 0            | 0            | 100          |                     |
| 3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.                                                                                                    | 33           | 0            | 67           |                     |
| 4 The composition of our governing body allows us to meet stakeholder and community needs.                                                                                                  | 100          | 0            | 0            |                     |
| 5 Clear written policies define term lengths and limits for individual members, as well as compensation.                                                                                    | 100          | 0            | 0            |                     |
| 6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.                                                                                 | 100          | 0            | 0            |                     |
| 7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.                                                               | 100          | 0            | 0            |                     |
| 8 We review our own structure, including size and sub-committee structure.                                                                                                                  | 80           | 0            | 20           |                     |
| 9 We have sub-committees that have clearly-defined roles and responsibilities.                                                                                                              | 100          | 0            | 0            |                     |
| 10 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues. | 100          | 0            | 0            |                     |
| 11 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.                                                      | 100          | 0            | 0            |                     |

|                                                                                                                                                |     |   |     |                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------|-----|---|-----|---------------------------------------------------------------------------------------|
| 12 Disagreements are viewed as a search for solutions rather than a “win/lose”.                                                                | 100 | 0 | 0   |                                                                                       |
| 13 Our meetings are held frequently enough to make sure we are able to make timely decisions.                                                  | 100 | 0 | 0   |                                                                                       |
| 14 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).   | 100 | 0 | 0   |                                                                                       |
| 15 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.                                        | 80  | 0 | 20  |                                                                                       |
| 16 Our governance processes make sure that everyone participates in decision-making.                                                           | 100 | 0 | 0   |                                                                                       |
| 17 Individual members are actively involved in policy-making and strategic planning.                                                           | 100 | 0 | 0   |                                                                                       |
| 18 The composition of our governing body contributes to high governance and leadership performance.                                            | 80  | 0 | 20  |                                                                                       |
| 19 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input. | 100 | 0 | 0   |                                                                                       |
| 20 Our ongoing education and professional development is encouraged.                                                                           | 100 | 0 | 0   |                                                                                       |
| 21 Working relationships among individual members and committees are positive.                                                                 | 100 | 0 | 0   |                                                                                       |
| 22 We have a process to set bylaws and corporate policies.                                                                                     | 100 | 0 | 0   |                                                                                       |
| 23 Our bylaws and corporate policies cover confidentiality and conflict of interest.                                                           | 100 | 0 | 0   |                                                                                       |
| 24 We formally evaluate our own performance on a regular basis.                                                                                | 100 | 0 | 0   |                                                                                       |
| 25 We benchmark our performance against other similar organizations and/or national standards.                                                 | 100 | 0 | 0   |                                                                                       |
| 26 Contributions of individual members are reviewed regularly.                                                                                 | 100 | 0 | 0   |                                                                                       |
| 27 As a team, we regularly review how we function together and how our governance processes could be improved.                                 | 100 | 0 | 0   |                                                                                       |
| 28 There is a process for improving individual effectiveness when non-performance is an issue.                                                 | 0   | 0 | 100 |  |

## Accreditation Report

|                                                                                                                                                                                 |     |   |    |                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---|----|-------------------------------------------------------------------------------------|
| 29 We regularly identify areas for improvement and engage in our own quality improvement activities.                                                                            | 60  | 0 | 40 |  |
| 30 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community. | 100 | 0 | 0  |                                                                                     |
| 31 As individual members, we receive adequate feedback about our contribution to the governing body.                                                                            | 75  | 0 | 25 |                                                                                     |
| 32 We have a process to elect or appoint our chair.                                                                                                                             | 100 | 0 | 0  |                                                                                     |
| 33 Our chair has clear roles and responsibilities and runs the governing body effectively.                                                                                      | 100 | 0 | 0  |                                                                                     |

## Patient Safety Culture Survey

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

### Summary of Results

Number of survey respondents = 58 respondents \*

\* Based on the total employees in your organization, the minimum response rate for this instrument has not been met. The Priority for Action Column therefore cannot be populated. The results below are presented for your information only and may not be representative.

