ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

Eastern Health

St. John's, NL

On-site survey dates: September 10, 2017 - September 15, 2017

Report issued: December 18, 2017

About the Accreditation Report

Eastern Health (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2017. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

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A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Eastern Health 's accreditation decision is:

Accredited with Exemplary Standing

The organization has attained the highest level of performance, achieving excellence in meeting the requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: September 10, 2017 to September 15, 2017**

- **Locations**

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

1. Burin Peninsula Health Care Centre
2. Carbonear General Hospital
3. Central Kitchen
4. Central Laundry
5. Chapel Hill Site
6. Charles R. Bell Building
7. Clarenville Protective Care Community Residence
8. Dr. G.B. Cross Memorial Hospital
9. Dr. H. Bliss Murphy Cancer Centre
10. Dr. Leonard A. Miller Centre
11. Grace Centre
12. Health Sciences Centre (General Hospital)
13. Janeway Children's Health and Rehabilitation Centre
14. Major's Path
15. Mount Pearl Square - Community Services
16. Pleasant View Towers
17. Saint Luke's Homes
18. St. Clare's Mercy Hospital
19. Topsail Road
20. Tuckamore Centre
21. Waterford Hospital

- **Standards**

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

System-Wide Standards

1. Governance
2. Infection Prevention and Control Standards
3. Leadership
4. Medication Management Standards

Population-specific Standards

5. Population Health and Wellness

Service Excellence Standards

6. Ambulatory Care Services - Service Excellence Standards
7. Assisted Reproductive Technology (ART) Standards for Clinical Services - Service Excellence Standards
8. Assisted Reproductive Technology (ART) Standards for Laboratory Services - Service Excellence Standards
9. Biomedical Laboratory Services - Service Excellence Standards
10. Cancer Care - Service Excellence Standards
11. Case Management - Service Excellence Standards
12. Community-Based Mental Health Services and Supports - Service Excellence Standards
13. Critical Care - Service Excellence Standards
14. Diagnostic Imaging Services - Service Excellence Standards
15. Emergency Department - Service Excellence Standards
16. EMS and Interfacility Transport - Service Excellence Standards
17. Home Care Services - Service Excellence Standards
18. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
19. Long-Term Care Services - Service Excellence Standards
20. Medicine Services - Service Excellence Standards
21. Mental Health Services - Service Excellence Standards
22. Obstetrics Services - Service Excellence Standards
23. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
24. Perioperative Services and Invasive Procedures - Service Excellence Standards
25. Point-of-Care Testing - Service Excellence Standards
26. Public Health Services - Service Excellence Standards

27. Rehabilitation Services - Service Excellence Standards
28. Reprocessing of Reusable Medical Devices - Service Excellence Standards
29. Substance Abuse and Problem Gambling - Service Excellence Standards
30. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	136	0	0	136
Accessibility (Give me timely and equitable services)	176	0	0	176
Safety (Keep me safe)	1035	21	25	1081
Worklife (Take care of those who take care of me)	228	19	1	248
Client-centred Services (Partner with me and my family in our care)	761	20	4	785
Continuity (Coordinate my care across the continuum)	160	0	2	162
Appropriateness (Do the right thing to achieve the best results)	1618	63	15	1696
Efficiency (Make the best use of resources)	105	1	0	106
Total	**4219**	**124**	**47**	**4390**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	48 (96.0%)	2 (4.0%)	0	35 (97.2%)	1 (2.8%)	0	83 (96.5%)	3 (3.5%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	92 (95.8%)	4 (4.2%)	0	142 (97.3%)	4 (2.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	30 (96.8%)	1 (3.2%)	0	70 (98.6%)	1 (1.4%)	0
Medication Management Standards	71 (97.3%)	2 (2.7%)	5	60 (95.2%)	3 (4.8%)	1	131 (96.3%)	5 (3.7%)	6
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	41 (93.2%)	3 (6.8%)	2	76 (97.4%)	2 (2.6%)	0	117 (95.9%)	5 (4.1%)	2
Assisted Reproductive Technology (ART) Standards for Clinical Services	57 (96.6%)	2 (3.4%)	2	118 (99.2%)	1 (0.8%)	4	175 (98.3%)	3 (1.7%)	6

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Assisted Reproductive Technology (ART) Standards for Laboratory Services	58 (98.3%)	1 (1.7%)	1	68 (98.6%)	1 (1.4%)	2	126 (98.4%)	2 (1.6%)	3
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Cancer Care	101 (100.0%)	0 (0.0%)	0	128 (100.0%)	0 (0.0%)	0	229 (100.0%)	0 (0.0%)	0
Case Management	46 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	126 (100.0%)	0 (0.0%)	0
Community-Based Mental Health Services and Supports	44 (100.0%)	0 (0.0%)	0	93 (98.9%)	1 (1.1%)	0	137 (99.3%)	1 (0.7%)	0
Critical Care	44 (88.0%)	6 (12.0%)	0	105 (93.8%)	7 (6.3%)	3	149 (92.0%)	13 (8.0%)	3
Diagnostic Imaging Services	67 (100.0%)	0 (0.0%)	0	68 (100.0%)	0 (0.0%)	1	135 (100.0%)	0 (0.0%)	1
Emergency Department	62 (87.3%)	9 (12.7%)	0	105 (98.1%)	2 (1.9%)	0	167 (93.8%)	11 (6.2%)	0
EMS and Interfacility Transport	108 (94.7%)	6 (5.3%)	5	118 (97.5%)	3 (2.5%)	0	226 (96.2%)	9 (3.8%)	5
Home Care Services	48 (100.0%)	0 (0.0%)	0	74 (98.7%)	1 (1.3%)	0	122 (99.2%)	1 (0.8%)	0
Hospice, Palliative, End-of-Life Services	41 (91.1%)	4 (8.9%)	0	103 (95.4%)	5 (4.6%)	0	144 (94.1%)	9 (5.9%)	0
Long-Term Care Services	49 (89.1%)	6 (10.9%)	0	97 (98.0%)	2 (2.0%)	0	146 (94.8%)	8 (5.2%)	0
Medicine Services	40 (88.9%)	5 (11.1%)	0	75 (97.4%)	2 (2.6%)	0	115 (94.3%)	7 (5.7%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	90 (97.8%)	2 (2.2%)	0	140 (98.6%)	2 (1.4%)	0
Obstetrics Services	67 (94.4%)	4 (5.6%)	2	86 (98.9%)	1 (1.1%)	1	153 (96.8%)	5 (3.2%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Organ and Tissue Donation Standards for Deceased Donors	54 (100.0%)	0 (0.0%)	0	89 (95.7%)	4 (4.3%)	3	143 (97.3%)	4 (2.7%)	3
Perioperative Services and Invasive Procedures	110 (95.7%)	5 (4.3%)	0	107 (98.2%)	2 (1.8%)	0	217 (96.9%)	7 (3.1%)	0
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	46 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	2
Public Health Services	45 (95.7%)	2 (4.3%)	0	67 (97.1%)	2 (2.9%)	0	112 (96.6%)	4 (3.4%)	0
Rehabilitation Services	41 (91.1%)	4 (8.9%)	0	76 (95.0%)	4 (5.0%)	0	117 (93.6%)	8 (6.4%)	0
Reprocessing of Reusable Medical Devices	84 (97.7%)	2 (2.3%)	2	39 (97.5%)	1 (2.5%)	0	123 (97.6%)	3 (2.4%)	2
Substance Abuse and Problem Gambling	45 (100.0%)	0 (0.0%)	0	81 (98.8%)	1 (1.2%)	0	126 (99.2%)	1 (0.8%)	0
Transfusion Services **	70 (100.0%)	0 (0.0%)	5	68 (100.0%)	0 (0.0%)	1	138 (100.0%)	0 (0.0%)	6
Total	**1694 (96.4%)**	63 (3.6%)	24	2414 (97.9%)	53 (2.1%)	18	4108 (97.3%)	116 (2.7%)	42

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

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Assisted Reproductive Technology (ART) Standards for Clinical Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Assisted Reproductive Technology (ART) Standards for Clinical Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Case Management)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (EMS and Interfacility Transport)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Critical Care)	Unmet	3 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	0 of 4	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Unmet	3 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	3 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Unmet	6 of 8	0 of 0

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Medicine Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics Safety (EMS and Interfacility Transport)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Assisted Reproductive Technology (ART) Standards for Clinical Services)	Met	1 of 1	2 of 2
Hand-Hygiene Compliance (EMS and Interfacility Transport)	Met	1 of 1	2 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Assisted Reproductive Technology (ART) Standards for Clinical Services)	Met	1 of 1	0 of 0
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Critical Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Home Safety Risk Assessment (Case Management)	Met	3 of 3	2 of 2
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Suicide Prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

Eastern Health (EH) is commended on preparing for and participating in the Qmentum accreditation program. The organization has embarked on a rigorous quality improvement journey as reflected in its strategic plan. A robust strategic planning process included engagement surveys with staff, physicians, and the community and public. It is focused on five pillars tied closely to performance measures. Feedback was compiled and themes were reviewed to inform the plan. The mission, vision, and values remained intact and key behaviours to support them were enhanced. A healthy workplace was identified as a new priority.

The EH strategic plan is approved by government. The next phase will include the development of targets for the programs. The organization has developed new processes to collect and report on performance. The corporate dashboard has been refined and the planning department is rolling out the new program this year. Communication, education, and support will be crucial elements that will need to be provided to the leadership team to ensure success. While this will provide EH with valuable information, it will also increase the workload of the leadership team, from managers to vice presidents. It will be important to closely monitor the process and evaluate what is working well and where there are opportunities to improve.

Through the strong leadership of the CEO and new leadership team, EH has focused on engagement and introduced initiatives to promote a just culture in the organization. The increased visibility of the leadership team through the “walk the talk” initiative has been noted, as has improvement in employee engagement. The senior leadership visibility and increased communication, and the monthly teleconference with the CEO and managers have been identified as positive. The work to promote and support a just culture has also been noted.

Many of the departments are undergoing similar change based on reviews or on quality improvement. They have also begun to introduce new systems and processes focused on staff and patients. Leaders are passionate about the upcoming work and see the benefits. Again, they will need to proceed cautiously. The integrated risk management plan is new and will require education and support for staff to understand the information.

The board has undergone significant change, with seven new members appointed by the government. They will assume their responsibilities at the end of September.

EH programs function with a co-leadership model. All clinical programs have a Quality Council and client safety leaders.

The organization has introduced the program budgeting and marginal analysis (PBMA) model to manage its finances. While it has made significant disinvestments and savings since the last accreditation cycle, budget challenges continue. At the same time, there continues to be a need to address aging infrastructure.

Workplace safety has been identified as an area of focus. The organization has an opportunity to work with leaders to develop action plans based on the Worklife Pulse results. The leaders spoke of the importance of implementing the psychological safety standards.

The organization is commended for taking a comprehensive and sustained approach to patient flow. The creation of a Patient Flow Task Force to address this complex issue has resulted in significant improvement in several key indicators. The adoption of a Home First program and the investment in additional long-term care beds has reduced the number of patients waiting for alternate levels of care who occupy acute care beds. Daily huddles, a focus on discharge planning, and investments in LEANing efficiencies are just some of the initiatives that continue to assist with flow. There are further gains to be made as the organization works with communities on primary care solutions.

A community engagement process took place to address the reduced physician presence in Bonavista. This resulted in a new model of primary care. This exciting initiative will likely be adopted in several other communities. In Burin, there has been work with the community in response to a higher number of suicides. There is a downtown health care collaborative with the provincial government and faith-based agencies to provide primary care to the homeless and marginalized populations. The continued work in primary care is going to have a positive impact on the EH community.

There is a comprehensive regional and provincial ethics program supported by government and Memorial University. Valued support and advice to EH programs and services such as assisted reproductive technology is part of the service. It is a busy consultation service. The service supports the review and development of difficult and complex organizational policies.

The organization has embraced the recommendations of the Towards Recovery all-party report of the government of Newfoundland and has made significant progress on initiatives to support them in a relatively short period of time. The addictions and mental health programs in community and facility settings demonstrated a commitment to the Stepped Care approach by introducing co-located interdisciplinary teams working with clients on a common care plan. On the acute end of the spectrum for adult inpatient programs, efforts are constrained by the physical plant at the Waterford, but programs are philosophically aligned. Access to specialized and residential care is provided appropriately via services at the Janeway and Tuckermore for children and adolescents and at the Waterford, Health Sciences Centre (HSC), and Harbour Grace for adults. The CAST program is an innovative community-based specialized team providing services for clients with concurrent disorders. The introduction of new group modalities and same day services is aligned with the strategic objectives to improve access, and these receive high praise from clients who have expressed concerns about languishing on wait lists for long periods of time.

Ten partners attended the community partners' meeting. Most of the group spoke of EH’s willingness to share information and reach out to partners. Partners identified that they had primary people to contact and felt that this was important. Other partners spoke to the frustration they encountered when they needed information from EH. They did not have a primary contact person and often did not get information for their clients in a timely manner. Themes included difficulty accessing staff and not knowing that staff have left the

organization and who was replacing them. Staff were not able to always fill their commitments as they could be seconded to their jobs by EH.

None of the partners recalled being asked for input into the strategic plan. There is a lack of understanding about which policies are EH policies and which are policies of the Department of Health and Community Services. Regardless, those organizations that work with facilities in other regions identified that policies are not consistently applied in EH. It is often difficult to get clarification from EH on a policy's application.

Communication is good if they have a primary EH contact. They described incidents when clients were treated disrespectfully when staff were not aware that they had a service worker. They spoke of receiving invitations to participate in EH focus groups with little notice.

The group was very focused on client care. Some participants who work with EH at a more systems level spoke of a positive and respectful relationship.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Emergency Department 10.5 · Perioperative Services and Invasive Procedures 11.6 · Long-Term Care Services 8.5 · Medicine Services 8.5 · Obstetrics Services 8.5 · Substance Abuse and Problem Gambling 8.5 · Critical Care 8.6 · Mental Health Services 8.6

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
2.3	The governing body includes clients as members, where possible.	
2.8	Each member of the governing body signs a statement acknowledging his or her role and responsibilities, including expectations of the position and legal duties.	!
2.11	The governing body's renewal cycle supports the addition of new members while maintaining a balance of experienced members to support the continuity of corporate memory and decision-making.	!

Surveyor comments on the priority process(es)

EH has a wealth of experience and engagement around the board table. Although there is no formalized skills matrix for board composition attention has been paid to ensuring a diverse range of backgrounds and experience on the board. The members who support the board's work by chairing committees, and the chair and vice-chair, have appropriate skills to lead the work and ensure proceedings that support the committee of the whole to fulfill its fiduciary duties.

There are strong relationships among the board, the CEO, and senior management. The board receives a robust information package prior to board meetings and benefits from the reports provided by the CEO, supported by the team. There are solid processes in place for CEO recruitment, retention, performance review, and compensation.

The board has taken ownership of the development of a strategic plan. The plan has been recently renewed for 2017 to 2020 and evidence suggests there was broad consultation and consideration of client and staff feedback prior to approval. Some standards are partially out of the control of the organization due to the process for appointing members; however, there are mechanisms to provide feedback to the The Department of Health and Community Services on how to improve this process.

EH is actively working to increase patient/client involvement in its programs and activities at all levels. There is currently no mechanism to appoint patient/clients as members. With the recently established mechanism to have members appointed to the board and with the plans to have routine meetings with the Minister of Health, there may be an opportunity to advocate for a more formalized role for patients and family members.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

Eastern Health has a dedicated planning department that is integrated with decision support. It is responsible for the strategic plan and for compiling and reporting on the organization's performance measures.

A robust strategic planning process included engagement surveys to staff, physicians, and the community and public. Feedback was compiled and themes were reviewed to inform the plan. The mission, vision, and values remained intact and key behaviours to support them were enhanced.

A healthy workplace has been identified as a new priority. There is acknowledgment that an organizational operating plan needs to be established. Since the last on-site survey, the strategic plan scorecard reflects a more streamlined process that is used throughout the organization. The next phase of the plan is to work with the programs to develop meaningful targets.

The organization has developed a software program and portal for updates on the program goals and objectives. This will be a new approach for managers and directors and education will be needed. EH may want to consider the support needed to manage changes in reporting. There is no formal evaluation built into the program and the organization will need to monitor compliance. The shift from owning accountability for the indicators to program ownership is in the planning phases. The planning department has been working with programs to ensure that indicators are SMART. Cognos has shifted from only finance to now include the clinical programs. The scorecard now reflects the strategic plan and its priorities. Annual performance reports will now be available.

Planning sees its role as educating the board and the director regularly attends the Quality Committee of the board to discuss organizational indicators and performance measures. The board has been engaged in identifying key indicators such as organizational cleanliness.

The team feels it would benefit from an expanded engagement process that would include more public input. The community engagement process used in Burin and Bonavista was very successful and is a

model that could be used in the future. “Population Health – Journey in the Big Land” has been a major initiative to improve the cancer care experience for the Aboriginal population in Labrador and it received an award last year.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is strong financial performance. EH has a $1.5 billion operating budget. It had a balanced budget due to one-time funding from the Department of Health and Community Services. Over the past five years it has accrued $60 millon in savings/expenditure reductions by focusing on waste reduction and performance efficiency improvement. EH is projecting a $34 million deficit for 2017/18. The organization is waiting for the 2108/19 budget guidelines from the Department of Health and Community Services. Members of the resource management team described how their department supports services and programs through tools and resources.

In 2014 the organization adopted the PBMA resource allocation framework which enabled it to reduce the deficit substantially. The process has criteria linked to the strategic plan and has been cascaded throughout the organization. Many disinvestments take considerable time for approval and get held up at the government level. Budget allocation decisions are scored and reviewed by a priority setting committee that has members from ethics, planning, and research. An ethics framework can be used to review the difficult decisions.

Contracted services are managed by clear policies and procedures. EH has three contracted services though Aramark, Compass, and Paladin Security. The staff are EH staff with the management of the organizations being the only employees. Performance-based models are used and performance is reviewed annually. The organization is moving toward a provincial shared services model. EH has participated in health care management benchmarking and process improvement and works closely with Newfoundland and Labrador Centre for Health Information which links with the Canadian Institute for Health Information. There is a good relationship with the Department of Health and Community Services and data are shared. EH describes the relationship with vendors as good. There are clearly defined processes for procurement and capital equipment replacement.

Departmental staff feel they have made gains in the past years through collaboration with all levels of the organization. They are challenged when they do not have an indication of their budget. They would like to take a more predictive approach to workforce management though the acquisition of new tools.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
10.5 There is a talent management plan that includes strategies for developing leadership capacity and capabilities within the organization.	

Surveyor comments on the priority process(es)

Based on a number of reviews of the human resources department, a new service model was implemented in April 2017. The focus is now on a business partner role to drive strategic initiatives. The department is focused on partnership and is moving from a manual system to an electronic one. The plan is a robust one and many pieces will be implemented over the year. With fewer silos in place, the team is focusing on increased collaboration and networks, and reduced hierarchy. Human resources and occupational health have created new positions for non-unionized staff to manage occupational health and safety concerns. There are 45 safety committees in the organization. Some human resources services have been regionalized while some remain centralized.

