ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Eastern Health

St. John's, NL

Sequence 1 of 3

On-site survey dates: November 20, 2022 - November 25, 2022

Report issued: February 10, 2023

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 November 2022. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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: November 20, 2022 to November 25, 2022**

- **Locations**

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

  1. Carbonear Community Services Building
  2. Carbonear General Hospital
  3. Caribou Memorial Veterans Pavilion
  4. Coish Place
  5. Dr. Albert O'Mahony Memorial Manor
  6. Dr. G.B. Cross Memorial Hospital
  7. Dr. Leonard A. Miller Centre
  8. Health Sciences Centre (General Hospital)
  9. Major's Path
  10. Mount Pearl Square - Administration
  11. Pleasant View Towers
  12. Pte. Josiah Squibb Memorial Pavilion
  13. Southcott Hall
  14. St. Clare's Mercy 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

Service Excellence Standards

4. Assisted Reproductive Technology (ART) Standards for Clinical Services - Service Excellence Standards
5. Assisted Reproductive Technology (ART) Standards for Laboratory Services -Service Excellence Standards
6. Medication Management (For Surveys in 2021) - Service Excellence Standards
7. Organ and Tissue Donation Standards for Deceased Donors - Service Excellence Standards
8. Reprocessing of Reusable Medical Devices - Service Excellence Standards

- **Instruments**

The organization administered:

1. Worklife Pulse
2. Canadian Patient Safety Culture Survey Tool
3. Governance Functioning Tool (2016)
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)	34	3	0	37
 Accessibility (Give me timely and equitable services)	23	1	0	24
 Safety (Keep me safe)	268	18	17	303
 Worklife (Take care of those who take care of me)	82	5	0	87
 Client-centred Services (Partner with me and my family in our care)	102	10	3	115
 Continuity (Coordinate my care across the continuum)	14	0	0	14
 Appropriateness (Do the right thing to achieve the best results)	404	37	13	454
 Efficiency (Make the best use of resources)	36	1	0	37
Total	**963**	**75**	**33**	**1071**

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	49 (98.0%)	1 (2.0%)	0	33 (91.7%)	3 (8.3%)	0	82 (95.3%)	4 (4.7%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	95 (99.0%)	1 (1.0%)	0	144 (98.6%)	2 (1.4%)	0
Infection Prevention and Control Standards	39 (97.5%)	1 (2.5%)	0	25 (80.6%)	6 (19.4%)	0	64 (90.1%)	7 (9.9%)	0
Medication Management (For Surveys in 2021)	86 (92.5%)	7 (7.5%)	7	45 (97.8%)	1 (2.2%)	4	131 (94.2%)	8 (5.8%)	11
Assisted Reproductive Technology (ART) Standards for Clinical Services	47 (82.5%)	10 (17.5%)	5	103 (88.8%)	13 (11.2%)	7	150 (86.7%)	23 (13.3%)	12
Assisted Reproductive Technology (ART) Standards for Laboratory Services	55 (94.8%)	3 (5.2%)	2	61 (88.4%)	8 (11.6%)	2	116 (91.3%)	11 (8.7%)	4

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	50 (92.6%)	4 (7.4%)	0	84 (90.3%)	9 (9.7%)	3	134 (91.2%)	13 (8.8%)	3
Reprocessing of Reusable Medical Devices	80 (93.0%)	6 (7.0%)	2	39 (97.5%)	1 (2.5%)	0	119 (94.4%)	7 (5.6%)	2
Total	**455 (93.2%)**	33 (6.8%)	16	485 (92.0%)	42 (8.0%)	16	940 (92.6%)	75 (7.4%)	32

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
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 (Assisted Reproductive Technology (ART) Standards for Clinical Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Assisted Reproductive Technology (ART) Standards for Clinical Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
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 (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 (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

Summary of Surveyor Team Observations

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

The board of directors at Eastern Health (EH) has an up-to-date strategic plan designed and branded thoughtfully. There are clear vision and value statements that are easily understood. Several board members are alumni of the well-respected Institute of Corporate Directors program, and all board members avail of training and resources provided through EH's membership. The board understands and respects the roles of governance and management. Board agendas are structured to ensure adequate time for generative discussions and opportunities for fiduciary and strategic responsibilities. The board reviews their by-laws and policies regularly. The roles and expectations of board members are explicitly outlined and understood. The board indicated great respect for the competence of its executive leadership team and received ongoing formal and informal reports and updates from the CEO. EH and other regional health authorities (RHAs) await the emergence of the new provincial authority. EH is actively participating in supporting the new authority's planning and consultations.

Community partners commended EH for its professionalism, responsiveness, and solution-focused collaborative approach. Examples of collaborations for health promotion and welcoming newcomers were shared. Partners were also complimentary of EH's COVID-19 response, particularly its flexibility and frequent communications.

Since the last accreditation survey, Eastern Health (EH) employees have faced considerable challenges. An air of fatigue and uncertainty exists, given the government's intent to consolidate all regional health authorities into one provincial agency. Leadership at EH are highly mindful of the challenges faced by their employees. A strategic priority identifying psychological safety has been established, and initiatives have been undertaken. Eastern Health (EH) is commended for its investment in and commitment to quality improvement, patient and staff safety, and risk management. While they note it has been frustrating to have lost ground in their journey to excellence because of myriad significant disruptive events, the team's enthusiasm and commitment are evident and infectious. The Department of Quality and Risk has expanded in numbers and functions and integrates strategic roles such as client relations and people-centred care. There is clearly an attempt to achieve an integrated quality management approach throughout the organization.