| A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care | % Disagree   | % Neutral    | % Agree      | Priority for Action |
|--------------------------------------------------------------------------------------------------------------------------------|--------------|--------------|--------------|---------------------|
|                                                                                                                                | Organization | Organization | Organization |                     |
| 1 Patient safety decisions are made at the proper level by the most qualified people                                           | 9            | 12           | 79           |                     |
| 2 Good communication flow exists up the chain of command regarding patient safety issues                                       | 16           | 19           | 66           |                     |
| 3 Reporting a patient safety problem will result in negative repercussions for the person reporting it                         | 86           | 14           | 0            |                     |
| 4 Senior management has a clear picture of the risk associated with patient care                                               | 16           | 22           | 62           |                     |
| 5 My unit takes the time to identify and assess risks to patients                                                              | 7            | 9            | 83           |                     |
| 6 My unit does a good job managing risks to ensure patient safety                                                              | 6            | 11           | 83           |                     |
| 7 Senior management provides a climate that promotes patient safety                                                            | 12           | 16           | 72           |                     |
| 8 Asking for help is a sign of incompetence                                                                                    | 95           | 3            | 2            |                     |
| 9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it                      | 96           | 4            | 0            |                     |
| 10 I am sure that if I report an incident to our reporting system, it will not be used against me                              | 19           | 24           | 57           |                     |
| 11 I am less effective at work when I am fatigued                                                                              | 4            | 7            | 89           |                     |
| 12 Senior management considers patient safety when program changes are discussed                                               | 11           | 26           | 63           |                     |

Used with permission from York University. All Rights Reserved.

# Accreditation Report

|    |                                                                                                                                    |    |    |    |
|----|------------------------------------------------------------------------------------------------------------------------------------|----|----|----|
| 13 | Personal problems can adversely affect my performance                                                                              | 22 | 22 | 55 |
| 14 | I will suffer negative consequences if I report a patient safety problem                                                           | 91 | 9  | 0  |
| 15 | If I report a patient safety incident, I know that management will act on it                                                       | 11 | 21 | 68 |
| 16 | I am rewarded for taking quick action to identify a serious mistake                                                                | 34 | 45 | 21 |
| 17 | Loss of experienced personnel has negatively affected my ability to provide high quality patient care                              | 36 | 40 | 24 |
| 18 | I have enough time to complete patient care tasks safely                                                                           | 22 | 24 | 55 |
| 19 | I am not sure about the value of completing incident reports                                                                       | 62 | 21 | 17 |
| 20 | In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time | 60 | 15 | 25 |
| 21 | I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care                              | 19 | 31 | 50 |
| 22 | I have made significant errors in my work that I attribute to my own fatigue                                                       | 85 | 11 | 4  |
| 23 | I believe that health care error constitutes a real and significant risk to the patients that we treat                             | 16 | 9  | 76 |
| 24 | I believe health care errors often go unreported                                                                                   | 18 | 30 | 53 |
| 25 | My organization effectively balances the need for patient safety and the need for productivity                                     | 14 | 45 | 41 |
| 26 | I work in an environment where patient safety is a high priority                                                                   | 10 | 12 | 78 |
| 27 | Staff are given feedback about changes put into place based on incident reports                                                    | 23 | 40 | 37 |
| 28 | Individuals involved in patient safety incidents have a quick and easy way to report what happened                                 | 19 | 23 | 58 |
| 29 | My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures              | 18 | 29 | 53 |
| 30 | My supervisor/manager seriously considers staff suggestions for improving patient safety                                           | 4  | 18 | 78 |

Used with permission from York University. All Rights Reserved.