While there are components of a human resources or talent management plan, there is no evidence of a consolidated plan that pulls together all the pieces the organization is working on. The Learning Leaders program promotes and supports managers who want to move up in the organization. Learning leaders were present at numerous accreditation sessions and spoke of the support and opportunities the program has created for them.

Human resources staff described successful initiatives, such as a reduction in sick leave from 162 hours per employee to 147 over a two-year period. They piloted a remote working policy that allows certain categories of staff to work from home. There was a reduction in turnover time for hiring internal candidates, from 35 days to 10. A just culture is promoted throughout the organization.

The Worklife Pulse Tool was used this year for the first time. In the past, EH used AON Hewitt Employee Engagement Survey.. It is now unable to compare between the two tools. The results have been shared with the programs and action plans will be developed incorporating psychological safety. A Learning Management System has been introduced that supports online orientation for new staff. Staff who leave the organization are asked to complete an exit interview; however, the uptake is low.

New performance review policies have been developed for management and unionized staff. This information is new and has not yet been shared broadly. Many staff have not had a current performance review. There are numerous formal and informal ways to recognize staff. WOW, a peer recognition program, has been positively received.

A code of conduct is implemented for physicians. It is not implemented for professional and non-professional staff by choice of the organization, who note many other staff policies governing behaviour. An area for improvement is to consider a code of conduct for professional and non-professional staff that applies to service in the organization.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
12.5 The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary.	

Surveyor comments on the priority process(es)

To assess integrated quality management during the on-site survey, a meeting was held with the Regional Quality Council, work on a medicine unit was observed, and a surgical quality improvement project was reviewed.

The framework for the quality program has been in place since 2007, when the Regional Quality Council was formed. Its mandate has expanded to address organizational quality issues with a focus on staff and patient safety. Members are representatives of portfolios and programs. Front-line staff were members in the early years. This shifted over time and the organization may be revisiting this idea. The committees are now ready to proceed with including a patient and family advisor. EH may want to consider having more than one advisor so they can support each other and ensure their voices are heard.

The Department of Health and Community Services has released new patient safety legislation that outlines the requirements on sharing information with clients and families. The quality team has been waiting for the legislation; with it, the team can now define quality assurance accountabilities and the processes to protect quality assurance activities.

EH programs function with a co-leadership model. All clinical programs have a Quality and Clinical Safety Leaders.

The client safety plan has integrated staff and patient safety and was developed based on occurrences, incidents, trends, and data from Required Organizational Practices. The organization has been focusing on a just culture and the Regional Quality Council feels that it is beginning to make a difference. Near miss reporting has increased and this data contributed to the client safety plan. Leadership has been “walking the talk” as part of the quality plan. There is a defined process to manage client complaints.

Committee members feel that the current quality improvement framework is a good infrastructure for the organization. Leadership will need to determine how to cascade new information and indicators throughout the organization. The board has established the current targets. The organization may want to engage more with the program staff on indicators and targets. An integrated risk management

approach from HIROC was adopted in June 2017 with a focus on quality and finance. This is new for the organization and expectations will need to be communicated.

The medicine team spoke of its review of falls. The team has developed a plan to put processes in place to reduce falls, such as posters in rooms, consistent use of alerts, and monitoring and surveillance. Information has been shared with patients and families. Ongoing audits will include falls assessment compliance, patient and family education, and an evaluation of a patient and family brochure.

In 2015 the organization committed to the development and implementation of enhanced recovery after surgery (ERAS) for elective bowel surgery resections at St. Clare's Mercy Hospital. A Steering Committee was established to provide oversight and strategic direction for implementation, evaluation, and sustainability. A coordinator was hired. A Divisional Working Group uses managers, educators, front-line staff, and other key partners to provide best practice expertise and guidance. The program was implemented in March 2016. Nursing staff spoke of the change in practice and the support received. Patients have identified the learning tools as being understandable and helpful in their recovery. The data show improved adherence to pre-op, intra-op, and post-op guidelines, as well as a reduced length of stay. The learnings from this quality project will now enable them to move to the HSC in 2018. Aligning ERAS with the national surgical quality improvement program (NSQIP) has enabled the surgical program to make changes based on data. The organization is encouraged to spread the learnings of this program through its quality structure of program quality committees.

Client- and family-centred care is promoted throughout the organization. It is at the beginning of this journey but there is a plan in place. Seven people participated in the client and family engagement focus group; five in person and two on the phone. They become involved with EH through personal experience of themselves or a close family member. Some new members responded to requests for family advisors from the media.

Two of the advisors sit on the Steering Committee which has been operational for one year. The committee has 15 members, with the two advisors. They do not feel listened to and feel there are times when the staff do not "come down to the patient and family level." The organization may want to consider increasing the number of advisors and reducing the number of staff. The advisors have not had any formal education to understand EH and how it operates, though they are learning through their participation. The organization may also want to look at how to educate patient advisors as they endeavour to increase this role in the organization.

Recruitment for Family Advisory Councils has begun and the first meetings will be at the end of September. Some of the participants spoke about their upcoming roles but were uncertain about expectations. One of the advisors has been involved in developing the family presence policy and spoke positively about the process.

Most of the advisors agreed that the care they or their loved one received was good. However, they feel there are opportunities for them to help EH address some of the concerns about staff attitude that have been raised. Staff do not always treat them or their loved ones with respect and often the simple things

are overlooked. They feel frustrated when information is not provided. They feel there is an opportunity to help patients and families learn how to access information, rather than being told they should not use the intranet. Overall, the advisors spoke of the need to help patients, and in particular families, deal with emotional issues.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
2.4 A code of conduct that applies to all those working in the organization is developed and implemented.	

Surveyor comments on the priority process(es)

The EH Ethics Committee resides in the pastoral care and ethics program, and is part of a provincial ethics network consisting of representation from all four health authorities, the provincial government, and Memorial University. This provincial focus on ethics was ramped up after the Cameron Inquiry and is called the Provincial Health Ethics Network (PHENNL). One of the Memorial ethicists is assigned as a lead to each of the health authorities.

The program is administered by a person with substantial education and experience in ethics, and the interdisciplinary operational committee includes representatives from EH administration, nursing, research, faculty from the department of bioethics at Memorial, and community representatives. There are five subcommittees from various health disciplines, each with two community representatives.

The program has a robust ethics framework that guides its work and relationships. The guiding principles are embedded in the values of Eastern Health, and present and past committee members have been integral players in the development of the organization's value statements, both in its past and new strategic plans. Staff focus groups helped refine the values in the latest strategic plan.

The program offers advice and support in three distinct areas: policy development and implementation, consultation, and ethics and related education.

The ethics administrator sits on the EH committee, developing policy and bringing an ethics lens to those discussions. For many policies, such as the recently implemented family presence policy, ethics involvement may reflect this representation. For others, involvement of the program and the Memorial ethicists is needed. Discussing and advising on an EH policy regarding medication shortages and feeding in long-term care are examples of this kind of involvement.

Discussions and policies on advance care planning are ongoing. Living at risk is another example of a policy requiring major involvement from the ethics program. The program supports other EH and provincial programs such as assisted reproductive technologies and is conducting research on and discussing aspects of medical assistance in dying.

The program conducted 62 ethics consultations over the last 16 months. Some consults were straightforward, but many were complex. While respecting confidentiality, the program trended the results of these consults, including analysis by the subcommittees. This trending led to changes in the consultation program. The committee believes EH staff are aware of the process to get advice and consultation through the administrator, although concern about the awareness of physicians and staff in smaller, more distant sites is acknowledged.

An ethics education certificate has been offered in the past to EH employees, with several modules offered in a formal way. Many of these employees have now retired. Plans to revive this program in an online format are nearly complete. The employees will use this knowledge to improve staff, patient, and family understanding of the role of ethics in delivering excellent health care. An opportunity to use this certificate to develop local champions may help develop more awareness of this program in all EH sites.

Multiple educational offerings using webinars and presentations discuss issues brought to the program by health care workers, patients and families, and health authorities. Generally, they are delivered to all four regions, but they can be tailored to the needs of one region. An upcoming webinar on caring for persons with addictions will be held shortly. This was developed after an increase in requests for consultations for opioid-related concerns. Community representatives and experts have been involved in presentations. The educational sessions are very well attended, suggesting intense interest by staff in ethics-related issues.

A provincially mandated Research Ethics Board reviews all proposed research proposals, guided by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2).

The program committee identified challenges that they feel need discussion. Promoting the ethics service and its offerings, particularly in remote areas of the region, has been noted. Continued orientation for staff, physicians, and patients and families is one potential way of dealing with this concern, as is the development of local champions.

Diversity in culture and recognizing the several cultures present in Newfoundland and Labrador is acknowledged as another gap. It is noted that there was previously a diversity committee at EH. Aboriginal navigators may be very helpful to the program in this respect. University medical and nursing school offerings offer a long-term strategy.

Finally, the need for continued work on advance care planning, focused on implementation, was discussed as a continuing gap.

During the on-site survey, various programs and services commented on the invaluable and continuing support offered by the ethics service. The program is commended for the comprehensive expertise and services offered to EH and the province and its essential contribution to excellent patient, family, and staff care.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a written communication plan for the strategic plan and other special projects as required. In addition to the incorporation of formal evaluation techniques, there is often a follow-up phone call to the area that was impacted to see what went well and what could be done better next time. There is no specific process to get feedback from patients/clients on the communication plan and, while patients/clients are not consistently brought into the design of plans, this could be considered for the future.

Appropriate leadership staff have had media relationship training and continuous training is available as new managers come on board. The organization has a variety of social media avenues to communicate with the public and staff and hits and followers are monitored regularly. The communications portfolio has received awards from the International Association of Business Communicators on some of its work and the staff are commended for this. A communications awareness week is planned for February 2018 to concentrate on educating internal audiences on the value of communicating effectively, openly, and collaboratively. The organization is encouraged to add a patient/client representative to this group.

There are privacy policies and action is taken to correct breaches immediately. It is clear this issue is taken seriously and all staff, volunteers, and physicians sign a confidentiality code of conduct oath. Meditech is used as the clinical documentation system and is updated and used in most areas. The IM/IT Committee reviews requests for IT solutions for clinical situations and gaps and uses a ranking tool, factoring in the strategic direction, to make decisions on which department systems get prioritized for IT system fixes or improvements. The team is creative and innovative in using local talents. The ED bed board, business continuity planning documents, and the way the organization monitors strategic objectives are examples of locally created results.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has recently contracted with Honeywell to do energy audits and make changes to enhance environmental efficiency. Also in progress is a wayfinding project focused on improving signage and helping patients find their way to locations, particularly within the HSC complex. Input from clients, patients, and families as well as the new best practice standards from CSA are being incorporated into the final plan.

Ambulances were observed to be cleaned after every patient transport and there is now a deep cleaning protocol in place. Fleet management is contracted to Element and there is a regular vehicle maintenance and replacement schedule. Emergency medical services (EMS) drivers have initial driving training but there is little opportunity to revisit and retrain driving skills. The organization is encouraged to explore opportunities within the province to partner with other agencies like fire and police who may have such programs.

The organization has decided to focus on cleanliness and decluttering as a priority for this year. Adequate work and storage space was observed to be inconsistent across program areas and the sites. Some units have done LEANing processes to clean, reorganize, and remove clutter. It is suggested that these successes be modelled throughout the organization to make maximum use of available space.

Aging infrastructure is a challenge. The building envelope (windows, roof, brick siding, etc.) at the Waterford Hospital continues to need constant maintenance to keep patients and staff safe. At Carbonear there are ongoing issues with leaks and there are also infrastructure issues with the new long-term care facility that are still under discussion with the contractor.

Many renovation projects are underway throughout EH, and others waiting for approval. Appropriate safety hazard signage, hoarding, and negative pressure were in place where construction is taking place, and infection prevention and control (IPC) staff are involved and the worksite is monitored and audited. The organization is commended on its policy that requires external contractors to go through an orientation process that includes training on safety and infection control in a health setting.

There are back-up generators at all sites and a mobile generator is also available for emergencies. There are regular fire drills throughout the organization. The organization is commended on its attention to issues of occupational health and worker safety.

Building maintenance and biomedical staff are considered part of the health teams. Feedback from clinicians on responsiveness to work orders and building concerns was generally positive. Throughout Eastern Health the maintenance and support staff work hard to stay on top of issues, as they are very conscious that this affects patient care. The soon-to-be released computerized work order system will help with tracking and monitoring work orders.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The emergency management leadership is under the Regional Protection Services portfolio. They work well with community partners, site operations, program operations, and infection control to plan emergency planning for the region. The team provides templates and training in all-hazard responses in all areas in the region. Staff are trained in emergency management, fire life safety, business continuity planning, and incident command systems. This team provides the support and leadership for staff training in these areas.

All EH sites have excellent relationships with EMS, fire, and police. Back-up systems for suction, oxygen, and power are in place at all sites. Each site has an identified location to set up an emergency operations centre (EOC) or site command if required. Health emergency planning committees are active and meet regularly.

St. Clare's Mercy Hospital has exercised a mock code orange and then experienced one. Other departments were very responsive and the EOC was set up. The team held a debriefing with appropriate participation and acted on the lessons learned. The site has had several occasions when it has successfully implemented hazardous material precautions due to fentanyl.

The organization coordinates its planning for pandemics and outbreaks with Public Health.

The organization is commended for its progress in putting the training, skills, and infrastructure in place to respond to emergent events.

Code reds are routinely tested at all sites. There was a code grey at the HSC in the last 18 months related to the medical device reprocessing system which tested the EOC, communications, continuity planning, and other aspects of the emergency response. This was debriefed with the site and provided an excellent opportunity for real time learning of the EOC processes.

Not all sites have had front-line staff practice code green or code orange although there have been tabletop exercises at the management level. Some action sheets were missing in the disaster manuals reviewed with the front-line staff, but staff on most units and sites knew where the manuals were located.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has invested in focused strategies to address patient flow. The creation of a Patient Flow Task Force to address this complex issue has resulted in significant improvement in several key indicators. For example, the adoption of a Home First philosophy and the investment in additional long-term care beds has reduced the number of patients waiting for alternate levels of care who occupy acute care beds.

EH has incorporated daily bed management meetings, discharge rounding, and LEAN methodology to create flow efficiencies within services. The investment in change management, facilitation, and coaching resources for teams has helped with culture change and sustainability. Many programs have initiated daily or weekly huddles.

The overcapacity protocol (OCP) was triggered at the HSC during the on-site survey. The entire organization, including community supports, is prompted to discharge from inpatients and pull patients from the emergency department (ED) to create capacity. Each inpatient service has designated OCP beds that are used. Home First and community care are actively involved in finding solutions. It is suggested that the daily status updates from the organizational bed management meeting be shared with all site-based care facilitators so they can see the situation throughout the region at a glance. The escalation protocol involves ambulance diversion from one site to another if one ED is overwhelmed. There are guidelines and triggers to be assessed by leadership before escalation and this process was observed during the on-site survey.

The organization is encouraged to also include EMS in its notification and problem-solving discussions. There are opportunities to further standardize prehospital care throughout the region and province and to maximize the use of paramedic skills within the system.

Sustaining the gains in client flow is supported by involving programs with LEAN methodology and resources. There is an expectation that these efforts will continue to create efficiencies to reduce lengths of stay. Regular reports on this initiative are presented to the board, senior management, and the Medical Advisory Committee. There is progress toward having staff document and discuss with patients and families the expected date of discharge at the time of admission.

EH has been involved in finding community-based options for enhanced primary and urgent care in Burin and Bonavista to alleviate demands on acute and emergency care.

The organization is commended for taking a comprehensive and sustained approach to patient flow.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices		
3.5	Appropriate environmental conditions are maintained within the MDR department and storage areas.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	

Surveyor comments on the priority process(es)

There have been a significant number of improvements since the last on-site survey. Many of the areas now have proper handwashing sinks installed in the departments. Flash sterilization has been reduced to almost no incidents. Dental equipment has been purchased. The medical device reprocessing department (MDRD) is readily informed of new equipment that is brought into the organization. There is a notification box for new equipment on capital equipment forms. There is a strong relationship with biomedical engineering. All transport to and from the department is appropriately covered.

Staff are comfortable with completing the Clinical Safety Reporting System (CSRS) form for occurrences and gave many examples of submissions. The HSC has a major three-phase renovation project underway. The first phase includes a new decontamination area that will be complete later in the fall. This new area will be a significant improvement from the present location. Staff have had input into the renovations. Most departments have ergonomic sinks; those that do not have them on order. The challenge for some of the departments is the location of new equipment in the older buildings. Foot care instruments are now centrally reprocessed.

MDRD and biomedical engineering work closely together. Biomed is responsible for preventive maintenance of all equipment unless there is a specific-service contract. They describe a positive working relationship with the vendors. Each department has large screens that have education information broadcast throughout. The information is not only specific to MDRD.

The code grey experience was very challenging for the organization. MDRD staff spoke of the improved relationships that resulted with all the MDRD sites across Eastern Health. It has promoted collaboration, networking, and team spirit. Relationships with the operating room and MDRD were good. Managers

meet on a regular basis to discuss equipment and areas of concern. Education is broadcast to all sites via Skype.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

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

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

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness

Increasing and significant attention is being given to the area of seniors population health and wellness. The team is able to demonstrate and discuss the wide range of activities and opportunities that provide the necessary foreground for a comprehensive and robust program to address existing and emerging needs of the elderly population and other populations throughout the catchment area.

There are several innovative and unique initiatives underway to assist and support the team to provide comprehensive services while considering the needs of the population and clients served. Some notable programs and services include the community pull process (Home First initiative) aimed at expediting the return of clients admitted to hospital back to the community and their home environment; the continued provision of immunization clinics by public health nurses, mainly in light of the provincial changes in compensating family physicians to hold immunization clinics and activities; the screening services becoming an official registry for personal health information allowing for more seamless and robust information gathering, processing, and understanding, and potentially leading to improved health services planning and delivery considering local trends and needs.

The creation and roll out of a regional public health plan allows public health to play a more significant and central role in shaping health delivery in the region and impacting health services delivery through sharing information and education on the determinants of health and healthy living. The team is commended on its work in the area of mental health and addictions and managing polypharmacy through the Choosing Wisely Canada initiative.

It is evident that the team collaborates and integrates its work throughout the range of its programs. As there are always multiple improvement opportunities and priorities to manage, the team is encouraged to consider a more formal structure where information, decision making, and evaluation are done consistently to allow for more seamless service planning and delivery. The team is also encouraged to consider the voice of the customer/client in such forums to ensure authenticity and validate findings and planning.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

- Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions

Diagnostic Services: Laboratory

- Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions

Public Health

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

Point-of-care Testing Services

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Ambulatory Care Oversight Committee monitors department utilization and plans resources accordingly. Impact analysis is done when onboarding a new physician. Each department determines physician manpower requirements based on the utilization information, specific patient needs, and emerging practice changes.

A community needs assessment was completed and patient satisfaction surveys were reviewed. This is done on an annual basis in conjunction with the budget and operating plan cycles. Utilization data, patient feedback, and wait times are considered when establishing goals and objectives.