The organization has devoted significant resources and efforts related to medication reconciliation. Most tests of compliance for the Required Organizational Practice (ROP) are met. However, the organization is challenged to have reconciliation completed in emergency before admission to the medicine units.

A robust risk management program exists based on well-regarded Healthcare Insurance Reciprocal of Canada HIROC resources and the commitment of the executive and the team. A risk register is created and reviewed regularly.

The organization has embraced many tenants of people-centred care (PCC). Eastern Health (EH) has a well-developed client and family engagement framework that aligns with the organization's strategic values.

More than eighty client and family advisors have been recruited. Advisors receive orientation and ongoing support to be successful in their roles. Leaders have seen a marked increase in the demand for advisors to serve on program and site committees and project teams. The organization has a clear vision for expanding people-centred care, and work is required, so the tenants of people-centred care are hard-wired into how EH conducts its operations.

Since the last survey, the team has integrated all 12 disaster codes into one “all hazards” plan. The plan is the responsibility of the Regional Protective Services team. The team is to be commended for their work to make Eastern Health “disaster ready”.

The organization has recently experienced three major disasters besides battling a global pandemic. Teams implemented their disaster plans, were nimble, and adapted to evolving events. The organization conducts monthly fire drills. Business Continuity Plans (BCPs) are up to date. The Regional Protective Services team has strong relationships and partnerships with police, ambulance, fire teams, municipalities, and Paladin (who provides security for the organization).

There have been significant investments and improvements in the medical device and reprocessing department (MDRD). The investments were due to MDRD leadership's efforts, personnel engagement, and new state-of-the-art endoscopy reprocessing technology at the Carbonear General Hospital and the MDRD unit at the Health Science Centre. More investments are recommended to be made at other sites to address the absence of physical separation in the sterilization and sterile sections. The goal is to bring all the sites to the same level.

The biomedical department has rigorous preventive maintenance not only for MDR equipment but all equipment on all sites. Objectives and quality indicators are monitored, and follow-ups are done. Regional educators are assigned to specific programs and help ensure standardization. The quality culture is very much present in the MDRD and Biomed through the addition of three full-time quality positions, which are responsible for all the quality programs of both departments.

EH operates on a $1.7 billion budget that is allocated following established best practices and supported by policies to guarantee proper utilization and monitoring of resources, including yearly audits. Infrastructure varies within the health authority. There are new modern facilities, stable and still highly functional facilities, facilities undergoing renovations and redevelopments, and other facilities that are aging and challenging to maintain. A major equipment investment was made 12 years ago, and much of the equipment are at end of life and will all have to be replaced at the same time. In the future, one of the major challenges is defining the new normal and building operational and capital budgets that are stable and sustainable.

The Assisted Reproductive Technology (ART) team practice is guided by Health Canada’s Assisted Human Reproductive Act and Safety of Sperm & Ova Regulations. Patients and families experiencing infertility can have an investigation, testing, and Intrauterine insemination performed at the ART Clinic at Major’s Path. The ART team works hard to remove barriers for their patients/families, mainly by doing preparation work and follow-up care for invitro fertilization that must occur outside the province.

The fertility clinic has recruited a world-class scientific director who is a pioneer in the fertility field. This addition has increased quality and staff confidence tremulously. The laboratory became a separate entity in 2022.

The Infection Prevention and Control (IPAC) team was integral to the COVID-19 pandemic response. IPAC resources which were increased to provide support, are coming to term, and it is recommended to review the level of funding and its impact on IPC's regional mandate.

The pharmacy team works with several regional committees, including quality, drugs & therapeutics, and smart pump. Since the last survey, the team has implemented new compounding standards, technologies, expanded clinical services and scopes of practice. The pharmacy team is commended for their quality work and innovative projects, such as the Chemotherapy Vial Optimization Program, which has clinical benefits and generates $1.75 million in savings annually.

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		
4.1	The governing body works in collaboration with the organization's leaders to develop the organization's mission statement.	!
4.2	When developing or updating the mission statement, input is sought from team members and external stakeholders, including clients, families, and partners.	
4.4	The organization's mission statement is regularly reviewed and revised as necessary to reflect changes in the environment, scope of services, or mandate.	

Surveyor comments on the priority process(es)

The board of Eastern Health (EH) is appointed by the government and is subject to term limits as specified in their by-laws. The board has worked with the government and the Independent Appointments Committee of the province to utilize a skills matrix to highlight competencies and gaps in membership that can guide the recruitment and selection processes. A comprehensive orientation, onboarding, and mentoring are provided to new members. New members were satisfied with the orientation process. It was suggested that an orientation package be sent to new members before the first meeting so new members could read and be well-prepared and updated on board issues. It is understood that work has been done for a common orientation for all board members of regional health authorities in the province and will likely be utilized under the auspices of the new provincial health authority due to assume control in April of 2023.

The board has an up-to-date strategic plan that is thoughtfully designed and branded. There are clear vision and value statements that are easily understood. The board has opted not to have a mission statement, and the government does not require regional health authorities to have one. Leaders and governors who transition into the new provincial authority are encouraged to review the purposes of a mission statement and how it can aid in motivating members and complying with evidence-informed accreditation expectations.

Several board members are alumni of the well-respected Institute of Corporate Directors program, and all board members avail of training and resources provided through EH's membership. Travel restrictions because of COVID-19 have significantly curtailed the board's efforts to meet community members served by the authority and reduced learning events outside the province that has traditionally fueled innovation, awareness of best practices, and benchmarking.