|                                                                                                                                                                                   |                         |                     |                       |                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------|-----------------------|----------------------------|
| 31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts                                                                  | 84                      | 12                  | 4                     |                            |
| 32 My supervisor/manager overlooks patient safety problems that happen over and over                                                                                              | 82                      | 11                  | 7                     |                            |
| 33 On this unit, when an incident occurs, we think about it carefully                                                                                                             | 10                      | 16                  | 74                    |                            |
| 34 On this unit, when people make mistakes, they ask others about how they could have prevented it                                                                                | 14                      | 24                  | 62                    |                            |
| 35 On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future                                               | 8                       | 12                  | 81                    |                            |
| 36 On this unit, when an incident occurs, we analyze it thoroughly                                                                                                                | 16                      | 25                  | 59                    |                            |
| 37 On this unit, it is difficult to discuss errors                                                                                                                                | 67                      | 19                  | 13                    |                            |
| 38 On this unit, after an incident has occurred, we think long and hard about how to correct it                                                                                   | 14                      | 22                  | 65                    |                            |
| <b>B. These questions are about your perceptions of overall patient safety</b>                                                                                                    | <b>% Good/Excellent</b> | <b>% Acceptable</b> | <b>% Poor/Failing</b> | <b>Priority for Action</b> |
|                                                                                                                                                                                   | Organization            | Organization        | Organization          |                            |
| 39 Please give your unit an overall grade on patient safety                                                                                                                       | 67                      | 29                  | 3                     |                            |
| 40 Please give the organization an overall grade on patient safety                                                                                                                | 48                      | 43                  | 9                     |                            |
| <b>C. These questions are about what happens after a Major Event</b>                                                                                                              | <b>% Disagree</b>       | <b>% Neutral</b>    | <b>% Agree</b>        | <b>Priority for Action</b> |
|                                                                                                                                                                                   | Organization            | Organization        | Organization          |                            |
| 41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions                                        | 5                       | 25                  | 69                    |                            |
| 42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers | 6                       | 31                  | 63                    |                            |
| 43 Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event                               | 7                       | 33                  | 60                    |                            |

Used with permission from York University. All Rights Reserved.

# Accreditation Report

|    |                                                                                                                                                                                                                             |    |    |    |
|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|----|----|
| 44 | The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events              | 11 | 47 | 42 |
| 45 | Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it | 11 | 25 | 64 |
| 46 | Changes are made to reduce re-occurrence of major events                                                                                                                                                                    | 5  | 18 | 77 |

Used with permission from York University. All Rights Reserved.

## Worklife Pulse

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

### Summary of Results

Number of survey respondents = 83 respondents \*

\* Based on the total employees in your organization, the minimum response rate for this instrument has not been met. The Priority for Action Column therefore cannot be populated. The results below are presented for your information only and may not be representative.

| How would you rate your work environment                                                | % Disagree   | % Neutral    | % Agree      | Priority for Action |
|-----------------------------------------------------------------------------------------|--------------|--------------|--------------|---------------------|
|                                                                                         | Organization | Organization | Organization |                     |
| 1 I am satisfied with communications in this organization.                              | 19           | 22           | 59           |                     |
| 2 I am satisfied with communications in my work area.                                   | 12           | 8            | 80           |                     |
| 3 I am satisfied with my supervisor.                                                    | 1            | 11           | 88           |                     |
| 4 I am satisfied with the amount of control I have over my job activities.              | 8            | 16           | 76           |                     |
| 5 I am clear about what is expected of me to do my job.                                 | 8            | 8            | 83           |                     |
| 6 I am satisfied with my involvement in decision making processes in this organization. | 14           | 27           | 59           |                     |
| 7 I have enough time to do my job adequately.                                           | 33           | 14           | 53           |                     |
| 8 I feel that I can trust this organization.                                            | 10           | 30           | 60           |                     |
| 9 This organization supports my learning and development.                               | 12           | 22           | 66           |                     |
| 10 My work environment is safe.                                                         | 6            | 14           | 80           |                     |
| 11 My job allows me to balance my work and family/personal life.                        | 17           | 22           | 61           |                     |