Utilization data is analyzed on an annual basis to determine whether there are clinics that need to be adjusted to meet the needs of the patient population. Physicians who support each program determine whether the manpower is adequate to meet workload demands and whether new modalities need to be introduced based on new modalities or evidence. When reviewing utilization data, the Ambulatory Care Oversight Committee considers the location of the patients and the capacity of the nearest facility to meet their needs. Specialists can either travel to that locale or provide some services through telemedicine, or use a combination of these resources.

Clinics have an extensive array of written material available in the clinical setting regarding their services and health-specific topics. There would be some value in expanding the patient education available on the website. Teach back methodologies are used to ensure patients understand the messages being taught.

There is an electronic request program for capital equipment needs. Managers are provided with assistance from purchasing and/or materials management to ensure compliance with procurement guidelines and from vendors to determine costs.

The oncology program has integrated a patient advisor into its quality program and there are plans to do the same within other ambulatory care services.

Priority Process: Competency

The team has been working through challenges arising from inadequate referral information. This has resulted in improvements in the referral forms, which direct the referring physician to provide more clinical information. Referrals are then assessed by team members to identify when initial assessment appointments can occur. Further efficiencies in this regard are being sought.

Team members identify that they haven't had a performance appraisal in a very long time.

Therapeutic crisis intervention training is provided to staff to help them identify and manage potential or actual incidents of violence. The organization is working toward establishing an alert system for patients who have previously demonstrated violent behaviour.

Cultural diversity resources are available on the intranet for employees. This program is being reviewed and formatted so it can be posted into a new electronic software program. Formal education was done with employees in 2009/10. A Diversity Day will be held in November 2017.

There are several research initiatives within ambulatory care services. Partnerships between the university and hospital support these studies once research approval processes are complete.

Priority Process: Episode of Care

A significant amount of work has gone into monitoring and managing wait lists for each of the ambulatory clinics.

In response to a high level of left without being seen (LWBS) patients, initiatives have been put into place to remind patients of their scheduled appointment through text messaging, e-mails, or telephone calls, and a no show policy has been implemented. A roster of patients who could arrive within a short period of time is also maintained.

In response to patient feedback, changes were made to the assessment process to ensure greater privacy.

Patients who were interviewed said they are well informed about their treatment processes and are treated respectfully by the provider team. Patient rights complaints are handled through the incident reporting system. A partnership with a teaching centre helps the health care team stay current with emerging practices.

Priority Process: Decision Support

Staff feel very comfortable entering incidents into the clinical safety reporting system. The organization is encouraged to review this system regarding the location of the incident. Currently, the system asks twice for information about the employee's work location, but does not ask for information about the location of the incident. Incident location is more pertinent to investigating the root causes of the incident. Managers spend excessive amounts of time tracking this information down so they can redirect the report to the manager of the area where the incident took place.

The organization is also encouraged to cue the incident author about recommendations for potential ways in which the risk can be mitigated to avoid similar incidents in the future.

Priority Process: Impact on Outcomes

Staff report consistently receiving feedback that there has been an analysis of an incident report they have submitted. They are aware that the purpose of an incident report is to avoid future occurrences by adjusting workflow processes.

Standards Set: Assisted Reproductive Technology (ART) Standards for Clinical Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
7.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
13.13	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		
Priority Process: Infection Prevention and Control		
The organization has met all criteria for this priority process.		
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		
Ten to twelve patients have been identified as patient advisors for the women's health program. A Committee for Women's Health is developing orientation information for these volunteers. An example of how partnerships have impacted service design was provided. This involved the communication between the in-vitro fertilization (IVF) clinic in Calgary and patients from the island who use this clinic for service.		

Extensive energy is expended in ensuring continuity of care for those patients who travel off-island to receive IVF. The preparation period for IVF therapy is extensive, contributing to the cost of pursuing this option if they didn't have support from the EH clinic. Through partnering in care, patients can stay at home with their families longer and costs are reduced. With careful management and coordination with the receiving IVF clinic, the patient can remain at home, with their support systems, for a longer period of time.

Multiple performance metrics are monitored monthly and tabulated for calendar and fiscal years. Several trends were identified. A business case is being investigated for bringing an embryologist into the team, which would allow for the full suite of IVF services to be provided on the island, thereby avoiding the challenge of going away for this aspect of fertility treatment.

The IVF clinic particularly appreciates the support it receives from the Ethics Committee, the women's health psychologist, and the public health agency. Each of these partners supports challenging aspects of the service in a timely fashion.

An initiative is underway to address the retention period of patient charts and to reduce the volume of on-site inpatient charts for those who are no longer in active treatment.

The nurse call role is highly valued by the clientele who use this service. Multiple requests are received on a daily basis and adjustments are made to scheduling and communication flow based on these requests. Call data are being looked at to determine if process efficiencies may be found to reduce the workload.

Priority Process: Competency

Assisted reproductive technology (ART) is a highly specialized field, with no national education programs to support staff to learn the content. Program leaders carefully plan orientation periods to ensure there is adequate coverage of knowledgeable staff.

The orientation program is delivered on site by the program leaders. Following the formal orientation, a buddy system is put into place for the orientee to be coached in the various roles. New employees are not asked to take the on-call roster until they have worked in their new role for a minimum of one year.

While performance evaluations are not formally completed, team members are provided with growth opportunities within their roles. For example, they are currently looking toward expanding their role through a medical directive for Epipen administration.

Priority Process: Episode of Care

Patients in this service are well informed about the processes they are experiencing. They used the same terminology, asked procedural questions about their treatment, and led decision-making discussions about next steps. Documentation is exemplary.

Particularly impressive is the cross-referenced documentation regarding sperm donors and recipients, thereby ensuring the same donor is not used too often within the population.

Satisfaction surveys are completed. Observations of patient interactions showed that these patients are highly informed about the care they receive and have in-depth discussions (and negotiations) with the team about their care protocols.

Priority Process: Decision Support

Patient charts are kept in the ART program. This creates challenges when patients may appear in the acute care sector. ART can see the acute care record, but acute care cannot access the ART record. Unifying these records in the electronic medical record would support continuity of care for these patients.

Priority Process: Impact on Outcomes

Multiple process and outcome performance indicators are tracked. Trends are analyzed and initiatives are underway to determine causative factors and improvement opportunities.

Priority Process: Medication Management

The team has access to pharmacists at the acute care hospital. Medications are administered very rarely at the clinic and of those, the risks to the patient are low. This likelihood will diminish further once the medication inventory is adjusted. Patients are provided with prescriptions for their IVF treatment, which are available through community pharmacies. As these medications are quite specialized, the majority of patients obtain them through the independent pharmacy that is in the same building as the clinic. The pharmacists are very well informed about these treatment protocols and are reported to be fabulous in answering questions that the clients and/or families may have.

There are very few medications in the medication cupboard at the clinic, and the clinic is in the process of removing all but a couple. One of these items is an epi kit. This is going to be replaced by an Epipen and the team is awaiting approval for a medical directive so the Epipen can be given independently by nursing staff. A fulsome medication history is obtained and the team is currently establishing a process for providing the patient with a copy of the best possible medication history form so they can complete it prior to going to the acute care setting to deliver their baby.

There are no high-alert/high-risk medications provided. Independent double-check was observed.

Priority Process: Infection Prevention and Control

Last year, it was decided to use single-use speculums, which has resulted in a significant reduction on items going to the central MDRD.

Standards Set: Assisted Reproductive Technology (ART) Standards for Laboratory Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
5.4 The laboratory's Director has the necessary credentials or license from the appropriate professional college or association.	
Priority Process: Episode of Care	
8.5 There is a process to regularly monitor and inventory cryopreserved specimens.	!
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The assisted reproductive technology (ART) laboratory service is located in the fertility clinic. The laboratory is staffed by medical laboratory technologists. The technologists are part of the EH laboratory service and they work in the fertility clinic. Services are provided to meet the needs of clients, and service volumes are reviewed. This service has been expanding and has the potential to provide additional services to clients.

The clinic is located is in a building leased by EH. The space is adequate to complete the current test menu and to allow for proper storage for gamete samples. Staff have appropriate equipment and supplies to support their work.

The specimen collection area used for collection of semen specimens is located near the laboratory. The collection room has a wooden table and the reclining chair has wooden arms. It is suggested that these be replaced with furniture that is easily cleaned.

Priority Process: Competency

Staff working at the assisted reproductive laboratory have the required qualifications and are trained to work in the clinic. It would be beneficial if staff were able to expand their knowledge and be able to obtain continuing education to support their work. This is the only laboratory in Newfoundland and Labrador to provide this service; therefore, it is essential that staff are given the resources to access the most up-to-date information about the service they provide. This may be achieved by supporting staff to attend conferences or allowing them to visit other fertility clinics to become aware of new or emerging technologies.

The clinic laboratory director does not have ART experience. It is suggested that a laboratory director with ART experience and training be available to the clinic. This will also support the technologists and ensure up-to-date procedures are in place. The current medical director is very supportive and provides leadership to the staff by investigating and researching appropriate information. The team of physicians, nurses, and laboratory staff work together to provide quality care to clients and families.

Priority Process: Episode of Care

The laboratory maintains appropriate environmental conditions to appropriately carry out testing procedures. Monitoring of work areas, equipment, and gamete storage is performed. The appropriate alarms are in place to protect the storage units 24 hours per day, 7 days per week. Staff are trained to perform the work with attention to details such as accurate record keeping. This documentation is mostly paper based. Staff have processes in place to protect samples and minimize risks. Sample integrity is protected.

Shipments of donor sperm received from outside organizations are tracked and all paperwork is maintained. All samples must have full traceability.

The process of sperm storage is well documented and there are procedures for disposal of these banked specimens. On occasion there have been situations where staff have not disposed of stored samples, possibly because the donor could not be reached or due to legal reasons. These cases are reviewed and decisions are made with the assistance of leadership and legal counsel.

Priority Process: Decision Support

There are procedures to maintain accurate client records. Staff understand the need for security and ensure that all client records are secure and client privacy is maintained.

Many documents are paper based and there is no integration of client records from the clinical and the laboratory divisions of the fertility clinic. The clinic may benefit from a database that can be accessed by both laboratory and clinical staff.

Priority Process: Impact on Outcomes

The laboratory measures quality indicators and tracks them regularly. Indicator targets were set in consultation with another fertility clinic in Canada. The targets focus on laboratory-specific procedures and the staff could benefit from measuring indicators that reflect the work performed by the laboratory in relation to client outcomes. Nursing staff have begun to share data pertaining to client outcomes with the laboratory staff.

Laboratory staff have made improvements to their processes based on information gathered from the clients. The specimen drop-off window did not provide adequate privacy for clients so changes were made to ensure only one client is at the specimen drop-off window at a time. This was supported by the clinical team and the clients.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

The laboratory service is accredited by the Institute for Quality Management in Healthcare.

The laboratory has recently implemented a document control system that allows the team to maintain an electronic document control system. The previous system was manual.

The laboratory team measures quality indicators and makes improvements based on the information gained from these indicators. Quality indicators are shared with staff.

The organization's strategic plan is the foundation of organizational planning. Laboratory goals are developed to directly link the work of the laboratory to the strategic pillars. When the laboratory service operational plan is complete the organization is encouraged to engage clients and families in the planning and improvement process as appropriate.

Staff are dedicated to process improvement and to providing quality care to clients.

Standards Set: Cancer Care - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The cancer care program is a provincial program operated by Eastern Health. There are four regional cancer centres. The largest centre, located in St. John's, is the Dr. H. Bliss Murphy Cancer Centre. The others are in Gander, Grand Falls-Windsor, and Corner Brook.

Services include systemic therapy, radiation therapy, supportive care, specialty clinics, clinical trials, cancer patient navigation, and provincial screening programs for breast, colon, and cervical cancer. In addition, the program is responsible for the tumour surveillance and systemic therapy surveillance programs. Radiation therapy for the Newfoundland and Labrador is provided only at the Dr. H. Bliss Murphy Cancer Centre.

The provincial cancer care program has a passionate and highly engaged leadership team. There have been a number of accomplishments since the last on-site survey. In particular, the cancer program leadership team is commended for the initiative "A Journey in the Big Land: Enhancing Cancer Services for First Nations, Inuit and Metis." In true partnership with patients and families, Labrador-Grenfell

Health, and Indigenous governments and organizations, a three-year project to enhance cancer care for Indigenous people in Labrador was completed. This work truly embodied patient- and family-centred care principles with a cultural competence lens. Outputs included educational material in multiple languages (two Innu dialects and Inuktituit) as well as a tele-oncology toolkit, glossary of terms, and body part teaching aids. The team received two leadership awards for this work.

Priority Process: Competency

This is a high-functioning, dynamic, interprofessional team with all key disciplines engaged in patient- and family-centred care. Team members spoke with pride about the strong focus on excellence in patient- and family-centred care and a team-based culture.

Competency-based orientation programs in systemic and radiotherapy are in place. Staff roles and responsibilities are clearly delineated. There is access to continuing education for all disciplines on a regular basis to support continued knowledge development in cancer care.

Priority Process: Episode of Care

Patients undergo a comprehensive interprofessional assessment followed by a modality plan of care to treat their disease. The patients interviewed in systemic and radiation therapy spoke highly of the compassion and caring of staff and their responsiveness to individual needs to enhance their experience.

There are wait times in systemic and radiation therapy and steps are being taken to streamline wait times and ensure targets are met. To support flow for palliative patients, a palliative radiation oncology clinic has been established. A rapid response team is in place to address urgent, non-formulary needs.

The pharmacist-led oral chemotherapy follow-up program continues to be a program of excellence and is in high demand for consultation to other centres on processes and outcomes. A manuscript has been submitted for publication.

A number of initiatives to enhance the patient experience have been implemented including distress screening and updated patient and family education information and tools. In addition, the program is active in a number of national initiatives. Two surveys focused on the patient experience were conducted. The information will be analyzed and used to direct priorities and initiatives.

The program is poised to launch its first Patient and Family Advisory Council this fall.

Priority Process: Decision Support

The program's fully integrated oncology electronic health record (ARIA) was implemented in 2014. Central regional centres came online in the spring of 2017 and in the fall the western regional cancer centre will go live. The system provides comprehensive documentation, supports communication among caregivers, and enables system efficiencies and medication reconciliation. HEALTHe is accessible to the team to support medication reconciliation.

The NL Cancer Care Registry (NLCCR) will be publicly launched in October 2017 after receiving official registry status in May.

Priority Process: Impact on Outcomes

The cancer care program has a strong focus on standardization throughout the province to ensure patient safety and high-quality care. Activities to achieve standardization include evidence-based guidelines, preprinted orders that reflect the guidelines, systemic therapy audits in centres outside St. John's, and standardizing height and weight guidelines for the provinces. In addition, oncology continuing medical education has been implemented to support rural oncology physicians and teams in caring for patients receiving chemotherapy.

Evidence-based guidelines are in place for lung, gastrointestinal, and breast. The genitourinary group has tumour boards in place. A guidelines coordinator supports the teams in the work to review, adapt, and finalize guidelines.

Parallel processes for evidence-based guidelines and quality are in place in radiation oncology. A Radiation Clinical Management Committee provides oversight for the delivery of radiation and quality assurance committees are active per site group. Guidelines for the program reflect the Canadian Partnership for Quality Radiotherapy guidelines. The program complies with provincial and federal regulations. Technical safety, quality, and auditing are comprehensive. Peer review has been successfully implemented in radiation oncology and response to treatment is monitored and documented to support service and quality.

The NL Tumour Surveillance program (tumour registry) received gold certification for three consecutive years. Supported by a Canadian Partnership Against Cancer grant, the provincial therapy database was launched in 2016, providing significant support for comprehensive data collection and reporting on cancer treatment.

Priority Process: Medication Management

There is a strong focus on safety in medication management in the cancer care program. Although outpatients and radiotherapy were the focus, the systemic guidelines were deemed to be met based on standard processes used in the program whether it be inpatient or outpatient care.

Standards Set: Case Management - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
There is a collaborative and team approach to service delivery and design. The team involves clients and families in considering the level of services, diversity of needs, as well as client wishes when considering the range and kinds of services required to promote well-being and quality of life.
Priority Process: Competency
There is a high degree of team work and collaboration. Staff are up to date and aware of new information and have access to education via a range of activities. Education is provided as practice standards and technology change and new practices and expectations are implemented. Staff are committed to client and family education and are keen to support their clients through the continuum of care and as required.
Priority Process: Episode of Care
The team involves and collaborates internally and externally with stakeholders and clients. Clients are interviewed and assessed for specific needs and service requirements, and great consideration is given to the wishes of the client and needs of the family to keep clients safe at home longer. Robust assessment tools auch as RAI are completed before service initiation, and ongoing and regular re-assessments occur

to ensure service levels are appropriate and relevant to the client's needs and requirements. There is ongoing and open communication with the client and their families and/or significant others.

Team members communicate well with each other using various modes of communication. Much of the communication takes place through the CRMS system, and email system. There is ongoing documentation with regard to client cases and staff feel they are well aware and informed.

As the integration between home and community and community support continues to evolve, there may be greater opportunities for collaboration and effectiveness, and to address inefficiencies. It is suggested that evaluation frameworks be examined to ensure outcomes meet expectations and clients continue to be at the centre of all changes and improvement activities.

Priority Process: Decision Support

Staff use information technology as relevant and appropriate to their practice setting. The use of CRMS is appropriate for patient/client records, registration, documentation, and financial activities and is used to document appropriate information that can be shared among team members.

The CRMS system is a provincial system used within the community sector, while the acute care sector uses Meditech. Consideration could be given to exploring opportunities to merge or inter-phase both systems to complete the patient/client record for a more seamless platform for information exchange and management.

Priority Process: Impact on Outcomes

The team is aware of quality indicators and is involved in collecting information to inform quality work. Information is shared both upwards and downwards to improve client experience and outcomes. Safety and risk are assessed and monitored to ensure risk is mitigated and decreased as much as possible.

Standards Set: Community-Based Mental Health Services and Supports - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.4 Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a high degree of alignment between the organization's leadership activities and the recommendations of the Report of the All-Party Committee on Mental Health and Addictions. There is significant evidence that the organization has undertaken a fast-tracked change management process to implement the recommendations across the mental health and addiction program areas.

The teepee care approach to service delivery that has been adopted focuses on the strengths of clients and their ability to participate in and take ownership for their own recovery strategies while accessing a continuum of program offerings as needed. Some bold initiatives are being trialed and implemented to fundamentally change the way services have been traditionally offered in a medical model of service delivery. These include same day brief interventions; co-located and integrated interdisciplinary teams; voluntary brief admission options that empower the client to identify what is needed to manage crisis and build a personalize care plan with support from a professional team; and inpatient services where the focus is on assessment, intervention, and early discharge.

The work that has been done to align programs with provincial priorities in a short time is remarkable. One area for improvement is the opportunity to develop measurable goals and objectives at the unit

level, with indicators that can be monitored and posted to provide the teams with clear evidence that their efforts are achieving desired results.

Across the board, staff and site management speak articulately about their passion for and efforts to deliver excellent care but there is no evidence that the focus is on specific targets aligned with the organization's strategic priorities. Quality is discussed in terms of episodic events that may or may not be tied to improvements in peoples' daily work. With all of the good work that is being done, using a more structured approach to operational planning at the unit level would put the organization in a better position to celebrate success and showcase the best practices that are being implemented and pioneered here.