The board understands and respects the roles of governance and management. Board agendas are structured to ensure adequate time for generative discussions and opportunities for fiduciary and strategic responsibilities. Implementing a consent agenda has afforded the organization efficiencies at board meetings that have been regarded as helpful.

The board has by-laws and policies that are regularly reviewed. Roles and expectations of board members are explicitly outlined, and members are required to sign pledges of confidentiality.

The board indicated great respect for the competence of its executive leadership team. The board receives ongoing formal and informal reports and updates from the CEO. EH followed a thoughtful process in selecting an interim CEO as EH and other regional health authorities (RHAs) await the emergence of the new provincial authority. EH is actively participating in supporting the new authority's planning and consultations.

EH has adopted the tenants of People-Centred Care (PCC) and encourages and supports over 80 client and family advisors who are active and seen as partners on most committees and projects. The board knows that increasing engagement opportunities and having supportive structures and options will take time.

The organization is encouraged to ensure staff are coached on the tenants and expectations of PCC within EH. Patient stories are shared with the board twice per year. The board is encouraged to consider beginning each meeting with a brief agenda item where a member of leadership shares a positive patient story and a less than positive story.

Credentialing of medical staff occurs with regularity and rigour. The Credentialling Committee is regarded as a prime training ground to assist members in obtaining a complete picture of the healthcare milieu and the challenges, particularly concerning the recruitment and retention of medical staff. The Vice President of Medical Staff sits on the board, and the medical school dean is an ex-officio member.

The board is knowledgeable about quality and patient safety and receives regular reports through its sub-committees and directly to the entire board. The board has developed a schedule to receive presentations from each program area. The board provides detailed formal feedback to these programs. The board has focused on developing a "just culture". It is beginning to see the benefits of supporting the identification of errors and remediation without fear of unjust punitive measures and shaming.

A key challenge for the new authority will be recruiting and supporting governors willing to commit time and energy to the complexities of healthcare governance. The board has shared this concern with the Minister and advocated for the diversity of membership with people willing and able to assume such important and challenging roles. The board subjects itself and individual members to ongoing evaluations of performance.

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	
4.1 There is a process to develop or update the mission statement with input from team members, clients, families, and key stakeholders.	

Surveyor comments on the priority process(es)

Eastern Health (EH) has developed and shared a comprehensive and easy to understand strategic plan. The board is commended for the style and format of the presentation and for colour coding the strategic directions. A Community Health Assessment was undertaken to assess the needs and concerns of those served by the organization. The assessment process also allowed EH to supplement its information on the health status of citizens. Several mediums were utilized to reach as many people as possible. Local, provincial, and national information providers such as Citizen Advisory Committees, the Newfoundland Labrador Centre of Health Information (NLCHI), and the Canadian Institute of Health Information were also engaged. Processes to ensure the validity and reliability of information exist, and the organization is encouraged to continue its assessment of best approaches to optimize its information gathering strategies.

Client and family engagement has become a key component in decision-making processes. Several relevant examples were shared during the survey.

The organization has invested in powerful software and enthusiastic and highly capable staff to ensure data is collected, interpreted, and shared in line with the board's needs and the requirements of the Transparency and Accountability Act. This team compiles regular reports on the strategic directions and assists programs in aligning their respective operations to the strategy, as well as developing performance measures that are readily accessible through a portal and reported to the leadership and board on a regular or on-demand basis. The organization is challenged to ensure employees understand how their operations align with and contribute to the broader strategic directions. EH also has developed limited internal capacity to support program and service evaluation and alignments. Planning processes are reviewed, and enhancements are made as needed. The organization is encouraged to continue its initiative to move to more outcome-based measures and find an appropriate number of key performance indicators. The organization is also encouraged to acquire increased data measurement and data analyst capacity to support teams. Through collaboration and rigorous processes, the team appears driven and capable of enhancing accountability within EH. It has begun establishing the potential for transformative change in healthcare quality and safety and its diverse population's health.

Leadership and planning staff demonstrated an understanding of the key components of change management. While no formal model was adopted, COVID-19 taught EH that change could happen quickly, and they see this as a time to reflect on how change was managed and how the organization could do better.

Risks are a part of healthcare and are identified and managed at the program and strategic levels by the board and leadership. A risk register is utilized and updated regularly. The board and leadership are encouraged to utilize a “heat map” approach to monitoring risks and encouraging the organization to understand the importance of ongoing monitoring and mitigating risks.

The organization has embraced many of the tenants of People-Centred Care (PCC). More than eighty client and family advisors have been recruited. Advisors receive orientation and ongoing support to be successful in their roles. Plans exist to increase the number. Leaders have seen a marked increase in the demand for advisors to serve on program and site committees and project teams.

The organization and community partners identified numerous examples of working together to promote health, wellness, and disease prevention. It was evident EH is well connected to its community partners and was frequently visible and supportive of community events and initiatives. EH is a strong and active advocate for healthy public policy. EH partners with a myriad of groups and agencies in their communities on significant public health initiatives such as housing, immigration, cost and security of food, access to primary care, and a “living wage” for citizens.

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)

The Eastern Health Authority has a strong resource management team that has faced many major crises over the last three years. Their resilience, innovation, response, and partnerships enabled them to overcome these significant provincial events and ensure patient, and staff safety was their priority. Overcoming these events permitted them to be recognized as leaders in the province and are well respected by the Ministry of Health.