# Accreditation Report

| Individual Outcomes                                                                                                                                             | % Not Stressful        | % A bit Stressful    | % Quite or Extremely Stressful | Priority for Action |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------|--------------------------------|---------------------|
|                                                                                                                                                                 | Organization           | Organization         | Organization                   |                     |
| 12 In the past 12 months, would you say that most days at work were...                                                                                          | 17                     | 55                   | 28                             |                     |
|                                                                                                                                                                 | % Very Good/ Excellent | % Good               | % Fair/ Poor                   | Priority for Action |
|                                                                                                                                                                 | Organization           | Organization         | Organization                   |                     |
| 13 In general, would you say your health is...                                                                                                                  | 61                     | 28                   | 11                             |                     |
| 14 In general, would you say your mental health is...                                                                                                           | 61                     | 31                   | 7                              |                     |
| 15 In general, would you say your physical health is...                                                                                                         | 55                     | 34                   | 11                             |                     |
|                                                                                                                                                                 | % Very Satisfied       | % Somewhat Satisfied | % Not Satisfied                | Priority for Action |
|                                                                                                                                                                 | Organization           | Organization         | Organization                   |                     |
| 16 How satisfied are you with your job?                                                                                                                         | 89                     | 11                   | 0                              |                     |
|                                                                                                                                                                 | % < 10                 | % 10 - 15            | % > 15                         | Priority for Action |
|                                                                                                                                                                 | Organization           | Organization         | Organization                   |                     |
| 17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)             | 86                     | 4                    | 11                             |                     |
| 18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)? | 92                     | 4                    | 5                              |                     |
|                                                                                                                                                                 | % Never/ Rarely        | % Sometimes          | % Often/ Always                | Priority for Action |
|                                                                                                                                                                 | Organization           | Organization         | Organization                   |                     |
| 19 How often do you feel you can do your best quality work in your job?                                                                                         | 5                      | 18                   | 77                             |                     |

|                                                                | % Disagree   | % Neutral    | % Agree      | Priority for Action |
|----------------------------------------------------------------|--------------|--------------|--------------|---------------------|
|                                                                | Organization | Organization | Organization |                     |
| 20 Overall, I am satisfied with this organization.             | 10           | 30           | 60           |                     |
| 21 Working conditions in my area contribute to patient safety. | 6            | 23           | 71           |                     |

# Accreditation Report

## Indicator Results

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

### Medication Reconciliation at Admission

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

| Medication Reconciliation at Admission |                                      |                                                                  |                          |                                                       |
|----------------------------------------|--------------------------------------|------------------------------------------------------------------|--------------------------|-------------------------------------------------------|
| Flag                                   | Location                             | Team Name<br>(standard section)                                  | Dates<br>(dd/mm/yyyy)    | % Formal medication<br>reconciliation at<br>admission |
| GREEN                                  | Bay St. George Long Term Care Centre | Long Term Care and Supportive Services (Long Term Care Services) | 01/04/2010<br>30/06/2010 | 100                                                   |
| GREEN                                  | Bay St. George Long Term Care Centre | Long Term Care and Supportive Services (Long Term Care Services) | 01/07/2010<br>30/09/2010 | 100                                                   |
| GREEN                                  | Calder Health Centre                 | Long Term Care and Supportive Services (Long Term Care Services) | 01/07/2010<br>30/09/2010 | 100                                                   |
| GREEN                                  | Calder Health Centre                 | Medical Care (Medicine Services)                                 | 01/04/2010<br>30/06/2010 | 100                                                   |
| YELLOW                                 | Calder Health Centre                 | Medical Care (Medicine Services)                                 | 01/07/2010<br>30/09/2010 | 80                                                    |
| GREEN                                  | Corner Brook Long Term Care Home     | Long Term Care and Supportive Services (Long Term Care Services) | 01/04/2010<br>30/06/2010 | 100                                                   |
| GREEN                                  | Corner Brook Long Term Care Home     | Long Term Care and Supportive Services (Long Term Care Services) | 01/07/2010<br>30/09/2010 | 100                                                   |
| RED                                    | Dr. Charles L. Legrow Health Centre  | Long Term Care and Supportive Services (Long Term Care Services) | 01/04/2010<br>30/06/2010 | 50                                                    |