Priority Process: Competency

Staff demonstrate that the organization supports learning and development activities in terms of orientation and ongoing development, including mandatory training, and support for the implementation of new programs such as the recovery model.

Priority Process: Episode of Care

Tracers and interviews were conducted to assess standards compliance across community mental health programs. The objective was to understand and evaluate the experience of the client and caregivers throughout an episode of care. The evidence demonstrated compliance with standards.

Documentation in client files is relatively standard across programs. There is clear evidence of compliance with quality and safety standards around things like medication reconciliation, suicide risk assessment, falls assessment, and other key priorities. Documentation of interdisciplinary care plans is stronger in some locations than others. In several cases the team identified the physician notes as the place to find the plan of care. A standardized documented care plan that indicates the integrated planning that is actually occurring would be desirable. It would also lend itself to alignment with the goals and objectives of the units.

Teams consistently adopt a strengths-based/recovery model approach to care. There is a recognition that the continuum of care may include various stops along the road to recovery and that these programs should be connected and wrapped around the client. There were good examples of collaboration among professionals and respect for how each program can add value to the experience of the client. Every program referred to the importance of effective discharge planning and talked about linkages between services to avoid duplication. A high value was placed on having access to specialized services or the short stay unit depending on the client's experience.

Client- and family-centred care is a highly valued concept in the organization. Some tools and processes are being implemented to advance this work, such as whiteboards for the efficient exchange of information, opportunities to provide feedback on services received, and the inclusion of clients and families in care conferences. There is abundant opportunity to advance client and family involvement in

programs and planning. Generally clients expressed strong satisfaction with their experiences in the system, but did not feel empowered or invited to give advice to the organization or to have input and influence into the way business is done.

Priority Process: Decision Support

There is a rigorous process for records management and protection of privacy. In most cases there is a combination of paper and electronic charting with the latter being a process of scanning hard copy documents into the Meditech system. The programs will all benefit from the electronic charting system, both for sharing of information among interdisciplinary teams and for privacy.

Priority Process: Impact on Outcomes

It is clear that safety and quality are top priorities for the organization. Staff demonstrate an understanding of and compliance with incident reporting requirements and a strong interest in quality improvement. There is opportunity to build on the quality improvement framework so point-of-care staff are more engaged and proactive in how this work is approached. Generally the feedback is that "people from the quality department will occasionally choose to do a project in their area."

There was reference to lists of quality initiatives being sent to managers periodically but there was no evidence of structured quality improvement activity at the unit level. This is not to say that quality improvement work is not being done. There was plenty of evidence of changes in the service delivery model and the introduction of improvements based on best practice and client feedback. It is suggested that the organization better define the quality improvement framework and develop and define the toolbox of resources and methodologies that is available to support units in achieving their stated goals and objectives.

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.1	Services are co-designed with clients and families, partners, and the community.		!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.		
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
7.15	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.		!
8.2	The assessment process is designed with input from clients and families.		
8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.6.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	8.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
10.7	Where possible, the presence of the client's family members in the room is accommodated when performing emergency procedures.		
Priority Process: Decision Support			
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.		
Priority Process: Impact on Outcomes			
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.		

15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Newborn Medicine Clinical Services

NICU: (28 beds), combined Level ll and Level lll. Provides critical care services to severely ill newborns. The only services not provided are cardiac surgery, dialysis, and extracorporeal membrane oxygenation (ECMO) including care of newborns with conditions that require non-critical medical and surgical intervention and close monitoring, non-infectious community admissions up to three months of age. Provides the neonatal transport team for the province and St. Pierre and Miquelon as well as babies requiring transport to and from other provinces for cardiac surgery.

Pediatric Intensive Care Clinical Services

PICU (4 beds). Diagnosis is broad ranging, from trauma, major surgery, and acute respiratory conditions to medical crisis. All ventilated patients, patients with arterial lines and insulin drips are admitted to PICU. The PICU provides care to children up to their 18th birthday with the exclusion of trauma which is up to the 16th birthday.

Top achievements for PICU and NICU since last on-site survey include:

- Weekly quality huddles started in PICU
- Family room created in NICU

• Zero percent necrotizing enterocolitis rate for 2016
• PICU has the highest percentage of pediatric critical care CNA certified nurses in Canada
• PICU has implemented standardized electronic order sets

Adult critical care services are offered at five sites within Eastern Health: Health Sciences Centre, St. Clare's Mercy Hospital, Burin Peninsula Health Care Centre, Dr. G.B. Cross Memorial Hospital, and Carbonear General Hospital. Only Burin and Carbonear intensive care units were not visited on this on-site survey.

Twelve intensivists provide care in the intensive care units (ICUs) and the cardiac intensive care units (CICUs) at the HSC and St. Clare's Mercy Hospital. Other ICUs are closed to specialists such as general surgeons and internal medicine physicians.

There was no evidence of services or parts of services being co-designed with clients and families. The organization is in the beginning stages of moving to this new approach. However, generic patient satisfaction surveys, feedback loops, and patient concerns are taken into consideration when developing goals and objectives for the programs and services. New spaces have been designed but without input from clients and families, although there is an openness and willingness to move in this direction. A change in culture at all levels will be required.

Priority Process: Competency

Staff report that the orientation to work in critical care meets their needs and contributes to their confidence and competency to work in the area. Continuing education is offered regularly and staff are encouraged to take advanced cardiovascular life support, trauma nursing core course, pediatric advanced life support, and other relevant courses.

Although performance reviews are not formal, staff feel they are getting appropriate feedback on their work performance. Staff participate in the WOW appreciation program where employees highlight their fellow workers for a job well done.

The new overhead lifts in many of the ICU beds are greatly appreciated by staff and clients. The ICUs are affiliated with the University and many different types of learners are present and an equal part of the ICU team.

Priority Process: Episode of Care

Since the last on-site survey in 2013, the critical care program has had several achievements including:

• Implementation of self-auditing for hand hygiene in all critical care units, with most units exceeding 80 percent hand-hygiene compliance.
• Provision of training on safe patient handling for all critical care staff.
• Installation of ceiling lifts to facilitate patient mobility and reduce workplace injuries in all critical care units in St. John's.

• Elimination of ICU overflow to the CICU, resulting in a significant reduction in cancellations of cardiac surgery related to lack of CICU beds.

Continued success with ventilator-associated pneumonia (VAP) and central line infection (CLI) prevention is evident. An early mobility protocol was initiated in ICU, CICU, and CCU at the HSC site, with plans to initiate the protocol in critical care units across the region. At the HSC and St. Clare's Mercy Hospital, a standardized tool has been adopted to assess pain in patients who are unable to self-report, and there is participation in the Safer Healthcare Now collaborative on pain, agitation, and delirium.

In collaboration with human resources, a comprehensive workplace assessment was conducted in the CICU. As a result, an interdisciplinary committee was established and an education schedule developed.

Education sessions have been recorded and are available on the cardiac/critical care mini-web for staff to view at a time that is convenient for them. A comprehensive review of the critical care orientation resulted in significant changes to the orientation process. A half-day education session on organ donation was offered across the province via webinar during National Organ and Tissue Donor Awareness Week.

The organization is open to having family members present during emergency procedures, rounds, and other activities in the adult ICUs, but staff were observed asking family members to leave the bedside when rounds were starting or consultants were arriving.

There is little evidence that patients and families are involved in designing or implementing processes, or contributing to measures and other collaboration opportunities in processes that impact the patient experience. The organization is committed to these changes for the future but is at the beginning stages.

Priority Process: Decision Support

Some areas of the system have electronic documentation and some still have paper charting. This inconsistency has not caused a safety issue yet as the parts that are electronic and the parts that are not have been stabilized for a number of years. The organization is encouraged to stay diligent in this area to ensure safe practices are maintained as more areas become electronic.

There is no evidence that policies on electronic communication technologies were developed with input from clients and families.

There is an opportunity to gain input from patients and families on the way quality activities and results are displayed in the critical care units, for example using whiteboards or quality boards.

Priority Process: Impact on Outcomes

The units have access to staff who are dedicated to collecting and reporting on utilization data, audit results, and results of chart audits. These staff assist with chart reviews as required and collect audit results to report to the leadership team.

The public display of hand-hygiene results on each unit is commendable and an excellent demonstration of transparency of quality improvement goals related to this important patient safety issue.

The organization is encouraged to continue to include more patient advisors and patients and families in program design, service design, quality initiatives, measurable targets, and monitoring processes. There is evidence of willingness and openness to this new approach but it has not been fully implemented or embedded in the culture.

Priority Process: Organ and Tissue Donation

Newfoundland and Labrador does not have a provincial donor registry; however, residents can indicate their intent to be organ donor on the medical care plan application or on renewal.

Organ retrieval was done appropriately and consistently in the ICUs that were visited during the on-site survey. The region does not do organ donations but sends organs to Nova Scotia, Ontario, and even the USA at times.

Organ donor support staff speak with the families as required, getting all required consent and facilitating the retrievals with a respectful and dignified approach. Staff and physicians are comfortable with all aspects of this approach.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

Diagnostic imaging (DI) is a large regional service that provides many modalities across the region. Staff take pride in their work and strive to provide safe quality care to clients and patients. The DI service has improved on issues cited in the last Accreditation Canada on-site survey. The DI department has improved the patient registration area at Carbonear General Hospital.

Wait times for services are tracked and efforts are made to improve wait times. Various strategies are used to decrease wait times across the region.

Staff are trained to perform their duties and are offered opportunities to participate in continuing education. There are various options for staff to receive continuing education such as webinars, lunch-and-learns, and lectures. This is noted as an improvement from the last on-site survey.

While staff are evaluated, this is not done regularly. Staff receive feedback in real time. A new performance appraisal system is being implemented. Staff also have the ability to expand their knowledge to allow them to work within new modalities. EH recognizes the staff's desire to change modalities. For example, a general tech may be supported to learn ultrasound. This provides opportunities for technologists to move within the department.

The DI management team works to support services across the region. Managers may have responsibilities for a particular site and also have a discipline to support from a management perspective. This appears to connect DI departments across the region.

The HSC's renovation project can be disruptive, but staff seem to accommodate the inconvenience and will see the benefits of the project once it is completed. There is an opportunity at the HSC to improve the patient registration desk. The desk does not provide adequate privacy for patients during the registration process.

The department has documents such as procedures and manuals available online; however, staff prefer the paper copies and they have printed copies and made binders for their reference. This is a risk because the most up-to-date copy may not be in the binder. Document control is currently managed through a manual system. An electronic document control system would allow easy numbering and storing of documents and provide an option for online tracking of document review.

The new nuclear and molecular medicine facility is a beautiful addition to the HSC. The area is well designed and provides clients with a comfortable location for testing. Consultation with families and clients was conducted during the development process and changes to the design were made from the feedback provided. A nuclear physicist has also joined the team to support this department. Adding the positron emission tomography scanner will provide state-of-the-art testing for Newfoundland and Labrador.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.		!
Priority Process: Episode of Care			
10.2	The assessment process is designed with input from clients and families.		
10.5	Medication reconciliation is initiated in partnership with clients, families, or caregivers for clients with a decision to admit and for a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).		ROP
	10.5.1	Medication reconciliation is initiated for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers, and documented. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.	**MAJOR**
	10.5.2	The criteria for a target group of non-admitted clients who are eligible for medication reconciliation are identified and the rationale for choosing those criteria is documented.	**MAJOR**
	10.5.3	When medications are adjusted for non-admitted clients in the target group, a BPMH is generated in partnership with clients, families, or caregivers, and documented.	**MAJOR**
	10.5.4	For non-admitted clients in the target group, medication changes are communicated to the primary health care provider.	**MAJOR**
Priority Process: Decision Support			

14.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The EDs are part of a single program. This has facilitated standardization of processes, clinical leadership, and quality. EH has 24/7 emergency services at 13 sites.

EDs in Eastern Health collect typical process data such as volumes, wait times, time to see physician, and left with out being seen (LWBS). This information is used to determine staffing patterns and also provides opportunities for process improvement.

There have been several improvements to space and flow capacity at the HSC such as the creation of the RAZ - or rapid assessment zones. Patient privacy has been addressed as much as possible within the confines of the infrastructure. There are private rooms for families and isolation capacity as required.

An electronic record is available. Although physicians and nurses chart on paper, each chart is scanned into Meditech and is available online for subsequent visits.

At St. Clare's, concerns raised by patients about confidentiality at registration have been addressed with some infrastructure changes.

At the Janeway there continue to be concerns about signage in the ED. This is an opportunity to engage families and patients in finding solutions.

All sites reviewed had access to required supplies and equipment.

Priority Process: Competency

Clinical education is supported and good team dynamics were observed at all sites. Workload is shared and all available staff pitch in to provide optimum care to patients. The weekly simulation exercises at the Janeway are excellent for practicing collaborative care and ensuring staff competencies.

The organization is encouraged to find creative ways to provide coaching and feedback to clinical staff, as performance appraisals appear difficult to perform in this high acuity setting. Use of the WOW staff recognition program was visible in the departments.

Staff at all sites commented that previous security concerns had been addressed and that the current security personnel are responsive and helpful if needed.

Clinical educators are available and instrumental in making staff feel comfortable about new processes and technologies.

In the metro area all pediatric emergencies are handled by the Janeway but in rural areas staff have access to education, training, and supplies for pediatric populations that can be safely handled in those communities. The Janeway is a provincial resource for pediatric medical emergencies and also for advice and expertise regarding pediatric concerns.

The program is commended on its welcoming approach to learners and students of many disciplines.

Priority Process: Episode of Care

Excellent transfer of care documentation and reporting were observed. The SHARE tool was developed in house and is used to document transfer of accountability when the patient leaves the ED.

The Canadian Triage and Acuity Scale (CTAS) is now used at all sites, with the pediatric CTAS being used for that population. Falls risk is assessed and documented and allergy alerts are obvious.

The larger EDs are struggling with medication reconciliation at admission. The teams are encouraged to continue to work on this and look for innovative ways to make the capture of information less onerous

for clinical staff. In other jurisdictions this has meant finding dedicated resources or using "duty to accommodate" staff.

Staff see the introduction of the electronic whiteboard at the HSC as a welcome improvement, supported by the clinical educator. Training and support for implementation at other sites is underway. Communication among HSC staff is enabled by Vocera.

At the Janeway, staff have developed a suicide risk assessment and sepsis protocol that are more appropriate for pediatric populations. They are encouraged to continue to work on the falls risk assessment Required Organizational Practice.

During the on-site survey, compassionate and person-centred care that followed the patient throughout their journey was observed. Families were given privacy and support during difficult situations.

Priority Process: Decision Support

The organization and the program measure and monitor ED statistics as indicators of patient flow. Reports are discussed at the Emergency Quality Council and are available to staff on the intranet. The program section on the intranet is well organized and helps staff see what is new and follow the ED scorecard.

Policies and procedures are regularly updated and available to all staff.

Chart audits are done throughout the program to ensure consistency. Patient charts at all sites were observed to be complete with all information recorded appropriately. Nursing and physician notes were well done. However, there is a legibility issue with some handwriting. An electronic chart system would eliminate this potential patient safety issue.

Priority Process: Impact on Outcomes

The EH Quality Council has representation from across the region and includes front-line staff. The council is active in promoting standardization and quality initiatives.

The chief of staff is commended on the strategies to monitor and address physician quality and variation.

The sites use their ED scorecard to identify priorities for quality improvement. The regional LWBS is an issue for some locations even though the regional average has come down. LWBS are recorded and referred to the provincial health line for follow up, particularly with CTAS 3. The main reason for leaving in the past has been wait times which are being addressed through patient flow initiatives.

EH has set a target that 50 percent of patients are seen by the nurse practitioner or doctor within 60 minutes. The smaller sites are doing well and there has been improvement at the adult sites toward this target.

At the clinical interface there is excellent family and patient involvement in care processes. There have been some examples of responses to complaints by patients and family as well as patient involvement in creating comfortable and pleasing spaces. The next step is to have patients and their families actively participate in quality reviews and projects. The Quality Council is currently recruiting for patient advisors.

Priority Process: Organ and Tissue Donation

Staff have had education on the policy. When there is a potential donor, the organ donation team is immediately identified and the response is immediate. At the pediatric site the opportunity for organ donation is rare; however, when it happens the team is prepared.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
5.20	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.22	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
6.7	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
23.9	There is a process to monitor and evaluate record-keeping practices, designed with input from patients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
25.3	There is a standardized process, developed with input from patients and families, to decide among conflicting evidence-informed guidelines.	!
26.1	A proactive, predictive approach is used to identify risks to patient and team safety, with input from patients and families.	!
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from patients and families.	!
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from patients and families.	
27.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from patients and families.	
Priority Process: Medication Management		

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Metro Paramedic Services, located at the HSC, provide local land ambulance and patient transport service for the St. John's metro area. Annual call volume for fiscal year 2016–17 was 23,887 (one-third of provincial call volume). Staff comprise primary care paramedics and advanced care paramedics (58 FTE).

Carbonear Paramedic Services are provided from Carbonear General Hospital and only do emergency calls. Staff at Carbonear are dual qualified primary care paramedics and licensed practical nurses (9 FTE) and perform a dual role: assisting with in-hospital care and responding to ambulance requests as required.

Provincial Medical Oversight (PMO) is the provincial registrar for ambulance vehicles and ambulance personnel, with approximately 1,000 registrants. PMO provides medical oversight for paramedic practice throughout the province with standardized patient treatment protocols, quality assurance, and continuing education. Examples of ongoing quality audits include a review of all cardiac events and audits of 10 percent of case files for code 4 (most serious). The provincial land ambulance annual call volume is about 60,000 calls using approximately 170 ambulances.

The ambulance system in EH and the province has been described as "tangly" as it consists of EH, private, and municipal services. Coordination of care can be complicated and makes it hard to introduce standardized processes across providers. There have been several reports and reviews outlining the issues and potential solutions. Eastern Health EMS is encouraged to continue to look for opportunities to lead provincial quality improvement initiatives.

EH paramedics provide medical assistance at numerous community events. In St. John's they also visit day care centres and organize injury and health promotion activities such as the Protect Your Pals program in schools. However, there remains a concern among some staff that other professionals in EH, as well as the public at large, do not understand or value the role they play in the health system. The organization is encouraged to find opportunities to include paramedicine in its communication plans.

Priority Process: Competency

Qualifications and annual licensing competencies are set provincially and monitored for compliance by the PMO. Some staff expressed an interest in additional training and learning opportunities outside of those required for licensing. Students in paramedicine are welcomed and mentored as part of their practicum requirements. At Carbonear the paramedics are part of and often lead the regular site-based emergency area education sessions.

Although performance appraisals have not been routine, the managers do provide coaching and mentoring to staff as needed.

Staff may request counselling and help with stress through employee assistance at Eastern Health. Peer-to-peer help is also available. In some circumstances fire and/or police will invite EMS staff to their debriefing sessions. The EMS leaders are encouraged to provide education on stress recognition among staff and ensure crews have an opportunity to debrief soon after difficult calls.