The EH operates on a 1.7 billion budget that is allocated following established best practices and supported by policies to guarantee proper utilization and monitoring of resources, including yearly audits. Resource management is divided into three main categories: operational, capital projects, and capital equipment. The operational group has experience with the extreme need for human resources but has created partnerships with colleges and universities in the province and even internationally to fast-track certification and licensing to address the shortage of human resources. They utilize benchmarks for resource allocation and program budgeting, and marginal analysis (PBMA) with prioritization software to guide them with decisions. Certain aging structures challenge capital projects. A priority ranking system with specific criteria includes feasibility study, patient focus, patient risk and other help to establish priorities. Emergency funds are available for capital equipment, and equipment replacement or purchase always utilizes risk mitigation. A significant equipment investment was made 12 years ago, which means much of this equipment is at its end. It will all have to be replaced simultaneously, requiring important and careful planning for the major investments in replacing this equipment.

The careful monitoring of budgets relying primarily on utilization statistics for their resource allocation and spending has enabled them to have a contingency budget by using PBMA to reallocate resources to other programs in need.

Having experienced three major crises in a short time, one of the major challenges is defining the new normal. The new provincial accord will be a significant challenge for EH and all the health authorities in Newfoundland. They are in the process of evaluating their benchmarks. The partnerships that are still ongoing that EH has created with the other health authorities and their partners over these crises will be a valuable tool to move forward and certainly help them through the transition to the new health accord.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the last accreditation survey, Eastern Health (EH) employees have faced considerable challenges. An air of fatigue and uncertainty exists, given the government's intent to consolidate all regional health authorities into one provincial agency. Leadership at EH are highly aware of the challenges faced by their employees. A new workforce management solution has been implemented, and many human resource management functions have been automated. A strategic priority identifying psychological safety has been established, and initiatives have been undertaken. In addition, collective agreements dictate staff scheduling that also impacts the quality of work life and rules of engagement for what the organization can and cannot do.

The strategic plan has a prevention focus. Trends are followed, and key performance indicators related to overtime, violence, injury, and culture are tracked and reported. A workplace violence prevention policy exists, and there has been significant collaboration with the organization's five unions. There is a robust disability management group that works with Workplace NL to facilitate return to work opportunities. There is compliance with occupational health & safety legislation, and best practices are followed. Audits of internal occupational health and safety matters ensure standards are met and maintained. Fifty-four site Occupational Health & Safety Committees and a regional committee exist.

A conduct and discipline policy exists and was recently updated based on previous lessons learned. The policy also closely aligns with EH's move to implement a "just culture". A civility and respect campaign was launched, and examples of posters, pins, and T-shirts were noticed during the survey. EH is commended for establishing a harassment-free workforce facilitator role.

A human resource plan was developed with the help of a third-party expert. The perceived needs of employees were identified along with four pillars and corresponding action plans. The organization's culture is assessed annually, and Organization Development reviews the results and engages units and programs. Team charters are developed to define the type of culture aspired to.

A talent management plan exists with formal programs and individual pathway opportunities. Succession plans are developed at each level. New managers are assigned a buddy to help with the transition. It is commendable that EH has a strategic alliance with the Canadian College of Health Leaders to achieve advanced standing and Canadian Health Executive equivalency through its in-house leadership training. A learning management system is well subscribed. Learning system modules can be automatically assigned, and participation tracked. The organization is commended for sponsoring the Violence Safety Symposium, which boasted an excess of 1800 attendees.

Reporting relationships were noted to be problematic for the approximately 1500 temporary call-ins who often report to a manager they may never see. The organization is aware of this less than desirable situation and is encouraged to seek creative ways to improve the clarity of reporting relationships.

All staff are afforded opportunities for exit interviews online or in person; however, there is low uptake.

EH is encouraged to follow up directly with these former employees after a period of time to offer an interview again.

During the survey, a sample of employee records was examined and found to be complete.

The human capital team has made progress in adopting people-centred care principles into its operations. The inclusion of people-centred principles into daily practice sends a powerful message to the organization and the incumbent about a key strategic direction to better engage patients and family advisors in all aspects of the organization's work. Patient Advisors were afforded opportunities to interview short-listed candidates for senior leadership positions.

EH's executive articulated its appreciation and respect for its employees and their resilience through a significant weather event, COVID-19, and a cyber attack. They understand the fatigue of their staff and partners and are concerned about their general bandwidth to absorb the ongoing changes within the workplace and society in general. The organization is encouraged to maintain and, if possible, accelerate its recognition programs and seek every opportunity to support and communicate with frontline staff, physicians, and managers.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Eastern Health (EH) is commended for its investment in and commitment to quality improvement, patient and staff safety, and risk management. The Department of Quality and Risk has expanded in numbers and functions and integrates strategic roles such as client relations and people-centred care. There is clearly an attempt to achieve an integrated quality management approach throughout the organization. Productive relationships are established with other organizational departments and functions, including clinical and support programs. Quality and Risk provide specialized support throughout EH via collaboration and consultation with others such as the Planning Performance and Privacy Department. The team also has strong support from data analytics and a competent Administrative Assistant.

The organization has a well-developed Quality Plan entitled Journey to Excellence that links to EH's strategic directions. A Quality Council whose membership includes most of EH's executives meets regularly and oversees progress on the quality plan. There are also quality committees functioning throughout the organization. Executives have completed a substantial LEAN Management training program delivered by in-house expertise. Executives sponsor kaizen events. Patient representatives participate within the quality structure and are supported in their roles as members of quality committees. EH's strategic planning initiatives include the active involvement of the many members of the Quality and Risk department. Key performance indicators related to quality and risk are part of the board's strategic plan. The team is encouraged to task the expertise within its group to identify, measure, and report specific key performance indicators within its Journey to Excellence plan.