| Medication Reconciliation at Admission |                                        |                                                                        |                          |                                                       |
|----------------------------------------|----------------------------------------|------------------------------------------------------------------------|--------------------------|-------------------------------------------------------|
| Flag                                   | Location                               | Team Name<br>(standard section)                                        | Dates<br>(dd/mm/yyyy)    | % Formal medication<br>reconciliation at<br>admission |
| YELLOW                                 | Dr. Charles L. Legrow<br>Health Centre | Long Term Care and<br>Supportive Services (Long<br>Term Care Services) | 01/07/2010<br>30/09/2010 | 78                                                    |
| RED                                    | Dr. Charles L. Legrow<br>Health Centre | Medical Care (Medicine<br>Services)                                    | 01/04/2010<br>30/06/2010 | 68                                                    |
| RED                                    | Dr. Charles L. Legrow<br>Health Centre | Medical Care (Medicine<br>Services)                                    | 01/07/2010<br>30/09/2010 | 68                                                    |
| GREEN                                  | Protective Community<br>Residences     | Long Term Care and<br>Supportive Services (Long<br>Term Care Services) | 01/04/2010<br>30/06/2010 | 100                                                   |
| GREEN                                  | Protective Community<br>Residences     | Long Term Care and<br>Supportive Services (Long<br>Term Care Services) | 01/07/2010<br>30/09/2010 | 100                                                   |
| GREEN                                  | Western Memorial<br>Regional Hospital  | Medical Care (Medicine<br>Services)                                    | 01/04/2010<br>30/06/2010 | 100                                                   |
| GREEN                                  | Western Memorial<br>Regional Hospital  | Medical Care (Medicine<br>Services)                                    | 01/07/2010<br>30/09/2010 | 100                                                   |
| GREEN                                  | Western Memorial<br>Regional Hospital  | Surgical Care (Surgical<br>Care Services)                              | 01/04/2010<br>30/06/2010 | 100                                                   |
| GREEN                                  | Western Memorial<br>Regional Hospital  | Surgical Care (Surgical<br>Care Services)                              | 01/07/2010<br>30/09/2010 | 100                                                   |

Threshold for Flags

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

# Accreditation Report

## Surgical Site Infection

Post-surgical infection rate is a key outcome measure that reflects process interventions.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

| Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery |                                       |                                                            |                          |                               |
|-----------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------|--------------------------|-------------------------------|
| Flag                                                                  | Location                              | Team Name<br>(standard section)                            | Dates<br>(dd/mm/yyyy)    | % post-surgical<br>infections |
|                                                                       | Western Memorial<br>Regional Hospital | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 0                             |
|                                                                       | Western Memorial<br>Regional Hospital | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 0                             |

**Surgical Site Infection**

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

| <b>Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery</b> |                                       |                                                            |                               |                                                        |
|-------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------|-------------------------------|--------------------------------------------------------|
| <b>Flag</b>                                                                   | <b>Location</b>                       | <b>Team Name<br/>(standard section)</b>                    | <b>Dates<br/>(dd/mm/yyyy)</b> | <b>% timely<br/>administrations of<br/>antibiotics</b> |
| RED                                                                           | Western Memorial<br>Regional Hospital | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010      | 28                                                     |
| RED                                                                           | Western Memorial<br>Regional Hospital | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010      | 26                                                     |