Priority Process: Episode of Care

During the on-site survey, there was an opportunity to accompany crews on an interfacility transfer and an emergency call. At the HSC, transfers may be scheduled for a particular time, and this is accommodated unless there are emergency demands on the system. At Carbonear, the team only does emergency calls as they have only one ambulance.

The dispatch staff and the crew are in communication throughout an emergency call. It was reported that there is no problem getting police assistance if required. Patients are assessed and treated using standardized protocols. Medical oversight is always available through PMO. Patients are secured and monitored during transit. Treatment protocols are followed and recorded. The paramedics observed were compassionate and respectful with patients and their families. Patients and families interviewed during the survey expressed satisfaction with the EMS service provided by Eastern Health.

There is frustration at the HSC site because of overcrowding, fumes from the garage, and lack of storage. Fortunately the new dispatch centre for the HSC is almost finished and there are assurances of solutions for some of the issues. It is suggested that infection prevention and control do an assessment of the cleaning bay as there is no sink available and there is potential for spray contamination. The concern at Carbonear is that there is no inside ambulance bay, which makes it difficult during inclement and cold weather.

The organization is encouraged to include EMS staff and sites in the walk the talk rounds.

Priority Process: Decision Support

Records are paper based but standardized across EH and the province. The charts and records reviewed were clear and complete. Security and confidentiality of the patient record was observed. The record has multiple carbon copies which can become illegible by the bottom sheet. The introduction of an electronic system will solve this issue and make the information gathering and transfer process more efficient.

During assessments, paramedics obtained and documented information from the patients and their families in a respectful and professional way. Information was shared appropriately with ED staff at the time of transfer.

Dispatch and communication staff keep detailed records of the calls. Mining data from calls is difficult due to the lack of technology.

Priority Process: Impact on Outcomes

The provincial government requires EMS to report on basic volumes and response times. Collection of this information is manual. Clinical indicators are difficult to aggregate. At Carbonear the staff have developed a spreadsheet approach to gathering data and there is more information available at this site.

There are limited resources to develop a quality plan for EMS.

There is no clinical educator for this program. It is suggested that the organization develop a quality and patient safety plan specific to EMS.

Priority Process: Medication Management

Narcotics are treated appropriately and double locked (case and truck) at the HSC. There have been no incidents involving narcotics safety. Carbonear EMS does not use any narcotics.

Priority Process: Infection Prevention and Control

Ambulance patient areas and stretchers are cleaned and disinfected after each patient. It was noted by some staff that the steering wheels and consoles are not wiped down enough.

EMS staff hand-hygiene audits are usually done when paramedics are in the ED or on the floors. It can be difficult to determine which staff are from EH and which are from other ambulance crews. The leaders are encouraged to explore ways to gather more meaningful data for this service.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
15.1 Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The home care program provides essential and supportive services and activities to community members in remote and rural as well as urban settings. The program takes on an added and inadvertent role in connecting clients in remote and rural areas with each other and with support networks to help maintain them at home in a safe and secure manner. The interaction between staff and clients is commendable especially in rural and remote areas where health care providers are the lifelines for many older and disabled clients.

Staff are visibly dedicated, enthusiastic, and energetic in their communication and delivery of care, taking into account the needs of the clients within the context of the program and the resource limitations. There are ample opportunities for staff to meet with each other and exchange information, knowledge, and practice ideas, always with the aim of improving service levels and quality.

A significant amount of work is done as a result of team collaboration and involvement of clients and community, although some of the communication around outcomes and service delivery may not be formally shared with staff and clients. It is suggested that more visible venues be considered to share information and enhance transparency and communication internally and externally. This may be done in the form of communication/quality boards.

Priority Process: Competency

The home care services team is a highly functioning and collaborative team. There is a significant level of investment in staff and attention is given to providing the team with sufficient resources, information, and education to facilitate delivery of high-quality, competent, safe care.

The online educational system LEAP is highly used by all staff and contains all pertinent information to support staff in their day-to-day work and activities. A number of key positions are responsible for and dedicated to staff education (i.e., clinical educators, quality coordinators). In turn, most of the staff engage in ongoing client and family education and support clients and their families as appropriate and relevant to their condition and needs.

The organization is encouraged to continue to solicit clients and families with regard to their needs and educational requirements to improve and support healthy living and client outcomes.

Significant collaboration and community involvement and consultation takes place at the Bonavista peninsula through the primary care initiative. This initiative has allowed community members and health care providers to come together and exchange information, thoughts, and ideas with regard to service delivery, roles and responsibilities of health care providers, and community needs. This is a great initiative to improve services and enhance the client- and family-centred care approach.

Priority Process: Episode of Care

The home care program takes a collaborative approach to client management and service delivery. A range of tools and standards are followed as part of the EH's mandate in delivering health care services. Many of the activities and actions rely on regional standards, processes, and forms.

Continuous auditing cycles ensure staff adhere to expectations and are provided with appropriate and relevant education to help maintain knowledge and competence to deliver high-quality, safe care. Client assessment and service coordination occurs on a regular basis and adjustments are made to meet clients' changing needs and condition. Significant emphasis is placed on identifying, monitoring, and eliminating risk as much as possible. Clients and families are made aware of their roles and responsibilities in managing risk and safety concerns. There is clear communication among staff when risk is identified and specific alerts are indicated throughout the client charts, both online and paper.

This is a well-functioning program with defined service delivery standards and expectations. Ongoing communication occurs at all levels and among providers and clients and their families. The team uses standard forms and tools to relay information internally and externally to ensure client transitions throughout the system are as seamless and smooth as possible.

Priority Process: Decision Support

The team follows standard policies and procedures related to the management and transfer of information and client records. A combination of online and paper charts is used, in the form of the CRMS and paper charts. As well, elements of Meditech are used to manage information flow and transfer.

Authority-wide policies with regard to record keeping and maintenance are followed at all sites.

Priority Process: Impact on Outcomes

There is a significant emphasis on collaboration and client participation in decision making and team activities and services. The primary care initiative rolled out in the Bonavista peninsula has created a significant opportunity for community involvement and client empowerment in terms of soliciting and incorporating client needs, wishes, thoughts, and ideas into the design and delivery of services, staff education, and training.

Clients and families are made of aware of their rights and responsibilities and are empowered to voice their needs and concerns should any arise. There is honest and open communication among staff members, as well as health care providers, clients, and families. The sites are aware and informed of regional quality indicators and information is widely shared with staff at staff meetings and via other communication means such as emails.

Across the program and more specifically in the remote areas, technology is incorporated as much as possible to deliver care in the form of telehealth, telephone consultation, and virtual visiting. There is significant attention to staff and client safety. The use of technology such as the safety line is commendable and staff appreciate the sense of safety and security knowing that they are able to access help should they need it. The organization is encouraged to consider implementing quality and communication boards that are accessible and visible to the public in specific locations and sites.

In an effort to improve and enhance communication and transparency in relation to quality improvement and quality initiatives, it is suggested the organization consider additional avenues to share information with staff, clients, and families. It is also suggested that specific sites consider developing and monitoring site-specific quality indicators and quality improvement plans that would be of value to the local population and staff beyond the regional quality indicators and quality activities.

Standards Set: Hospice, Palliative, End-of-Life Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

The regional palliative care service is an integral part of the rehabilitation, continuing, and palliative care program. The objective of the service is to provide clients and their families with equitable and comprehensive palliative care and support throughout the region.

The palliative care network consists of five regional sector teams: the urban community sector team (home and community care in St. John's), the LTC sector team (long-term care in St. John's), the regional acute care sector team (acute care hospitals in urban EH), the rural avalon sector team (home and community health, long-term care and acute care for Avalon area), and the peninsulas sector team (home and community health, long-term care and acute care for Clarenville, Bonavista Peninsula, Marystown, and surrounding areas).

The role of the palliative care leadership team is to develop EH's palliative care services based on national norms and practices and provide direction, consultation, support, and education to each of the five sector teams.

The program provides essential and compassionate end-of-life support and services to accommodate the needs of clients and families in hospital (acute and long-term care), from outpatient clinics, and at home. The Dr. Leonard A. Miller Centre (LAMC) palliative care unit is a 10-bed inpatient unit that accepts admissions from acute care, the cancer clinic, and home.

All team members are very passionate about their contributions to the care and support provided for clients and families in the palliative care program.

Priority Process: Competency

Team members are knowledgeable and practice a client-centred approach. With changing community diversity, the organization is encouraged to ensure all team members are aware of and know how to access the translation line. Staff, physicians, and volunteers might benefit from cultural safety training.

Staff describe receiving a sufficient orientation to the service and have access to learning and development activities such as the LEAP (Learning Essential Approaches to Palliative Care). Training and education requirements for staff have been influenced indirectly by feedback from clients.

Team members have frequent touch points with their supervisor and appreciate getting regular formal feedback on their performance.

Priority Process: Episode of Care

The program offers a collaborative approach and a wide range of services including education, consultation, grief and bereavement education and therapeutic counselling for individuals and groups, and system navigation and palliative care services at the Dr. Leonard A. Miller Centre and the Carbonear General Hospital.

Grief and bereavement services consist of individual counselling, client and family education on the experience of grief and bereavement, an eight-week group bereavement program, and referral to various community support groups, including the Spousal Grief Support Group, the Parent-Loss Support Group, the Survivors of Suicide and Loss Support Group, and the Compassionate Friends (parents and grand-parents who have lost children). Family and informal caregivers say they are supported throughout the palliative journey.

The program receives many referrals and requests for consultation which are triaged to ensure the most vulnerable are considered first. Navigation services are critical for clients and their families in coordinating care and understanding the options available.

The program has successfully implemented standardized and validated assessment tools such as the palliative care performance scale and Edmonton Symptom Assessment System. The Braden score is used to assess skin integrity and the assessment is routinely updated based on the score results. A standardized assessment tool for pain management is in place. A falls risk assessment is completed on admission and clients at risk of falling are identified and appropriate measures are taken to minimize that risk. Home-based clients are also assessed and the team includes occupational therapy to assist in risk mitigation.

Care plans are modified daily and as needed in response to the client's situation.

Medication administration was observed with the appropriate safety checks in place. Independent double checks were observed for high-alert narcotics, two client identifiers were obtained, client assessment prior to administration was comprehensive, and the correct agents were administered safely. Allergies are clearly documented on client records. Team members are aware of their responsibility to report adverse drug events.

The team is acknowledged for its completion of medication reconciliation on admission. Do not use/dangerous abbreviations were not observed in this service area. Competency training for use of infusion pumps is delivered for all applicable team members.

Volunteers are an integral part of the team and they are often former consumers of the service. They provide invaluable formal and informal feedback to the organization. They are well respected by team members, clients, and families for the value they bring to the service. There are stringent requirements to becoming a volunteer which may deter some potential applicants. The volunteer coordinator provides quarterly reports to the site manager and to the volunteer lead. A volunteer handbook is being drafted and the organization is encouraged to approve this valuable resource.

The organization recognizes staff and volunteer grief and compassion fatigue and is piloting a support program for staff at St Clare’s Mercy Hospital. Team members also have access to EFAP and the medical association provides Employee and Family Assistance Program (EFAP) for its members.

This dynamic and passionate team is recognized for its integrity and for doing everything possible for the clients in the program.

Priority Process: Decision Support

Team members (including physicians) use the Meditech system to ensure comprehensive documentation, although medication orders still have to be hand written. The organization is encouraged to pilot a comprehensive electronic medical record that could be used by caregivers delivering services from acute care facilities, outpatient clinics, and homes to create efficiencies, improve medication reconciliation, and support the sharing of client information within the interdisciplinary team.

The program team shares best practice information and current literature and selects evidence-based guidelines for the provision of care.

A survey conducted in 2010 of all expected deaths provided a wealth of information to this service and perhaps has value in other programs. The organization is encouraged to provide support to repeat this survey.

Priority Process: Impact on Outcomes

The organization is acknowledged for having participated in process improvement training as a structured approach to quality improvement.

The team strives to respond to all consults within 48 hours and is able to triage these potential clients based on set criteria.

The organization is recognized for opening the pain and symptom management clinic (an outpatient clinic) to increase access to services for ambulatory clients.

Clients and families are very satisfied with the support and services they receive from this service.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
5.2 Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

The IPC team has made many improvements. The facilities are aging and offer challenges when trying to provide safe care from an IPC perspective. Facilities have been upgraded and dedicated handwashing sinks have been installed in many locations. Further improvements have been identified. Patient rooms at the HSC are small and more work needs to done to prevent mixing clean and dirty supplies and procedures. Work has been done to separate dirty and clean equipment but storage is an issue as space is limited. Strategies are being developed to help staff identify what equipment is clean and dirty and who is responsible for cleaning equipment. The St. Clare's site has identified areas where separation of clean and dirty supply and storage is also an issue. Work needs to continue to develop strategies to separate clean and dirty.

Hand-hygiene education has been provided to staff. There have been improvements in the hand-hygiene rates and staff are aware of these rates. Implementing staff auditors has helped embed the importance of hand hygiene at the unit or department levels. Results are posted on the units and the use of television screens allows staff and clients to be aware of how the organization is doing with hand hygiene. In departments without television screens the information has reached the front-line staff. Staff in long-term care and acute care have made improvements in this area.

The hiring and orientation of new staff has changed. There has been a move away from the one-day orientation; this is now achieved through online modules. There are many benefits to this type of change but it needs to be formally evaluated to ensure expected outcomes are achieved. During the hiring process staff are screened for appropriate immunizations. While provincial guidelines are followed, there is no organizational policy stating that the guidelines are being followed. There are policies for hepatitis and flu vaccines; however, more immunizations may be recommended for health care providers.

There are many construction projects underway at many sites. These projects have involved IPC staff, offering protection for staff and clients.

The kitchen facility is located outside the hospitals. The facility is well maintained and staff are trained to follow appropriate procedures. Work has been done to ensure transport vehicles are properly cleaned

before each delivery. Construction has started on the units in the HSC and the St. Clare's Mercy Hospital to allow for a new system of food handling that will permit heating meals on the units. This process will need to be carefully monitored and an evaluation conducted once the project is completed.

The laundry facility, located outside the hospitals, is aging. Soiled linen is delivered to the laundry by trucks. The trucks are cleaned between the dirty and clean deliveries. Some laundry carts are not covered during the shipping of dirty laundry. The laundry bags and sometimes loose laundry are placed on the open-sided cart. Carts are washed prior to having clean laundry put on the cart. It was identified that improvements have been made and fewer sharps are being seen in dirty laundry bags; however, there was garbage such as soiled gauze in the laundry bag. Laundry staff wear protective equipment during the sorting process. Staff education may be necessary to have staff better understand the risks on the laundry floor. Visitors should not be allowed on the laundry floor.

St. Luke's staff have made many improvements and are working on an action plan to improve handling of clean and soiled items.

Many of the facilities have wooden surfaces and these are difficult to clean. A policy has been developed to direct staff on appropriate fabrics to be purchased as items such as chairs are replaced.

There is a policy for flu and hepatitis B immunization for staff. This needs to be expanded to include other immunizations that are outlined in provincial guidelines.

The organization uses loaned or leased equipment, but there is no organizational policy to cover how these items are handled. While staff understand procedures to followed, a policy is not available.

Continuous improvement is evident in all areas. The IPC group is reviewing badges to help identify if staff are using the gel-based hand-hygiene stations prior to entering and after leaving patient rooms. Implementation of the adenosine triphosphate (ATP) technology will help staff evaluate cleaning programs.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.15 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
8.5 Medication reconciliation is conducted in partnership with the resident, family, or caregiver to communicate accurate and complete information about medications across care transitions. 8.5.5 Upon transfer out of long-term care, the resident and next care provider (e.g., another long-term care facility or community-based health care provider), as appropriate, are provided with a complete list of medications the resident is taking.	ROP **MAJOR**
11.1 Policies and procedures for POCT are developed with input from residents and families.	
Priority Process: Decision Support	
13.8 There is a process to monitor and evaluate record-keeping practices, designed with input from residents and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes	
15.2 The procedure to select evidence-informed guidelines is reviewed, with input from residents and families, teams, and partners.	
15.3 There is a standardized process, developed with input from residents and families, to decide among conflicting evidence-informed guidelines.	!
15.4 Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from residents and families.	!
15.5 Guidelines and protocols are regularly reviewed, with input from residents and families.	!

16.8 Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from residents and families. !

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Long-term care services across the region are designed to provide comprehensive services to the elderly with consideration for residents' needs, wishes, and requirements. Residents are assessed on admission and specific goals, objectives, and care plans are established and reviewed on an ongoing basis with input from staff, residents, and family members as relevant and appropriate.

There are policies and processes in place to facilitate a seamless and welcoming environment to address the range of needs and the delivery of quality and safe care.

Priority Process: Competency

There is significant evidence to demonstrate the organization’s commitment to continuing education and staff training. There is a comprehensive orientation and ongoing education is provided through the LEAP, an online internet-based training and development system available on site and remotely to all staff.

The range of educational modules and topics is in keeping with provincial requirements and standards, as well as professional and role-based requirements that support staff in the delivery quality, safe, and competent care. Staff are provided ample opportunities for personal and professional growth and development in the form of conferences, courses, and skill training. One example is the Learning Leader program developed in house and available to staff who wish to develop and grow as future leaders in the organization.

The team uses standardized communication tools and follows organizational policies and procedures when transferring information related to resident care and other care activities.

There is a significant emphasis on teamwork and collaboration and respectful work environment, as shown by the creation of diversity committees and the recognition of employees who are part of the LGBTQ community.

Additional benefit may be gained through formal sharing of such activities and events in the form of quality and communication boards to engage the wider public, residents, and their families and enhance transparency, knowledge, and information transfer.

The performance appraisal policy and procedure is being revised. Performance is expected to be evaluated at regular intervals. Staff and managers are aware and informed of this, and there is a plan to embark on appropriate activities to meet this criterion.

Priority Process: Episode of Care

A comprehensive admission and assessment process is in place in the organization and throughout the long-term care program. Residents and their families are interviewed and provide input into care needs, requirements, and wishes, and a continuous process is in place to assess care goals and objectives throughout the residents' stay.

Residents and families are informed and educated with regard to their rights and responsibilities and are followed up throughout their stay to ensure no significant changes have taken place with the team's ability to recognize and respond to any changes. The team is highly collaborative and demonstrates significant commitment to teamwork and respecting residents' wishes through customizing care plans and ongoing review and assessment processes. Good communication is evident through the use of standard communication tools and the availability of online and information technology tools.

Significant emphasis is given to providing a respectful work environment as well as to recognizing, addressing, and mitigating risk and abuse of both residents and staff. A comprehensive complaints process is in place for staff, residents, and families to identify and address concerns and issues.

This is generally a well-organized program with highly committed staff. The organization may want to consider implementing communication/quality boards to enhance information sharing, communication, and transparency throughout the program areas and with residents and their families.

Priority Process: Decision Support

The organization uses technology and information systems to deliver, monitor, and document the range of services provided to the residents and their families. The availability and use of technology to deliver services contributes to the smooth and seamless transition of residents throughout the system and the transfer of pertinent information to avoid gaps in service delivery and ensure continuity.