The board receives patient stories on a scheduled basis or if significant adverse events occur. Quarterly quality reports are presented to board committees and the board.

A robust risk management program exists based on well regarded HIROC resources and the commitment of the executive and the team. A risk register is created and reviewed regularly. Quality and risk managers are linked to organizational programs (a "boots on the ground" approach) to support managers in regularly assessing risks. The organization is encouraged to continue its education efforts to help managers understand that not all risks can be eliminated but have to be managed and mitigated.

The organization has been guided by a patient safety plan that is now due for review. The organization is encouraged to consider reducing the number of key performance indicators in the plan's next iteration to maximize focus and attention on a "vital few" areas and bring concerted efforts to make the desired improvements. EH continues to educate patients and families about reporting patient safety incidents. Pamphlets exist; However, feedback indicates that many still do not know when or how to report. Efforts continue with education. Unit managers are also encouraged to resolve matters through personal interactions.

The organization strives for transparency and truthfulness and is governed by its values and provincial legislation for patient safety. A comprehensive disclosure process exists when there are adverse events. Supports are made available to patients and family members under such circumstances.

Considerable strides have been made. EH has undertaken a phased approach toward achieving a “just culture” within the organization. There is evidence of leadership support and a successful collaboration involving the Quality and Risk Department, Professional Practice, and Human Resources. Management training has been provided, and education for staff is about to begin.

Prospective analysis related to patient safety occurs. Most recently, a failure mode effects analysis related to virtual care was undertaken, and lessons learned will be transferable to other category B sites within EH.

The organization has devoted significant resources and efforts related to medication reconciliation. Executives review progress regularly, and there has been physician engagement through memos and learning modules. Most tests of compliance for the Required Organizational Practice are met. However, the organization is challenged to have reconciliation completed in emergency before admission to the medicine units. While challenges with competing demands and high volumes within the emergency department are understood, the organization is encouraged to continue exploring ways to overcome this known deficit in patient safety and best practices. The team shared that it is optimistic that a new clinical information system (that has yet to be procured) will enable a “force function” within the charting. Until then, medication reconciliation on admission remains to be addressed.

Contracted services within EH are regularly evaluated. There are many examples of how EH has sought feedback from clients and partners and incorporated suggested changes such as dining experiences in long-term care, increased empathy training, complaint follow-ups, and better promotion of the client relations office.

The team is quite proud of its efforts and capacity to effect change. While they note it has been frustrating to have lost ground in their journey to excellence because of myriad significant disruptive events, the team’s enthusiasm and commitment are evident and infectious. Presentations to the surveyor related to quality improvement projects on stroke and reassessment by staff in several frontline programs demonstrated that there are capacities for, and interest in, seeking better ways for patients and families. They are also highly conscious that they are working with a tired staff that may have limited bandwidth to fully engage in quality improvement in the face of many ongoing and urgent demands.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There has been a longstanding tradition of principle-based care and decision-making founded upon ethics and values at Eastern Health and its predecessor organization. Today, Eastern Health's Pastoral Care and Ethics Department administer the Provincial Health Ethics Network Newfoundland Labrador (PHENNL), an ethics consultation service for the provincial health system of which Eastern Health (EH) can also avail. The service allows open and frank discussion of ethical issues and aids in making ethical decisions related to clinical cases, operations, policies, and systems. A symbiosis has been nurtured between EH, PHENNL, and Bioethicists at Memorial University to provide consultations and education. There are intake processes and timely and efficient responses. Legal services are also active in many consultation processes.

Pastoral Care and Ethics have become integral to EH's strategic planning processes and may be regarded as the organization's conscience.

Several frameworks exist as tools to facilitate ethical discussions. There are examples of changes in policies based on the dialogues and consultations. Key areas of focus in recent years include topics such as harm reduction, discharge planning, accessing services, and many COVID-19 related matters. The organization is encouraged to refine or develop tools to assist frontline staff and clients in identifying and considering ethical issues.

There have been many examples of how EH has worked to build organizational ethics capacity. A certification program comprised of eighteen modules has been developed and is accessible to staff. Lectures by local and international ethic experts are offered. Celebrations to recognize National Ethics Week include lunch presentations by Masters of Ethics students from the university.

The service will be challenged to maintain responsiveness as evolving world issues impact health systems and those seeking services. In addition, the transition to a single health authority will also increase the diversity of issues requiring attention and potential consultations and education. The voice of clients and family members will is recommended to become embedded in ethical decision-making discussions.

Although there is a contingent of four bioethicists engaged with PHENNL, these positions are full-time university faculty positions. As demands increase and bioethicists continue in their university roles, concern exists about the sustainability of the service. The organization is encouraged to continue its support of principle-based care and decision-making and advocate and lobby for resources to sustain this provincial program that has demonstrated its value.

All research applications are reviewed by a research ethics board that includes physician oversight and follows relevant legislation and policy. The organization is encouraged to be ever vigilant and rigorous in maintaining fidelity to its current ethically reviewed processes as it pursues increased clinical trial projects with industry partners and a "low rules" approach to its innovation agenda.

A code of conduct has been developed to guide employees and governors of EH.

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)

During the survey, communications at Eastern Health (EH) were assessed in several ways, including a substantial document and website review, interviews with a team from Corporate Communications and with a team comprised of Information Management, Information Technology, Privacy staff, and partners from the Newfoundland Labrador Centre for Health Information (NLCHI). Staff and clients were also interviewed.