**Threshold for Flags**

- RED: < 80/100
- YELLOW: >= 80/100 AND < 90/100
- GREEN: >= 90/100

# Accreditation Report

## Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

| Health Care-Associated MRSA & C. difficile - C. difficile |                                      |                                                         |                          |                                               |
|-----------------------------------------------------------|--------------------------------------|---------------------------------------------------------|--------------------------|-----------------------------------------------|
| Flag                                                      | Location                             | Team Name<br>(standard section)                         | Dates<br>(dd/mm/yyyy)    | # cases of infection /<br>10,000 patient days |
| GREEN                                                     | Bay St. George Long Term Care Centre | Infection Control<br>(Infection Prevention and Control) | 01/04/2010<br>30/06/2010 | 0                                             |
| GREEN                                                     | Bay St. George Long Term Care Centre | Infection Control<br>(Infection Prevention and Control) | 01/07/2010<br>30/09/2010 | 0                                             |
| GREEN                                                     | Bonne Bay Health Centre              | Infection Control<br>(Infection Prevention and Control) | 01/04/2010<br>30/06/2010 | 0                                             |
| GREEN                                                     | Bonne Bay Health Centre              | Infection Control<br>(Infection Prevention and Control) | 01/07/2010<br>30/09/2010 | 0                                             |
| GREEN                                                     | Calder Health Centre                 | Infection Control<br>(Infection Prevention and Control) | 01/04/2010<br>30/06/2010 | 0                                             |
| GREEN                                                     | Calder Health Centre                 | Infection Control<br>(Infection Prevention and Control) | 01/07/2010<br>30/09/2010 | 0                                             |
| GREEN                                                     | Corner Brook Long Term Care Home     | Infection Control<br>(Infection Prevention and Control) | 01/04/2010<br>30/06/2010 | 0                                             |
| GREEN                                                     | Corner Brook Long Term Care Home     | Infection Control<br>(Infection Prevention and Control) | 01/07/2010<br>30/09/2010 | 0                                             |
| GREEN                                                     | Dr. Charles L. Legrow Health Centre  | Infection Control<br>(Infection Prevention and Control) | 01/04/2010<br>30/06/2010 | 0                                             |

| Health Care-Associated MRSA & C. difficile - C. difficile |                                        |                                                            |                          |                                               |
|-----------------------------------------------------------|----------------------------------------|------------------------------------------------------------|--------------------------|-----------------------------------------------|
| Flag                                                      | Location                               | Team Name<br>(standard section)                            | Dates<br>(dd/mm/yyyy)    | # cases of infection /<br>10,000 patient days |
| GREEN                                                     | Dr. Charles L. Legrow<br>Health Centre | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 0                                             |
| GREEN                                                     | Rufus Guincharde Health<br>Centre      | Infection Control<br>(Infection Prevention and<br>Control) | 01/01/2010<br>31/03/2010 | 0                                             |
| GREEN                                                     | Rufus Guincharde Health<br>Centre      | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 0                                             |
| GREEN                                                     | Rufus Guincharde Health<br>Centre      | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 0                                             |
| GREEN                                                     | Sir Thomas Roddick<br>Hospital         | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 0                                             |
| GREEN                                                     | Sir Thomas Roddick<br>Hospital         | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 0                                             |
| GREEN                                                     | Western Memorial<br>Regional Hospital  | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 0.61                                          |
| GREEN                                                     | Western Memorial<br>Regional Hospital  | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 0.63                                          |

Threshold for Flags

RED: > 80/10,000  
 YELLOW: <= 80/10,000 AND > 60/10,000  
 GREEN: <= 60/10,000

# Accreditation Report

| Health Care-Associated MRSA & C. difficile - MRSA |                                         |                                                            |                          |                                                                 |
|---------------------------------------------------|-----------------------------------------|------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| Flag                                              | Location                                | Team Name<br>(standard section)                            | Dates<br>(dd/mm/yyyy)    | # cases of infection +<br>colonization / 10,000<br>patient days |
| GREEN                                             | Bay St. George Long Term<br>Care Centre | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 0                                                               |
| GREEN                                             | Bay St. George Long Term<br>Care Centre | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 0.98                                                            |
| GREEN                                             | Bonne Bay Health Centre                 | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 5.4                                                             |
| GREEN                                             | Bonne Bay Health Centre                 | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 0                                                               |
| GREEN                                             | Calder Health Centre                    | Infection Control<br>(Infection Prevention and<br>Control) | 01/01/2010<br>31/03/2010 | 0                                                               |
| GREEN                                             | Calder Health Centre                    | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 0                                                               |
| GREEN                                             | Corner Brook Long Term<br>Care Home     | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 0.48                                                            |
| GREEN                                             | Corner Brook Long Term<br>Care Home     | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 0.45                                                            |
| GREEN                                             | Dr. Charles L. Legrow<br>Health Centre  | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 6                                                               |
| GREEN                                             | Dr. Charles L. Legrow<br>Health Centre  | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 3.2                                                             |
| GREEN                                             | Rufus Guincharde Health<br>Centre       | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 0                                                               |