Opportunities for improvement and increased effectiveness and efficiency exist in the form of addressing and reducing the number of client/resident records and moving from a combination paper/electronic chart into one system. There is also an opportunity to amalgamate different electronic systems into one for improved record keeping and information transfer (Meditech Magic and Meditech client server).

Priority Process: Impact on Outcomes

The long-term care program demonstrates a significant commitment to staff and resident safety and to the use of data and quality indicators to understand trends. Service needs are completed on a regular basis and in a collaborative manner through regular reporting and support from the quality and risk specialists.

While there are many informal instances where program managers and coordinators engage residents and families to provide input and feedback on various quality and risk elements, this practice is not

consistent or formalized. There is a significant focus on staff and resident safety and an abundance of education is available to help staff achieve a safe and respectful work environment.

There are opportunities to develop specific frameworks and guidelines to help staff engage residents and family members in a more formal and consistent manner. Although most organizations have structured family and resident councils, participation on those councils remains inconsistent. As such, there may be additional avenues to solicit input and feedback from residents and families, such as the creation of a general email address to invite the public to share thoughts and opinions.

Communication and sharing of information might be improved through communication and quality boards, to help the organization share with residents and families information on quality and performance and enhance communication and transparency.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
3.1	The interdisciplinary committee sets criteria for adding and removing medications to the formulary.	
4.4	The effectiveness of training activities for medication management is regularly evaluated and improvements are made as needed.	
11.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	!
11.4	The limits set for soft and hard doses are regularly tested to make sure they are working in the smart infusion pump.	!
11.5	The limits set for soft and hard doses are regularly reviewed and changes are made as required.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

The Pharmaceuticals and Therapeutics Committee is responsible for activities regarding the safety and quality of the medication management system and all matters related to the use of pharmaceuticals. It is encouraged to ensure the roles and responsibilities outlined in the terms of reference describe all of the oversight functions expected. The organization is encouraged to ensure policies are broadly communicated and implemented so as to achieve intended outcomes.

A Pharmacy Quality Committee has recently been formed to shepherd quality improvement initiatives related to medication management. The committee has assessed gaps, created policies, and worked to successfully implement many initiatives. It is suggested the committee recruit client/family representatives while it is in its early stages.

The antimicrobial stewardship program is a successful collaboration to optimize antimicrobial use and reduce the risk of infections and levels of antibiotic resistance. Data regarding antimicrobial consumption in adult acute care (defined daily dose/1000 bed days) was compared with data from the QE2. This resulted in quality improvement initiatives including recommendations for order sets and the use of Ciprofloxacin in the surgical program. It is suggested that results and recommendations be shared with the Medical Advisory Committee.

The organization is recognized for its well-documented and coordinated approach to safely manage high-alert medications.

Staff members have received the education and training necessary to safely administer medications. Training on the medication management system is reported to take place at orientation and ongoing. The organization is encouraged to evaluate these training activities and make improvements as needed.

The organization is commended for enhancing clinical pharmacist services by re-aligning resources from within using a clinical pharmacy specialist position, and emphasizing rural areas.

Staff report having the information they need to safety manage medication processes and were observed using UpToDate, the online formulary, Healthe NL, and other resources.

The organization is exploring new smart pump options and is encouraged to pursue this for high-risk medications. A smart infusion pump maintenance team has just been formed to support clinical programs. Safety concerns are noted with different pumps being used in critical care areas. This is a potential risk when team members are expected to work between sites.

There are space pressures in some pharmacy departments and while the team has been creative in the short term to maintain a safe environment, the organization is encouraged to analyze current and potential requirements.

Unit dose and Pyxis technology are used to dispense medications in client service areas. The organization is commended for the development and approval of an ambitious timeline to expand Pyxis to all acute care hospitals by 2020. Since the previous on-site survey 21 machines have been added with 13 more expected by 2018. The resulting impact on safety is evident.

The organization has identified a list of abbreviations, symbols, and dose designations that are not to be used and has completed audits on their use. Staff and physicians have received education with regard to this list. Use of the abbreviations OD and sc or s/c were observed during the on-site survey. The organization is encouraged to identify and communicate with prescribers who use these dangerous abbreviations.

The organization is encouraged to review the most recent version of the formulary and develop criteria for removing medications.

A review of medication orders for accuracy and appropriateness is conducted consistently throughout the organization. Chemotherapy, IV, and TPN prep were observed being safely prepared in a sterile field with appropriate protections for the compounder. The organization has completed a chemotherapy gap analysis.

Medication administration was observed to have the appropriate safety checks in place. Independent double checks were observed where required, two client identifiers were obtained, client teaching was comprehensive, and the correct agents were administered safely. Allergies are clearly documented on client records.

Team members are aware of their responsibility to report adverse drug events and concur that the culture is becoming one of no blame. Incidents involving medications are reviewed, monitored, and reported by the organization with appropriate disclosure. Family members and clients state that they are made aware when there is a medication change and know who to talk to if they have questions.

The organization has identified medication reconciliation compliance rates as a key performance indicator in the 2017–2020 strategic plan. There is a consistent approach to obtain a best possible medication history (BPMH) and medication reconciliation on admission. Audits have been completed in all areas surveyed. It is suggested that areas with low compliance rates receive additional attention.

The organization is recognized for its ambitious plan to ensure medication reconciliation at transfer and discharge. It has been implemented at the Dr. Leonard A. Miller Centre in adult rehabilitation services and was also observed on discharge for several surgery patients. The organization is encouraged to ensure the necessary software is working well, nurses and physicians receive the training required, clinical pharmacist support continues, and successes are celebrated.

The organization is commended for receiving the BD and Company Hazardous Drug Safety Award at the platinum level. The award recognizes organizations that are committed to health care worker safety and process improvement in hazardous drug safety through leadership, best practices, innovation, and change management expertise.

The organization’s pharmacy leadership is diligent and committed to enhancing the quality and safety of the program. Their ongoing advocacy for the role of clinical pharmacists is noted and appreciated by many.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.5.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

EH's adult medicine program is widespread, with eight locations in addition to ambulatory and outpatient services across the region. There are 286 adult medicine beds and approximately 900 people work in the

program. There are secondary and tertiary responsibilities. Rheumatology and oncology are examples of provincial adult medicine programs.

The pediatric medicine program is centred mainly at the Janeway Hospital, which has 22 inpatient beds. There are one or two beds at other sites such as Carbonear, but it is expected that pediatric patients will be admitted to the Janeway. A number of specialty outpatient clinics occur weekly at the Janeway. The program is housed within the Women and Child Health program. The programs are regional, but hematology and oncology are examples of provincial programs provided by this service.

Quaternary services, such as the provincial genetics program, provide services to both adults and children.

The regional director for adult medicine services has recently joined the program, inheriting a strong quality framework put in place by the medicine team. There are strong leadership teams for adult and pediatric services with program managers, care facilitators, and clinical educators. Team members spoke of team function as a major strength of both services. Visibility of and mentoring by the leaders were acknowledged and appreciated by staff at all sites visited and are a tremendous strength of the programs.

A number of partners, both internal such as inpatient surgery at the Janeway and emergency at the adult sites, and external such as Heart and Stroke, are involved in planning and service design. There are linkages between the adult and pediatric programs, such as hematology. Both services discussed the desirability of pursuing further opportunities for collaboration.

The organization is implementing client- and family-centred care. There are examples of client and family involvement in designing and implementing services, such as the design of the new dialysis centre, and the family presence policy at Carbonear. Several examples, such as the design of the new dialysis unit, the ACE or acute care of the elderly, and the HIV program, were implemented using the results of patient, family, and staff surveys and information. Families have always been an important partner in the delivery of pediatric services. However, the formal involvement of clients and families on committees and decision-making elements of the organization is just being considered. Leaders suggest that quality and safety committees may be the best first steps to integrating clients and families into medicine programs. Moving ahead with implementation of this initiative is encouraged.

Space limitations at the HSC were discussed with staff. There are few wheelchair accessible washrooms and some four-bed rooms are expanded to five or even six beds when the hospital is at overcapacity, creating concerns for privacy, cleanliness, and falls. Overcapacity is related to the presence of alternate level of care patients, who represent 10 to 15 percent of the adult census at the HSC and the adult medicine program. The organization continues to monitor and deal with overcapacity. There is no concern regarding overcrowding at the Janeway, which is child- and family-friendly.

There is close collaboration with Memorial University in all aspects of care. To resolve some of the issues regarding service delivery and other concerns noted by the Royal College of Physicians and Surgeons of Canada, nurse practitioners have recently been introduced at St. Clare's Mercy Hospital, and other models for provision of medical care are being considered.

Priority Process: Competency

A standardized site and unit orientation program combined with mentoring is available on the adult and pediatric units for all staff starting work with the medicine program. Staff reported feeling well equipped and supported as they began their work with this program.

There are clinical educators in pediatrics and adult services who provide education to staff on a regular, formalized basis and as needed. There is only one educator for the three nursing units covering multiple subspecialties at the HSC. It seems unlikely that one person can provide the education needed for staff in all these subspecialty and general medicine areas, so consideration of current needs and opportunities is suggested.

Many units in this program use goal navigators who are assigned to work with patients and families to review, encourage, and assess goal achievement. This is a good mechanism to engage patients and families in care, and it offers opportunities to improve efficiency.

There are multiple opportunities for continuing education for nursing and allied health personnel in the adult and pediatric programs. Many of these are local, with sessions such as lunch-and-learn discussions and annual or biannual education days. Agendas for these sessions are often based on staff needs as well as organizational requirements. Funds for off-site learning, such as conferences, are limited, and mostly available through foundation and union support. EH is able to contribute more recently to continuing education for its staff, and this wise investment in growth and education is encouraged. An online learning resource known as LEAP has been developed to allow staff to learn at times suitable to them and about subjects of interest to them. Mandatory learning requirements are available through this program. The clinical educators are also available to staff on a just-in-time basis for learning. Both programs track uptake of the mandatory and elective learning offerings.

Human resources for the staffing of pediatric and adult units are generally felt to be adequate. At the HSC site, a concern regarding retention of staff was discussed, along with the possible factors affecting this. Senior leadership is working to develop strategies to deal with this concern. At the Janeway, some allied health report being stretched very thin between their inpatient and ambulatory caseloads, and a continuing assessment of patient needs and opportunities is suggested. The outpatient rehabilitation team confirmed this concern.

A clinical pharmacist is part of the hematology team at the HSC. Pharmacists are available as requested for the other units and teams, but are not assigned to them. Additional pharmacist resources would make a significant difference for some of the other subspecialty teams, such as oncology. Consideration of possible changes to the way pharmacists support the medicine units is suggested.

Performance evaluation is inconsistent across medicine services. Formal evaluations of nursing staff every two years are not being regularly done by the managers at the HSC. The program is moving toward

goal-based assessments and the managers believe that just-in-time feedback will be helpful for them and their staff. An online self-initiated program for feedback and assessment is in its early stages. Staff were aware of this but only one spoken with had used it. While allied health personnel have not had regular performance evaluations by their managers, they have peer reviews every two years and documentation audits every three years. Consistent application of the organization policy on performance assessments is suggested. Investigation of best practices in performance assessment and discussion of possible positive changes is also suggested.

Staff morale, enthusiasm, and pride in all the medicine units visited, both pediatric and adult, is impressive, as is the expert care they provide to patients and families. Staff recognition from peers, patients, and families was noted on the walls of all units. Staff recognition by the leadership of the program is mainly informal, but is very much appreciated by staff.

Priority Process: Episode of Care

Great pride and satisfaction in the care provided to patients and families by staff and the organization was a recurring theme in adult and pediatric units. Patients and families report a high satisfaction rate.

Several initiatives, such as the use of whiteboards, safety rounds, and goal navigators for each patient, were felt to be tangible evidence of the wish to improve services. Areas to consider, such as increased use of the whiteboards for non-private information, and more involvement of patients and families in handovers and safety rounds, were felt to be opportunities for improvement. Post-fall huddles have been shown to improve understanding and care of patients at risk of falling, and are planned and encouraged by the regional director.

Information binders are provided on the adult units. The information is appropriately focused on safety. Asking the patients and families what would be helpful for them to know may result in improvements. Respecting cultural diversity and consistency in documentation when these issues are discussed with staff is encouraged, bearing in mind that many patients and families may have difficulty reading the information.

Staff recognition by the organization, managers, peers, and patients and families is largely informal on these units, but is very much appreciated and welcomed. The WOW boards and "high fives" are two examples of this.

There are many good examples of the use of data and patient surveys to make changes and improvements in processes, and these should be shared. Concerns were expressed in pediatrics about no-shows to the outpatient clinics, a significant access issue. The rheumatology service at St. Clare’s has reduced its no-show rate with a telephone project that is now automated. This result may not work for other units, but is an example of the benefit of sharing information.

There is a sense of apprehension and a degree of reluctance from staff to involve patients and families to a greater and more formal degree in service design and quality and safety. Evidence from other health

jurisdictions suggests that carefully chosen clients and families will contribute successfully in many important ways to the excellent services and care provided by the medicine program.

Priority Process: Decision Support

Charting in the medicine program is largely paper based, with limited electronic support to pediatric and adult units depending on the site. St. Clare's charts much of its ssessment information electronically through Meditech, as does Carbonear. Computerized physician order entry (CPOE) was not noted.

Processes to protect private patient information on the units and with the charted information, and standardization of paper-based and electronic charting, appear to be appropriate and no concerns were noted.

Priority Process: Impact on Outcomes

The adult and pediatric medicine programs developed monthly auditing of several Required Organizational Practices and hand hygiene as a priority. These include use of the venous thromboembolism prophylaxis tool, hand hygiene, medication reconciliation at admission, skin assessment, and falls risk. The results of these audits are posted publicly in the nursing units along with the incident reporting analyses, and the program is commended for this transparency. Hand-hygiene compliance has improved and is at or above targets in all areas visited, and there is evidence that this transparency with clients and families has improved performance. The risk of falls is trending down, although falls are still a significant concern. Implementation of post-fall huddles, an initiative suggested by a staff member, is planned and will further address this ongoing concern. Continued discussion and education with clients and families is encouraged.

The program has developed a number of standardized order sets to prevent variations in practice, in conjunction with an external expert supplier who ensures they are up to date, as well as staff and physicians who regularly review them. Choosing Wisely Canada recommendations are considered in their development. The impact is lessened by variations in physician uptake and compliance. There are opportunities for physicians to work with teams to resolve issues causing difficulties with compliance, to better serve the patients.

Guidelines are used for many of the services offered by the medicine program. Examples are the Canadian Stroke Best Practice Recommendations and Febrile Neutropenia in Hematology and General Medicine. These guidelines are reviewed regularly by the program and revised as needed.

Examples of the improvement in quality and safety of services through process improvement projects at the HSC were discussed. Two examples are the development of the stroke unit on the neurology and general medicine unit, and improvement in access to services project on the 4SA unit.

Research opportunities that include patients are common on pediatric and adult units. Examples include those in GI medicine at the HSC, and oncology, gastroenterology, and nursing at the Janeway pediatric

medicine unit. These research projects are largely physician- or treatment-driven in the adult program. An opportunity for nursing and allied health to consider research, such as outcomes and patient and family experiences, is encouraged. There is nursing research from the pediatric program regarding end-of-life and palliative care, and cancer pain among children, indicating the many important research topics open to study by nursing staff.

Safety rounds follow handovers on a daily basis on the adult and pediatric medicine units. While the handovers occur at the nursing stations, the safety rounds consider several concerns noted in an organizational policy. At the Janeway, a safety discussion involving all staff specifically addresses any concerns for the pediatric patients. There is an opportunity to increase patient and family involvement in these important processes by considering bedside handovers and safety discussions. Privacy is a concern for some patients, particularly those in crowded four bedrooms at the HSC.

There is a comprehensive ethics program at EH. Staff at all sites know the processes to obtain ethical advice and consultation, and they provided examples of how the service has helped in the care of their patients.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.5	Service-specific goals and objectives are developed, with input from clients and families.		
Priority Process: Competency			
3.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.		
Priority Process: Episode of Care			
8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.6.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	8.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

EH offers an extensive range of primary, secondary, and tertiary programs and services to mental health clients and their families. Business lines are clearly defined and span the continuum of care from health promotion and prevention to early intervention, supportive care, acute and community-based intervention, rehabilitation, continuing care, and advancing knowledge. Along the continuum it is evident that leaders and staff are committed to their program areas and interested in improving their mechanisms to ensure client-focused care. This includes involving clients and caregivers in improvements and decision making about how facilities are planned and how work is carried out.

In the absence of clearly articulated goals and objectives supported by indicators and measures of success at the unit level, there is opportunity for improvements to be made so service delivery is seen to be clearly supportive of the high-level strategies of the organization. There is abundant evidence that staff and leaders have the best interests of clients in mind and have mechanisms in place to meet their share of accreditation standards. There is also evidence that the programs and services are consistently looking at current best practices that can be implemented to support continuous improvement.

With clear direction from government to implement an extensive list of recommendations to address perceived gaps in service, the organization is in a process of transition. Significant changes are underway to move from a medical model to a strengths-based recovery model that offers a range of service modalities designed to provide the right services in the right places at the right times. Specifically, this means expanding access to same-day brief interventions, re-direction of clients from EDs to voluntary short-term assessment and treatment services using an interdisciplinary and interagency approach, early assessment and intervention services, integrated primary care approaches, and robust discharge planning and case management to minimize the risk of clients getting hung up in tertiary centres beyond the requirement for acute interventions or safe residential or long-term care.

The organization is moving in the right direction in terms of using existing resources to strengthen the continuum of care and reduce duplication of effort and waste in the system. The organization is early in its ambitious change agenda. It would be worthwhile to continue the work of connecting the broad strategic objectives to the standard work being done at the point of care.

At the senior management level, there is a commitment to establishing operational goals and objectives with indicators of success. At the middle management and unit level, there is a sense of what the priorities for the organization and the individual units are, but these are not articulated clearly, communicated effectively to point-of-care staff, or clearly linked to the strategic priorities of the organization. The organization is encouraged to consider more robust communication strategies such as the use of visual management tools to communicate priorities and improvement initiatives to clients, staff, and visitors. There was some discussion about Kaizen activities that have been tested and have led to improvements, but these are not readily evident to people who are interested or directly impacted by the work. When asked about priorities, staff could speak articulately about what their unit-based teams were working on, but could not make any linkages to EH priorities. Staff could refer to priorities such as falls management and medication reconciliation as priorities for accreditation, or to objectives discussed during individual performance reviews, but there was no reference to measurable improvement initiatives for which progress toward targets is being routinely monitored and communicated.

Priority Process: Competency

This is a highly credentialed and engaged workforce with a sincere desire to provide a patient- and family-centred model of care that promotes independence through the provision of the right service in the right place at the right time. Staff generally have well-defined areas of responsibility and there are mechanisms to support professional development, collaborative case management, and best practice.

Opportunities to do structured supervision with disciplines that adopt that as part of their professional development described good processes that are in place and supported.

The organization is not consistent with its performance review and planning process. Most staff could not identify when their most recent performance appraisal was completed but they were aware that this is being changed, including a self-appraisal component. This is an area with which many complex health care systems struggle. There are opportunities to look at new ways to accomplish this work that include more meaningful and deliberate conversations among staff and direct reports in a less paper-based methodology. This may be an area to explore.