EH has a comprehensive communications plan aligned with the organization's strategic plan. Communication initiatives were developed as part of the broader strategic planning process and can also be needs driven and often responsive to opportunities that present themselves. The team is commended for its creative use of colour coding strategic initiatives and supporting materials.

Staff with Corporate Communications could be described as a small but mighty and hard-working team with diverse perspectives, creativity, and skill in their responsibilities. Key files are assigned to team members who relate to and have ongoing interactions with related programs. Corporate Communications have become trusted advisors and counsellors within the organization and are usually engaged early in many circumstances. Communication plans are created for most new policies and organizational initiatives. The team is also proactive and monitors traditional local and social media.

Communication initiatives are evaluated for effectiveness, and adjustments are made as deemed necessary. A standards document and templates guide clear policies for communicating exist and the organization's branding materials to ensure consistency. Accounts of corporate communication efforts are regularly reported.

Representatives from Information Management, Information Technology, and Privacy worked heroically together with other partners to respond admirably to a recent cyber attack. Legislative and political directives were followed, and the provincial Privacy Commissioner and law enforcement officials were also engaged. Breeches of privacy were publicly disclosed. Existing relationships with partners were leveraged to aid the recovery. Lessons were learned, and the cyber-attack has become a sentinel event, resulting in a significantly improved security posture. There has also been the acquisition of a suite of security products and educational and operational initiatives as part of a multi-year "breakwater" effort. EH lacks a single integrated health information system and maintains several disparate clinical support systems that are becoming dated. The organization is encouraged to continue its procurement of a single health information system. EH is also working with its service partner NLCHI to acquire a fully electronic health record to enhance patient and provider access to health information. Dedicated staff and EH's Privacy team will assist with the implementation anticipated for Spring 2023.

EH has worked with NLCHI to build the capacity to mine data to inform practices and create dashboards of performance indicators. Data analytics and decision support tools exist. A formal shared service model with NLCHI includes regular interactions and evaluations. Opportunities and demands in digital health are expanding beyond the capacity to respond to all requests. EH's executive is engaged in reviewing priorities.

Library Services exist, and utilization of key services is assessed and reported.

Priority Process: Physical Environment

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
9.1 The physical space meets applicable laws, regulations, and codes.	!

Surveyor comments on the priority process(es)

The physical environment at Eastern Health (EH) sites identified for visits during the survey did not fully meet applicable laws, regulations, and codes. Elevators at the sites visited contained expired certificates issued from Service NL, the provincial agency responsible. Surveyors brought this to the attention of EH, who were told that EH is following up with the government. Also, certificates on boilers, deaerator, and sterilizers at St. Clare's Hospital expired in October 2022. This presents significant risk, and the organization is encouraged to pursue inspections expeditiously.

While the facilities differ significantly in terms of age and unique challenges, it is clear that the regional and site infrastructure management are knowledgeable, committed and supported by regional expertise, technology, and high expectations. A Facility Condition Index (FCI) is established and benchmarked. A strategic asset management approach exists within the Infrastructure Support service. A quality division trains and supports sites. A computerized maintenance system is highly leveraged and valued to notify and track preventative maintenance and utilize project management. Code checks are undertaken before upgrades and renovations. Hazard assessments are performed and reported. Any staff can report any actual or potential hazard. One lead manager oversees all asbestos related work to ensure proper procedures are followed.

The Health Sciences complex engages in shared service arrangements with the university and requires ongoing collaborations, including the fire department. A collaborative professional relationship exists with the local fire departments. Fire departments are involved with specific user groups on new project steering committees to ensure all stakeholders understand requirements. Facilities are inspected, and directives are given.

Staff are trained on infection prevention standards and codes, asbestos abatement, and negative pressure. The latest standards are followed for staff and patient safety. Contractors require a safety orientation developed by EH, and permits are required for daily work. EH follows the Public Procurement Act, and contractor performance is assessed and ranked using data-driven metrics for safety and quality. All contractors must be CORE certified with the provincial construction agency.

Patient advisors are engaged and deemed invaluable resources in new designs and renovations. EH's team responsible for infrastructure support are to be commended for its investment in and application of technology.

Coordination between EH and NL Power exists concerning power supply at facilities. All generators have backup capacities and appropriate redundancies. Contingency plans and business continuity plans are in place. Redundancy loops allow for flexibility and isolation of key services, and multiple power feeds are available.

EH make significant efforts to be efficient and minimize operational impact on the environment. Innovations are pursued and have demonstrated success. Laboratory Services use drier reagents to facilitate multiple tests in a single test tube. Medical device reprocessing is exploring moving from blue wrappings and investing in reusable containers. There is a definite push to reduce carbon reduction and pursue increased electrification within operations as part of EH's journey to net zero initiatives. There is a reclamation of anesthesia gases initiative and electric vehicle charging stations being established. An energy performance contract exists, and savings verification facilitates facility renewal investments. An Energy Performance Manager tracks consumption and optimizes energy savings.

Infrastructure Support is a proactive regional service that provides efficient, effective, innovative, professional, and high-quality support to EH and its many sites.

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)

Over the last 2.5 years, the organization has had the opportunity to utilize its outbreak management plans to cope with the global COVID-19 pandemic. The outbreak policies are up to date and provide strong guidance and a blueprint for action.