| Health Care-Associated MRSA & C. difficile - MRSA |                                       |                                                            |                          |                                                                 |
|---------------------------------------------------|---------------------------------------|------------------------------------------------------------|--------------------------|-----------------------------------------------------------------|
| Flag                                              | Location                              | Team Name<br>(standard section)                            | Dates<br>(dd/mm/yyyy)    | # cases of infection +<br>colonization / 10,000<br>patient days |
| GREEN                                             | Sir Thomas Roddick<br>Hospital        | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 8.9                                                             |
| GREEN                                             | Sir Thomas Roddick<br>Hospital        | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 9                                                               |
| GREEN                                             | Western Memorial<br>Regional Hospital | Infection Control<br>(Infection Prevention and<br>Control) | 01/04/2010<br>30/06/2010 | 1.2                                                             |
| GREEN                                             | Western Memorial<br>Regional Hospital | Infection Control<br>(Infection Prevention and<br>Control) | 01/07/2010<br>30/09/2010 | 1.3                                                             |

Threshold for Flags

RED: > 80/10,000  
 YELLOW: <= 80/10,000 AND > 60/10,000  
 GREEN: <= 60/10,000

## Next Steps

Congratulations! You have just completed your Qmentum on-site survey visit. Please note the following check list items that you need to attend to in the coming days and months.

- We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.
- In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.
- You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

## Appendix A - Accreditation Decision Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. Population focus
2. Accessibility
3. Safety
4. Worklife
5. Client-centred services
6. Continuity of services
7. Effectiveness
8. Efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

### Accreditation Canada High Priority Criteria

Accreditation Canada identifies high priority criteria by their alignment with several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

### Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for healthcare organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2010 Qmentum surveys are:

# Accreditation Report

## Option 1: Accreditation

An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

- (a) 90% or more of high priority criteria met per standard section, AND
- (b) Compliance with all of the Required Organizational Practices, AND
- (c) Compliance with collection of all the performance measures,

If the organization is a CSSS, participating in the Joint Program with Conseil québécois d'agrément (CQA) and Accreditation Canada, the following additional criteria are required, which are specific CQA indicators relating to customer service and worklife:

- (d) Compliance with  $\geq 66.6\%$  of Client Satisfaction Indicators AND
- (e) Compliance with  $\geq 66.6\%$  of Employees Mobilization Indicators

## Option 2: Accreditation with Condition: Report and/or Focused Visit

An organization will receive Accreditation with Condition: Report and/or Focused Visit if any of the following criteria is met:

- (a) More than 10% and less than 30% of high priority criteria unmet in any standard section,  
OR
- (b) Non-compliance with any one of the Required Organizational Practices  
OR
- (c) Non-compliance with the collection of any one of the performance measures

If the organization is a CSSS, participating in the Joint Program with CQA and Accreditation Canada, the following addition criteria apply:

- (d) Compliance with less than 66.6% of Client Satisfaction Indicators,  
OR
- (e) Compliance with less than 66.6% of Employees Mobilization Indicators

The condition, i.e. submission of a report or focused visit; and timeframe, i.e. 6 months or 12 months; is based upon the nature of the recommendations. If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.

Organizations are required to submit follow-up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress, and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

For organizations that fail to complete a satisfactory focused visit within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

### **Option 3: Non-accreditation**

An organization will NOT be accredited if the following conditions exist:

(a) One or more ROPs not in place

*AND*

(b) 30% or more high priority criteria unmet in one or more standards sections

*AND*

(c) 20% or more criteria unmet overall for all standards applied to the organization

Should an organization wish to have their non-accreditation status reviewed within 6 months post survey, they are required to complete a focused visit within 5 months. Organizations that fail to complete a satisfactory focused visit within the required timeframe will maintain a non-accreditation status.

If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.