The work to engage patient advisors is underway and there are a variety of ways in which patients and family members are included in care planning and in providing feedback on services. The formal engagement of patients and families in planning and service design is not substantially implemented.

Priority Process: Episode of Care

There has been a concerted effort by the organization's leaders and clinicians to re-organize services to comply with provincial direction based on an all-party report that indicated improvements were needed to increase access to appropriate modes of care across the continuum. Staff who have been involved in the transition work over the past couple of years were positive in their feedback about how the re-design promotes better collaboration between disciplines and agencies and better client care through integration and co-location of services.

There are challenging scenarios for inpatient care and staff safety at the Waterford location because of the aging infrastructure and crowding in the inpatient units; however, staff provided many examples of innovative practices they have implemented to manage clients requiring complex care, group activities, and isolation in these conditions. The physical plant does place constraints on how programming is structured for inpatients but staff have been diligent and innovative in how they achieve compliance with standards.

Documentation of the intake, assessment, plan of care, and discharge activity is robust. It demonstrates compliance with high priority standards such as medication reconciliation at admission and medication management, falls assessment, suicide assessment, progress while on services, and discharge planning.

Team members see themselves as part of a broader continuum of care and acknowledge that high-quality care requires appropriate and confidential sharing of information among care providers and clients throughout the client's health care journey.

The most responsible caregiver is identified in every case, and clients are made aware of this.

Priority Process: Decision Support

Collecting, storing, and sharing information is partially paper-based and partially electronic. Charts are well organized with mostly standardized forms across mental health services and addiction programs. There are built-in mechanisms to ensure compliance with high-priority standards of care related to medication management, suicide risk assessment, falls management, and care planning and progress.

Privacy is protected through proper storage of records and documented agreements for sharing of information. The standardized limits of confidentiality form is a good tool for discussing with clients what information may or may not be shared.

Priority Process: Impact on Outcomes

There is no strong evidence of specific quality improvement activities with outcomes and indicators at the unit level. This is identified as an area for development. However, staff and leaders are consistently passionate in their descriptions of the commitment to quality and safety.

There is some reference to Kaizens and improvement projects but these are described as episodic and not necessarily connected to operational plans that are aligned with EH strategies.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.1	Services are co-designed with clients and families, partners, and the community.		!
Priority Process: Competency			
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.5.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	8.5.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.		
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.		!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.		!
Surveyor comments on the priority process(es)			
Priority Process: Clinical Leadership			
There are approximately 2,500 births per year at the HSC and approximately 120 in Burin. Patients are screened to determine their appropriate care setting based on risk to mom or babe. Patient choice is also			

a determination for low-risk pregnancies. Expectant mothers and fathers are invited to tour the clinical setting in order to establish a picture for themselves about what to expect for their birthing experience.

Service-specific goals and objectives are done on an annual basis and are currently being reviewed relative to the new 2017-20 strategic plan.

A leadership team provides clinical oversight to the obstetrics/gynecology program. National practice guidelines and emerging evidence are monitored to inform practices. There are excellent working relationships with the public health unit and the Children's Aid Society.

There has been considerable discussion and feedback regarding the distribution of gynecological and obstetrical beds within the unit at the HSC.

Priority Process: Competency

The MORE-OB program was completed by the teams several years ago and they are now looking toward returning to this initiative. Health care providers report excellent working relationships.

There are processes for physicians and staff to identify resource gaps. Bili-blankets are expected; these will provide ultraviolet therapy while allowing for rooming in with the mother.

Patients are welcome to bring doulas into the obstetrical setting to support their experience, in addition to a family member.

Priority Process: Episode of Care

Patients' level of risk is assessed by the ob/gyn to determine the appropriate care setting. High-risk patients in Burin are transferred expeditiously to St. John's.

The health care team consistently engages in designing patient and family plans of care in partnership with them. Families and support persons are fully embraced in supporting the mother throughout her pregnancy.

Priority Process: Decision Support

Multiple seminars, webinars, on-site educational sessions, and conferences provide staff with opportunities to maintain their competency and be consistent in their approaches to patient care.

Implementation of the electronic medical record will provide the team with a mechanism to more easily support continuity of care across sites.

Priority Process: Impact on Outcomes

The services monitor an array of metrics to evaluate their processes and outcomes. These include caesarean section rates and vaginal birth after caesarean.

Standards Set: Organ and Tissue Donation Standards for Deceased Donors - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.11 A written agreement is established with at least one specific OPO.	
Priority Process: Competency	
7.1 The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	
7.2 There is a policy regarding maximum consecutive work hours.	
7.3 The policy for maximum consecutive work hours is adhered to.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a strong and highly dedicated team in the Organ Procurement and Exchange Program (OPEN) of Newfoundland and Labrador. Staff include a medical director from critical care, and one full-time and two part-time organ donor coordinators. In addition to Eastern Health, the OPEN team provides service to the other three regional health authorities in the province. Since the last on-site survey, a Provincial Advisory Council with representatives from each regional health authority has been launched to champion the advancement of organ donation in the province. Staff are active on a number of local, regional, and national committees to promote organ donation.

OPEN staff are guided by organizational policies, the Health Canada Safety of Human Cells, Tissues and Organs for Transplantation guidance document, and the Canadian Standards Organization. The OPEN program staff have a number of responsibilities including donor screening, allocation of organs, coordination of organ procurement and distribution, and education on organ and tissue donation. In addition, EH is licensed through Health Canada as an importer and distributor of tissue. As a result, OPEN staff are responsible for the importation, storage, tracking, and distribution of tissue for transplant.

An Organ Donor Committee is in place and has been expanded to include regional representatives and a donor family spokesperson.

There is a plan to establish a new committee that will have more family members, with two to three representatives from the OPEN program and/or other health professionals. The organization is encouraged to support the plan to establish this committee so as to advance client- and family-centred care in this important area.

Those who live in Newfoundland and Labrador can now indicate their intent to donate on their Medical Care Plan (MCP) card. In addition, OPEN staff are working with the Newfoundland and Labrador Centre for Health Information to have organ donation intent accessible at the point of care.

Priority Process: Competency

The organ donor coordinators are highly skilled and qualified nurses. Orientation is provided to new staff, and roles and responsibilities of team members are clear. The position description for the organ donor coordinator role has been updated in the past year. The coordinators have a self-directed competency tool that they update on an annual basis and is signed by the medical director or designate.

The program does not have a policy regarding maximum consecutive work hours. The organization is encouraged to develop a policy so this gap can be addressed.

Priority Process: Episode of Care

The OPEN team actively works to reduce barriers to organ donation through education, public speaking, and building partnerships within the city and across other regional health authorities. A standardized approach is used to obtain information about potential donors.

Priority Process: Decision Support

Organ donor records are comprehensive and are retained as per regulations. Donor information is shared with key partners. Data are submitted to the Canadian Organ Replacement Register for each organ donor.

In 2014, 20 organs were retrieved. In 2015, there were 31, including heart, lungs, liver, pancreas, and kidneys.

The team does an excellent job of collating and reporting key metrics; however, this work is done manually and is very time consuming. The organization is encouraged to establish a database to enable

the collection and reporting of key activities, including donor referrals and tissue imported and distributed. This would be a great asset for the team, program, and organization.

Priority Process: Impact on Outcomes

Guidelines for the program are embedded in policies. The program reports organizationally to the cardiac-critical care program. There is strong collaboration with the ICUs, and the form for neurological determination of death was updated in 2016.

There is a strong focus on quality. The organ donor coordinators review charts of all deaths, and identify missed opportunities for donation. This information is used by the medical director and the coordinators to provide feedback to various centres by visiting them to provide education and advance learning to enhance donation rates. These visits are important for building and sustaining relationships. To advance donation in rural areas, the organization is encouraged to advocate for ongoing support and funding for regular education. This would help advance the EH strategic priority for increasing the organ donation consent rate per year.

EH has contracted with the New Brunswick tissue bank and organ program so a representative can conduct audits. Organs are done one year and tissue the next. Quality initiative reporting (QIR) systems are in place and the reports are sent to the auditor quarterly to review and provide feedback. Corrective and preventive action (CAPA) reporting is also active.

Priority Process: Organ and Tissue Donation

The process of organ and tissue donation is well managed in the organization. Staff are aware of the OPEN program and there are donation pamphlets in many areas. The comprehensive organ donation resource manual was revised last year and is available to all staff and programs.

Family satisfaction surveys are conducted periodically. Since the last on-site survey, 32 surveys were administered. Results were very positive with respect to the donation process and support and communication with the OPEN team. Three donor family members who were interviewed by telephone spoke highly of their experience with the organ donation process. The OPEN staff were described as being caring, compassionate, open, honest, and comforting in their approach.

A new family experience survey that will be used for future surveys has been developed with the EH research department.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.		
Priority Process: Competency			
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.		
6.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.		!
Priority Process: Episode of Care			
11.6	FOR INPATIENTS ONLY: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	11.6.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	11.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.		!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.		!

24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A meeting was held with the regional program leadership for surgical and perioperative care (administrative and medical directors for surgery and perioperative), as well as the administrative director and a surgeon from the Janeway, to discuss successes, challenges, and opportunities.

The clinical leadership teams in surgery, perioperative, and endoscopy units, and the HSC cardiac catheterization (Cath) lab, have extensive experience, with the exception of the Janeway operating room having a new manager and educator. Staff at the Janeway have experienced significant management turnover in recent years; however, they feel they are now moving in the right direction. All of the leadership teams are commended for their focus on patient- and family-centred care, as well as quality and safety.

Some of the clinical areas are challenged with space, and they do the best they can to deliver care and manage the flow of people and supplies. Pyxis supply and medication cabinets have been implemented in a number of areas, with positive results.

Priority Process: Competency

The teams in perioperative services and invasive procedures are highly collaborative and interprofessional. Orientation programs are in place in all areas, and roles and responsibilities of staff are clear. Mandatory education is completed as per organizational requirements. Clinical educators support the staff in their learning and are seen to be highly valuable and supportive in advancing knowledge.

For many staff, there was a great source of pride in the collaboration and teamwork that supported them in providing patient care.

Some staff were able to identify ethical issues related to patient and family care and decision making. All staff were able to describe the process to follow if they needed further support on an ethical issue (i.e., team social worker, pastoral care, and ethics).

Regular feedback on performance was inconsistent. Some managers do this regularly and staff appreciate their efforts. However, there are a number of staff who have not had a review in years. This needs to be a priority for the organization so staff engagement and learning can be supported in the workplace.

There was no evidence of support for client and family engagement on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.

Teams in all areas have appropriate the skill mix and experience; however, there was no evidence of input from clients and families.

Priority Process: Episode of Care

Flow across the clinical areas is well-integrated in surgery and perioperative services. Standardized tools and checklists are used across all areas, as are hand-offs from pre-admission, pre-op area, operating room, recovery areas, and inpatient units. There is a strong focus on safety and risk and staff follow procedures carefully to mitigate risk. Patients and family members are well prepared for their procedures.

Processes are in place to address urgent patient needs for surgery and procedures. As all areas are fully booked, emergencies and more urgent cases are accommodated. However, this impacts other patients, leading to delays and potentially cancellations. All teams do their best to review booking and resources to reduce the impact to patients.

Patients and families express great satisfaction with patient education and materials. Efforts are made to ensure they understood the procedure and care path. Patient education is documented in all areas.

At the Janeway, parents talked about being an equal partner on the team, and about the excellent care and concern demonstrated for their children. The only issue of concern voiced by parents was access to parking. One mother spent close to an hour trying to find a place to park so she could take her very sick child to the ED. The Janeway team is encouraged to explore how best to address this issue for those who need access to the ED in a timely manner, and so parents and their children can be on time for appointments.

Some staff noted that recognition is informal from colleagues and managers, though others were well aware of the WOW program and how EH has used it. WOW notes were seen on boards in a few areas and some were full.

The endoscopy suites at the HSC and St. Clare's are busy areas. They have highly engaged, knowledgeable staff who are very patient centred in their approach. Despite space and volume challenges, the teams are highly collaborative. The HSC unit is small and cramped, but the team works diligently to maximize flow.

Endoscope reprocessing is carried out in a small room. The technicians are careful to ensure they follow dirty-to-clean flow to reduce cross-contamination. At St. Clare's, there have been renovations to expand capacity and a new reprocessing suite with separate dirty and clean space is in operation. At both sites, there are a large number of add-on cases each month. This leads to significant bumping and re-organizing to ensure more urgent cases are completed.

A wait times coordinator role has been introduced and early results from the pilot saw some reduction in wait times. Ultimately the endoscopy program is under-resourced in space given volume demands. The strategic imperative to increase participation in the Newfoundland and Labrador colon cancer screening and an aging population will only serve to increase demand. The organization is encouraged to review endoscopy space demands and requirements in a timely fashion so a plan can be developed to address wait times, improve patient experience (there is a lot of bumping now), and enhance bed use.

Despite space pressures, the endoscopy units are commended for a strong focus on quality and resource management. The Pyxis supply cabinets and EndoManager Electronic Report Writer have been implemented for physician documentation. With Pyxis, financial savings as well as supply management efficiencies have occurred in both units in the first year. The EndoManager system has improved the transfer of information and also provides quality data reports for endoscopy such as withdrawal times and adenoma detection. There have also been efforts to reduce variation in care by introducing the skills enhancement program for endoscopy and the Canadian global rating scale.

The cardiac catheterization laboratory at the HSC is the provincial centre for invasive cardiac procedures. On the day of the on-site survey, there had been several sick calls and a number of emergencies, and the unit was very busy. The team is commended for their calm, cool, and patient-centred perspective in such a pressure-filled time. They have standardized processes to enable patient flow and care. Not all staff have the same clinical background, so the charge nurse may have to juggle assignments in the procedure rooms and pre- and post-care.

The implementation of operating room standards in the cath lab is a challenge that the team is working on to ensure interventional cardiology procedures are provided in the right environment.

A pediatric electrophysiology study was being completed in the unit. The Janeway hospital sent an anesthesiologist and operating room nurse with the patient, as well as their anesthesia cart. The cart was found unlocked and unattended in the hallway with drug vials sitting on top. This was rectified immediately by the manager.

The cath lab has a comprehensive database called APPROACH NL. The information is used to collect and report wait times and patient outcomes, and inform service planning.

An external review has recently been completed. This will help the team set strategic priorities to address patient care demands.

Priority Process: Decision Support

Comprehensive records are kept for all patients, and standardized tools are used across surgery and perioperative areas. Managers have access to Cognos reports that provide them with a significant amount of data to review performance metrics, sick time, overtime, and quality and risk. In addition, an operating room manager system is used in the operating rooms for scheduling and documentation. This provides the team with access to comprehensive data for metrics and performance reporting.

There is a need to establish a scorecard for the operating rooms, and there is plan to get this underway in the coming year. This will help establish benchmarks and performance reporting to guide efficient and effective use of resources and well as enhance patient experience by reducing cancellations and bumped cases.

Priority Process: Impact on Outcomes

A number of successes have occurred since the last on-site survey, with a focus on enhancing quality, safety, and efficiencies. The success of central intake on orthopedics has been extended to other services, with thoracic and urology being implemented. Last year, the American College of Surgeons' national surgical quality improvement program was implemented to support the measurement and improvement of quality of care. Also in 2016, enhanced recovery after surgery was implemented for bowel resection cases at St. Clare's, leading to reduced length of stay. The program was recently expanded to lung lobectomy. Quality committees have been established for surgery and perioperative services. Finally, following a pilot, remote monitoring was implemented at the HSC for obstructive sleep apnea; this will be expanded to St. Clare's.

Teams have been working to develop best practice pathways and pre-printed orders to reduce variation and length of stay. Many of these initiatives will help support evidence-based guidelines in the regional surgery program; however, continued focus is needed to continue to develop pathways and pre-printed orders to reduce variation. There is no evidence of a standardized process for clients and families to decide among conflicting evidence-informed guidelines. There is no evidence of client and family input into verification processes used to mitigate high-risk activities.

Impact analyses have been implemented for new procedures to ensure a business case can be developed to support the approach with resources and funding.

The Janeway team has been looking at opportunities to reduce travel time for patients and families to have a pre-admission visit. A plan is under development to create a video teleconference pre-admission visit. There have been some challenges in balancing adult and pediatric needs in purchasing and equipment. It is suggested that the organization review the purchasing process for equipment to ensure the unique needs of pediatric patients can be addressed in the procurement process.

Priority Process: Medication Management

There is a strong focus on safety with medications in the surgery, perioperative, and invasive procedure areas. Medication supplies and storage complied with standards with the exception that narcotics used by the anesthetist in one hospital were not locked and were left on top of the cart unattended.

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

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

The organization has met all criteria for this priority process.

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

The point-of-care testing program has been developed to support clinical and laboratory staff in providing safe point-of-care testing. Staff are trained in the proper procedures to be followed and standard operating procedures are available to them.

An interdisciplinary committee supports the point-of-care program.

A variety of tests are performed in various locations across the region. Glucose testing has been implemented and there is evidence of appropriate training, quality control, and patient identification. Patient results are part of the electronic medical record. This program is in acute care and long-term care settings.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.2	Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Impact on Outcomes		
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Public Health		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The public health team is dedicated to improving the health of the population. The organization regularly examines roles and responsibilities, future staffing requirements, and the need for specialty public health competencies.

The clinical and support staff mix is appropriate for the clientele served. Clients are pleased with the amount of time care providers are able to spend with them. The organization is commended for a model that allows and encourages this level of service.

The public health team regularly updates client information in the electronic medical record. The team is commended for regularly reviewing the program and services and making changes when opportunity and resources allow.

The organization is connected with many other health and community agencies. There appear to be sound relationships and good will among the partners to meet the needs of the community. The organization is encouraged to formalize some of its most promising relationships.

Priority Process: Competency

Team members are knowledgeable and passionate, and practice within a client-centred approach when providing direct care to individuals and families. A population health approach is necessary for most public health initiatives, and it is sometimes difficult for team members to maintain competencies in both.

Although it is difficult to recruit for some public health specialty positions such as epidemiologists, the organization has managed to work with others to access people with these skill sets when necessary. With the changing community demographics, team members use the translation line more often. They might benefit from cultural safety training.

An upcoming community health restructuring may provide an opportunity for the organization to examine the opportunities and gaps within the existing team with regard to the competencies required for population health assessment, monitoring, planning intervention, and evaluation.

Team members appreciate hearing regular feedback on their performance and the organization is encouraged to formalize this according to policy.

Priority Process: Impact on Outcomes

Immunization coverage is regularly monitored and reviewed. This includes primary series, school-based programs, and seasonal influenza. A new database with inventory and vaccine management modules has been developed with support from the organization's IT staff.

Communicable disease prevention and control and health promotion collaborated with many internal and external partners to successfully implement a syphilis outbreak management campaign. This consisted of a social media campaign as well as individual counselling, testing, treatment, and contract tracing.

A Healthy Beginnings Review Working Group has been formed to recommend improvements to the healthy beginnings program. The group plans to to engage public health team members, complete an environmental scan of evaluated home visiting programs and other postpartum/ parenting programs, complete a summary of evidence regarding best practice in universal postpartum follow-up, and identify those who require added support to improve child developmental outcomes. This could have a significant impact on early childhood developmental outcomes.