Since the last survey, the team has integrated all 12 disaster codes into one “all hazards” plan. The plan is the responsibility of the Regional Protective Services team. The team is to be commended for their work to make Eastern Health “disaster ready”. The Incident Command methodology is used for disasters. All staff are encouraged to attain ICS100, particularly if they will be in an Emergency Operations Centre (EOC). Staff in the Regional Protective Services team have a minimum of ICS200, with several team members attaining ICS300 or higher.

The organization has 12 codes, and all staff have access to videos regarding these codes on their learning system (LEARN). The team works closely with all departments within the organization to ensure they know where their “teal” or “blue” binder is in case of a disaster.

The organization has experienced three major disasters in recent history: Code Red in a Mental Health unit that required evacuation, Code Grey in October 2021 (regional cyberattack), and Code Orange in September 2022, an explosion at a local refinery. In addition, they have been battling a global pandemic. Through these disasters, the teams used their disaster plans, were nimble, adapted to evolving events, and then debriefed and updated their plans accordingly. In speaking with a staff member whose husband works at the refinery, she remarked that “people are still talking about how wonderful Eastern Health responded to the event.” Five people had to be transferred out of the province via helicopter, another was kept on a ventilator, and two fatalities. The teams ensure there is psychological support for staff following these events.

The organization conducts monthly fire drills in “bedded” sites and regular fire drills in non-bedded sites. The drills are recorded. Learnings are shared, and plans are updated if required. There is ongoing training on EOCs. Business Continuity Plans (BCPs) are up to date. The team is now working on drilling down on their BCPs and increasingly ensuring they are comprehensive.

The Regional Protective Services team has strong relationships and partnerships with police, ambulance, fire teams, municipalities, and, of course, their close partners Paladin who provides security for the organization. The team is sometimes requested to participate in mock disasters led by their partners and appreciate these opportunities.

The disaster plans are tailored to the individual sites. There are Health Emergency Management (HEM) committees throughout the region where appropriate. When sites are small, they may be joined with a larger team. Fan out lists are kept up to date. The organization is recommended to continue to review plans involving partners and sites they do not have control over (such as evacuation sites owned by municipalities) and ensure they are accessible 24/7, 365 days per year. In sites that use “panic buttons,” ensure these work as designed and are tested regularly.

Priority Process: People-Centred Care

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

Unmet Criteria		High Priority Criteria
Standards Set: Assisted Reproductive Technology (ART) Standards for Clinical Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
7.4	A comprehensive orientation is provided to new team members and client and family representatives.	
7.12	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.	
18.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
19.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Assisted Reproductive Technology (ART) Standards for Laboratory Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
4.10	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
16.1	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Governance		
2.3	The governing body includes clients as members, where possible.	
Standards Set: Organ and Tissue Donation Standards for Deceased Donors		
5.7	A comprehensive orientation is provided to new team members and client and family representatives.	

18.8	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
19.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

Eastern Health (EH) has a well-developed client and family engagement framework that aligns with the organization's strategic values. A consultant has been hired and is active in recruiting and supporting client advisors, EH programs, and managers seeking advisors.

Demand for client advisors is growing, and the organization is encouraged to increase its contingent of advisors to meet the needs. EH's approach to utilizing advisors is to match the right approach to the right situation. They share, consult, involve, and collaborate components of the framework, which are well explained and practical examples of engagement activities for each component is highly insightful and appropriately simplistic and easy to understand. Teams shared examples where this has happened and resulted in high quality advice from their advisors.

The organization has a clear vision for expanding people-centred care, and work is required, so the tenants of people-centred care are hard-wired into how EH conducts its operations at all sites and programs. There are excellent examples of services being co-designed with patient and family advisors. However, this is not always the case; examples exist where this Accreditation criterion has not been met.

The human capital team has made progress in adopting people-centred care principles into its operations. Patient advisors were afforded opportunities to interview short-listed candidates for senior leadership positions. This sends a powerful message to the organization and the incumbent about a key strategic direction to better engage patients and family advisors in all aspects of the organization's work.

Executives are encouraged to promote PCC, continually set expectations, and hold programs and units accountable for progress. Capacity appears to help the growth of the PCC initiative, and sites/programs that do not avail are encouraged to seek support from the Client and Family Centered Care Consultant. Some sites/programs have yet to engage and utilize patient and family advisors.

A focus group of client advisors was convened during the survey. It comprised advisors from Eastern Health's catchment area and the province representing tertiary care service recipients. Advisors were pleased with the orientation they received. Client advisors hold the consultant in very high regard and felt she was a strong advocate and gave meaningful opportunities for participation. They felt leaders in the organization supported the advisory role and identified many ways EH made it easy for advisors to participate. Examples of how advisors were already able to contribute to improvements were shared.

Virtual meetings were identified as one of the biggest challenges faced by advisors, and the hope was that face-to-face meetings and networking opportunities would resume. Members of the group felt more education with managers on the value of the patient's voice would be beneficial. Advisors also suggested there were opportunities to have full access to the educational opportunities and documentation that was provided to the team. This would help them feel fully engaged as team members.

In summary, an advisor shared that in light of so much bad news regarding health care, the people-centred care initiatives were a great comfort – "such a bright light in a dark era."

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)

Management of patient flow is a priority of Eastern Health (EH).

There has been investment in a Clinical Efficiency unit that includes managers, discharge planners, and social work positions. A Clinical Efficiency program review was completed in March 2021, and recommendations were enacted. Core groups of staff from numerous programs huddle daily and weekly concerning bed management. Information and visual management systems track relevant indicators and are widely dispersed into the regional system. Sites maintain bed boards that track key indicators.