The team is encouraged to consistently test the quality of its improvement activities, regularly evaluate its indicator data, and continue to review and evaluate quality improvements for feasibility.

The organization is acknowledged for its new public health plan 2017–2020, and is encouraged to continue on its quality journey.

Priority Process: Public Health

EH is responsible for the delivery of provincial public health programs and services as well as regional strategic priorities. The accountability for public health programs and service delivery is now within the portfolio of one vice president. There is a respectful and open relationship with leadership.

A community health restructuring is planned which will create many opportunities for the organization as public health and community health are realigned. It is hoped this will allow for a renewed focus on population health issues (a strategic goal of the organization), health equity, and the social determinants of health, and assessing, planning, and protecting the health of the population.

Team members feel supported by the organization. They are proud to represent EH at community tables and are empowered to make decisions within their role. The team meets regularly to plan and use the varied skills and interests of team members to enhance services.

There is a robust commitment to client and population safety across the organization. Staff report through the safety incident management system and improvements are made as a result.

EH is recognized for having some of the highest vaccine coverage rates in Canada. Vaccine delivery occurs in clinics, schools, and community settings. Public health is expected to provide the majority of childhood and most adult immunizations. Recent government announcements will increase the workload of public health staff significantly. The organization is encouraged to explore business continuity options to support public health in this work and to advocate for appropriate resources to enhance population-based immunization programs.

The organization is encouraged to explore vaccine delivery options including provider type, hours of operation, scheduling (such as school year employees), and a process review for vaccine distribution to create efficiency (i.e., tablets in the field and a fax/copier in the vaccine room).

Vaccines are stored safely, within acceptable temperature ranges, and monitored with all the necessary checks and contingency processes. A new fridge maintenance contract will increase confidence in the cold chain infrastructure.

Vaccines are distributed from the provincial bio-depot based in St. John’s to the Mount Pearl location where they are redistributed throughout the eastern region. The organization is encouraged to work with the ministry to explore potential options for provincial vaccine storage and distribution.

Infant immunization was observed to use all necessary checks. Two client identifiers were obtained, parent teaching including after care was comprehensive, and the correct agents were administered safely. Team members are aware of their responsibility to report adverse drug events.

Health promotion activities are focused on the social determinants of health and again there is evidence of strong partnerships based on respect and understanding of each organization's unique mandates.

There is strong collaboration with diverse community partners, which vary from community to community based on the needs identified. The team is highly credible and is able to establish new partnerships to address population health needs. Of special note is the syphilis outbreak response which was a collaborative response with the involvement of many well-connected and some new partners.

Public health supports two regional Wellness Coalitions to promote wellness thorough community awareness, collaboration, and action. These coalitions are collaborative in nature and include community organizations, health agencies, municipal governments, educational organizations, service groups, businesses, and community volunteers.

Team members were able to identify several program ethical concerns and described how they accessed the organization's ethics consultation services.

The team works closely with community physicians, laboratories, provincial public health, acute care, and others to identify threats to public health, contain potential threats, and plan coordinated responses to potential threats.

The organization's communication department works closely with the ministry and public health for both urgent and routine needs and together they are commended for some innovative and edgy campaigns.

It is hoped the Public Health Nursing Quality and Safety Committee will evolve into a Public Health Quality Improvement and Client Safety Committee with representation from clients and families. The team is encouraged to be creative when recruiting for these positions. Having input from clients and families will facilitate planning, collaboration, and quality improvement across public health areas of focus.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
12.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Inpatient and day hospital rehabilitation services at EH were discussed with the rehabilitation team. Services include tertiary services such as acute brain injury and spinal cord injury, as well as secondary services such as stroke rehabilitation. A low intensity unit is an initiative developed to improve the

rehabilitation provided to acute care patients needing short courses of hospital-based rehabilitation. An example of the use of this unit is a successful project for hip fracture patients taken within five to seven days from acute services that is felt to have significantly improved recovery for these patients, with 86 percent returning home.

There are other tertiary services such as prosthetics for amputees, with an active outreach to these patients in acute care settings. Chronic pain management is another important part of this program.

Stroke patients make up 40 percent of the inpatient load at this centre. Canadian best practices in stroke are implemented in the management of these patients. The second most common diagnosis is orthopedic.

While the rehabilitation program has a provincial mandate for many of the services it offers, it does not have responsibility for the provision of services in the other regions in Newfoundland. A significant challenge is the variable and generally low levels of service in EH's rural facilities, which is felt to be a factor in the length of stay statistics for services such as stroke rehabilitation.

The day hospital services were developed to recognize the need for lower acuity services, which can be delivered to home-based patients. This recognizes a trend to more home-based services for patients, realizing greater efficiency.

Goals and objectives based on the organization's priorities were noted. An opportunity to involve clients and families in a more formal way in the development and assessment of services was discussed. A goal achieved was the automatic referral of ALS patients as a result of discussions with patients and their families.

Opportunities for improvement were discussed. More involvement in planning service for the greater EH region, with input from patients and families through surveys and town halls, could result in a reallocation of some resources and improved length of stay on the inpatient unit. Optimizing the use of the day hospital and outpatient services according to best practices could help achieve the same efficiency. The enhanced use of telehealth, which is currently limited to prosthetic services, may improve opportunities for some patients to go home earlier. Despite these opportunities, the significant geographical and rural recruitment challenges are acknowledged as points needing discussion.

The team is encouraged to use outcome and best practice data to help drive possible solutions for the problems affecting length of stay. This would address two of the program objectives, which are to improve access and promote early discharge.

Priority Process: Competency

Orientation to the rehabilitation units is comprehensive, and staff reported feeling comfortable with it.

There are opportunities for local education such as lunch and learns on subjects such as new equipment and technologies. Webinars and yearly education days enable staff to pursue their educational interests.

Physiatrist recruitment is a challenge for this program. There is only one physiatrist in Eastern Health, which is significantly understaffed, and one in the western region. Most of the medical care for the inpatients is provided by interested family practitioners, who provide a holistic approach to patient management that is appreciated by staff.

One of the main strengths of this program is the team approach to patient care. Human resources on the units is generally felt to be adequate.

Allied health personnel undergo peer evaluation every two years. Performance appraisal by managers has not been achieved per policy in a consistent fashion. A new approach is in the planning phase. Regular review of all staff as per the EH policy is suggested.

Priority Process: Episode of Care

An intake manager reviews all referrals to the inpatient units. Intake rounds to discuss referrals are now held more frequently to help efficiency and access. The team tries to educate acute care services as to the appropriateness of referrals, finding that there is wide variation in understanding among these services. Similarly, the day hospital takes patients from the inpatient services as clinical status permits.

Referrals to the day hospital are from a variety of sources in the community and are triaged for appropriateness and the need for an interdisciplinary approach. Patients requiring a single service intervention are usually referred to outpatient services.

Wait times for services on both units are monitored and are within target. Stroke wait times are patient dependent but usually meet the stroke practice guidelines.

The program works with community partners such as Heart and Stroke to provide services and support for patients on discharge. A post-stroke survivor supports stroke survivors in the day hospital program.

Setting individual goals with each patient and their family starts at about two weeks post-admission for inpatients. A goal facilitator is assigned to each patient. The goals are monitored and often changed with the patient and family, depending on progress made. The continual involvement of the patient and family in individual decision making is a great strength of this program.

Interpreters for French- and Indigenous-speaking patients and their families are easily available. An Aboriginal navigator provides cultural education for the staff and support for Indigenous patients and families.

Discharge planning begins just after admission to any of the units, allowing planning for needed resources.

A challenge noted by the team is a lack of community resources. Standardization of care delivery is an evolving process, and is recognized as an opportunity to further improve outcomes for patients.

Patients express great satisfaction and appreciation for the expertise and compassion of the staff, and are pleased with their involvement in decision making and recovery.

Priority Process: Decision Support

Charting for the rehabilitation program is manual.

This unit is piloting electronic medication reconciliation through transitions of care to discharge. Bugs related to the early rollout of the program are being resolved, and compliance is steadily improving, particularly with the physician group. There is a plan to expand e-medication reconciliation to St Clare's as the next stage of this project. Strategies such as having physician champions and lots of support and opportunities for improvement based on user feedback are encouraged.

Priority Process: Impact on Outcomes

The rehabilitation program monitors quality data such as hand hygiene, where results above the target of 80 percent compliance have been achieved. It also monitors incidents and reports the results of its auditing publicly to staff on a regular basis.

Wait time and length of stay data are also monitored and compared to other programs. For instance, the stroke unit is aware that its length of stay for inpatient rehabilitation is longer than the Canadian experience and benchmarks. It is understood that this is largely due to deficiencies in home and community resources, which cause patients to remain longer in hospital than they might otherwise. Opportunities such as increased use of the day hospital, telehealth, and programs such as early supported discharge in stroke require a lot of discussion with the organization and the department around resource allocation, but may help deal with length of stay issues. Staff need to be supported as they deal with discharge of patients for whom home resources may not be optimal.

Waiting times for service and length of stay depend on the diagnosis, but are otherwise reported as being similar to national data and on target. Wait times to access the day hospital are about one week from acceptance of the referral, and are felt to be acceptable.

Outcomes of treatment are felt to be excellent. These outcomes are public on the unit and discussed with staff. Quality and safety, as measured by these outcome measures, are good ways of formally engaging patients and families.

The program is encouraged to continue to analyze its length of stay data and its outcomes to further understand the reasons for increased length of stay, and to use this information to consider and implement solutions for these overages.

Few protocols or order sets are used to avoid unnecessary variation in service delivery. No evidence of input from clients and families was presented. Research and the use of best practice protocols are encouraged.

Standards Set: Substance Abuse and Problem Gambling - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.3	Service-specific goals and objectives are developed, with input from clients and families.		
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
8.5	Client medications are reconciled in partnership with the client, family, or personal support system at care transitions.		ROP
	8.5.4	Upon transfer to another service provider or at the end of service, the client and their care providers (e.g., family physician) are provided with a copy of the updated medication list.	**MINOR**
	8.5.5	The process is a shared responsibility, undertaken in partnership with the client, service providers, the family physician, and community pharmacists, as appropriate.	**MINOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			
Surveyor comments on the priority process(es)			
Priority Process: Clinical Leadership			

Tracers were conducted at the CAST program and the Grace Centre. These are both relatively new programs. The Grace Centre is a residential treatment program that has been in place for just over a year. It is based on a recovery model with routines that have been developed at the Homewood Health Centre in Ontario but tweaked based on lived experience here.

The CAST program is a specialized treatment program for individuals with concurrent addictions and mental health needs.

Both programs employ a combination of group and individual treatment modalities designed to support people at various stages of recovery. Group work is used to maximize client exposure during an episode of care. This is consistent with the authority's efforts to improve access to care. One of the tracers offered an opportunity to participate in an after care group. This experience provided solid evidence from the clients' point of view that there are connections between detox, residential care, and community-based programs.

There is no strong evidence of measurable goals and objectives at the unit level.

Priority Process: Competency

All staff have job descriptions and a solid understanding of their roles. There is a high value placed on the contributions of the interdisciplinary team. There is good role delineation in terms of how investment is made in resources that contribute positively to what the team is trying to accomplish in its service delivery model. For example, the investment in clinical pharmacy at the Grace Centre demonstrates a commitment to best practice in a harm reduction approach to treatment. The CAST team delivers assessment and treatment to complex needs clients who might otherwise access emergency or acute inpatient services.

As with other programs throughout EH, an improved model for performance review and planning needs to be considered and adopted so staff receive well-considered and regular feedback on how their work contributes to the strategic objectives of the organization.

Priority Process: Episode of Care

Intake, assessment, treatment, and discharge planning procedures are thorough. Client rights and confidentiality are respected. Clients are fully involved in decisions about their care and in identifying goals for treatment and discharge. There is evidence that clients' rights are respected when, for example, decisions are made about who will be invited to participate in the program as significant others. Assessments and treatments are interdisciplinary, and, where indicated, the broader circle of care in the community is accessed for assessment and discharge planning purposes.

There are procedures and forms to ensure appropriate exchange of information at transitions of care. Safety is acknowledged as a high priority and measures are in place to ensure security within the facilities and while on pass. There is flexibility in terms of length of service available to clients who require additional time to achieve their treatment goals. This flexibility was identified as significant by clients who were interviewed, particularly for those who have heightened concerns about relapse prevention as discharge approaches. The after care group is a good example of how continuity of care is considered post-discharge.

In the residential treatment programs, there is concern about handwashing compliance. Staff identified that alcohol-based rubs could not be used in these settings. It is suggested that best practice guidelines be researched for how hand-hygiene standards can be met in these settings.

Priority Process: Decision Support

There is a standardized approach to documentation that respects client privacy and incorporates high priority standards for things like falls prevention, medication management, and suicide risk assessment. They system is partially paper based and partially in electronic format, which poses some issues in terms of how information is retrieved and in terms of paper documents having to be transported and scanned.

Priority Process: Impact on Outcomes

The standards for implementation and measurement of quality improvement initiatives are met.

It is suggested the organization identify measurable goals and objectives at the unit level that are aligned with the strategic plan. A lot of work has been done to meet the recommendations of the Towards Recovery report and there is a good sense of what individual programs and teams are working toward in terms of client outcomes.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

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

The transfusion service as well as the laboratory service are regionally based programs.

The laboratory leadership supports the measurement of quality indicators that are used to improve services. Transfusion medicine has implemented electronic crossmatching as a quality improvement initiative. Staff are trained on the procedure changes and there is continuing monitoring of the data to ensure the desired benefits are achieved.

Staff training could be improved. The laboratory documents staff training; however, more frequent review of these records during the training period would be beneficial. Staff are responsible for training new staff and students who are enrolled in the laboratory technologist education program. The support of a laboratory clinical educator might be beneficial. The diagnostic imaging model for use of clinical educators might translate to the laboratory service. This would provide consistent and dedicated resources to support training, education, and ongoing competency assessments. The laboratory clinical educator could also support nursing staff with various training such as venous and capillary blood collection.

Nursing staff at St. Clare's Mercy Hospital have a clear understanding of the steps to be followed for the safe transfusion of blood products.

Home transfusions are not performed; therefore, no policies or procedures have been developed to support this practice.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: June 6, 2016 to June 11, 2016**
- **Number of responses: 13**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	15	85	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	8	92	N/A
3. Subcommittees need better defined roles and responsibilities.	77	8	15	N/A
4. As a governing body, we do not become directly involved in management issues.	0	8	92	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	8	92	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	69	0	31	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	8	8	85	N/A
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	N/A
12. Our ongoing education and professional development is encouraged.	15	15	69	N/A
13. Working relationships among individual members are positive.	0	8	92	N/A
14. We have a process to set bylaws and corporate policies.	8	8	83	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	18	82	N/A
17. Contributions of individual members are reviewed regularly.	27	18	55	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	60	40	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	8	8	85	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	31	23	46	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	23	15	62	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	8	8	85	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	27	27	45	N/A
27. We lack explicit criteria to recruit and select new members.	33	25	42	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	23	15	62	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	15	85	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	8	17	75	N/A
31. We review our own structure, including size and subcommittee structure.	15	15	69	N/A
32. We have a process to elect or appoint our chair.	27	9	64	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	8	23	69	N/A
34. Quality of care	8	31	62	N/A

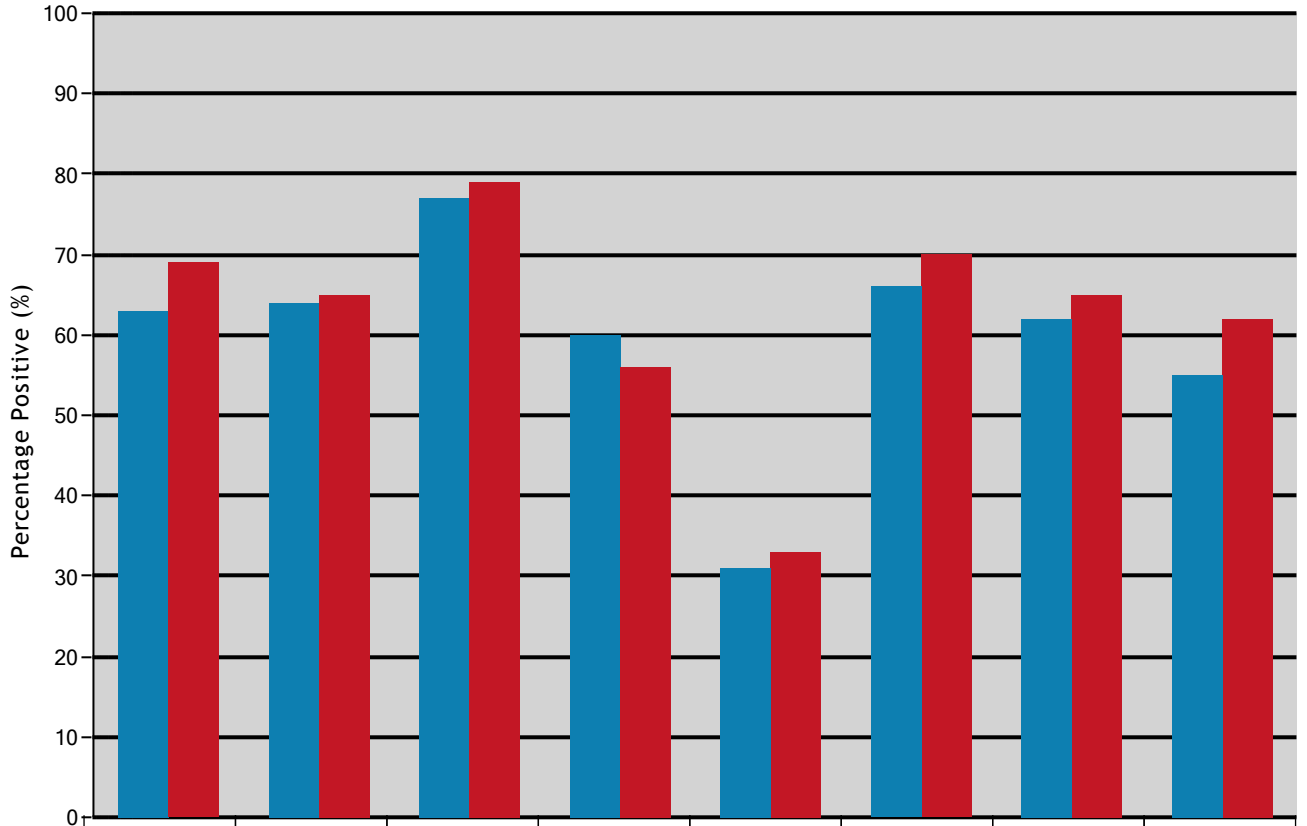
Canadian Patient Safety Culture Survey Tool

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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife. Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: February 8, 2016 to March 6, 2016**
- **Minimum responses rate (based on the number of eligible employees): 371**
- **Number of responses: 1065**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	63%	64%	77%	60%	31%	66%	62%	55%
	69%	65%	79%	56%	33%	70%	65%	62%

Legend

Eastern Health

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2017 and agreed with the instrument items.

Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

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

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