Executives also have access to daily site reports. There is a concerted effort to increase local awareness of flow-related system challenges, and tools exist to facilitate decision-making. There have been presentations to physicians sharing data on key indicators such as alternate levels of care, length of stay, and time of day discharge. Patient flow status updates for St. John's sites are shared with physician leadership daily. A Patient Flow Challenges Committee was established to evaluate patient flow data, and action plans were developed.

Based on CIHI, CTAS, and CAEP standards, appropriate benchmarks and targets are developed. Flow-related policies have been updated, and the Patient and Family Advisory Committee were utilized for many reviews. The time to consultation policy was recently reviewed and updated. Clinical chiefs were engaged in this process. It is suggested that when these types of policies are reviewed, patient advisors would present interesting and relevant input and not including patient advisors was a missed opportunity to advance people-centred care. A patient advisor has been recruited for the flow program.

The team demonstrated the ability to assess their strategies and make adjustments. Executives were "disinvited" from the "10:45 daily" event as the team felt the presence of executives stifled lower-level managers' abilities to problem solve and worked out matters before engaging executives. As a result, new protocols for escalation and standard operating procedures were developed and implemented. Related issues to flow remain a constant on the executive's Thursday meetings.

The team has pursued several changes and innovations in trying to improve flow. Clinical practice guidelines were established with physician groups. Advisors from the Visual Management Office have worked with the team and challenged pre-existing mindsets and practices. In addition, community advisory committees in rural sites are active and challenge operations and policies concerning flow, patient access, and transitions.

An ethics review was undertaken concerning the increased volume of community emergencies presented to acute care. The Ethics Committee had been engaged for issues dealing with patient flow. Those involved in the process found the results helpful and the experience valuable.

An Alternate Level of Care Planning group is active and comprises representatives from across the continuum of care. Representatives from acute care attend huddles with community support staff to understand and break bottlenecks in the system. Leadership in rural sites takes a proactive approach to bed management and flow processes. Efforts have been made to build bridges among the various continuum partners within EH and the broader health sector. EH's Overcapacity policy from 2009 is currently under review, and the organization is encouraged to complete this review without delay.

In summary, EH has a multi-prong strategy to address matters of patient flow. Technologies, data, information, and key performance indicators are utilized. Targets are established and monitored daily. A multidisciplinary team are proactive and undertake interventions and innovative way of facilitating improved flow. Their efforts are constantly assessed and evaluated, and changes in thinking and practice are encouraged and supported. Leaders are engaged and collaborative.

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		
3.2	The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
4.7	Routine testing of reprocessing equipment is performed and documented as per manufacturers' instructions.	!
8.3	Training is provided on proper hand hygiene techniques.	!
8.6	Eating and drinking, storing food, applying cosmetics, and handling contact lenses are all prohibited in the reprocessing area.	!
11.2	All flexible endoscopic reprocessing areas are physically separate from patient care areas.	!
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
12.1	The MDR department has an appropriate storage area for sterilized medical devices and equipment.	!

Surveyor comments on the priority process(es)

Since the last survey in the medical device and reprocessing department (MDRD), significant investments and improvements have been made. These improvements are due to the implication of the MDRD leadership and engagement of personnel. The significance of the staff in the planning and the realization of these improvements reflect this success.

Physical space was completely renovated over the years, such as the new endoscopy reprocessing at the Carbonear General Hospital and the MDRD unit at the Health Science Centre with state-of-the-art technology. More investments are recommended to be made at certain sites, such as the Carbonear General Hospital and St. Clare`s Mercy Hospital, to address the absence of physical separation of sterilization and sterile sections. It is suggested that the decontamination section of the Carbonear General Hospital be renovated to install a cart washer to make space more efficient and to address the issue of no personal space for staff. The goal is to bring all the sites to the same level. Currently, the OR's prostheses are stored in the sterile area of the MDR department. These nonsterile items are stored in an area that could only contain sterile items. These items need to be relocated outside the MDR department. This practice goes against all best practices.

A major investment in MDR equipment was made, and ergonomics was placed at the forefront. All the new equipment is completely adjustable, including the Rotomat in the Health Science Center and the St. Clare`s Mercy Hospital, which will prevent work-related injuries. Consideration could be made to purchasing a Rotomat for the Carbonear General Hospital. The deployment of the CareFusion in all three sites to manage the inventory of orthopedics supplies simplifies the confection of instrument trays. St. Clare`s Mercy Hospital optimized the utilization of this technology to oversee their complete inventory, automatically ordering missing supplies. This would be very beneficial to the other two sites.

There is a very strong relationship between MDRD and the biomedical department. The biomedical department has a rigorous preventive maintenance schedule for MDR equipment and all equipment in different sites. It is noted that the two sterilizers at St. Clare`s Mercy Hospital preventative maintenance, which were due in October 2022, were not performed.

Regional educators assigned to specific programs are responsible for the orientation, training, competency evaluation and continuous education, which guarantee standardization through the different processes.

The MDRD has shown innovation by installing cameras in the OR soiled room to optimize and be more efficient for picking up instruments ready to return to the MDRD. Also implemented a traceability system to deliver instruments to the OR, which can easily confirm the delivery was made.

The quality culture is very much present in the MDRD and Biomed through the addition of three full-time quality positions, which are responsible for all the quality programs of both departments. Objectives and quality indicators are monitored, and follow-ups are done.

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

Standards Set: Assisted Reproductive Technology (ART) Standards for Clinical 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.	
1.6	Services are reviewed and monitored for appropriateness, 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.	
2.6	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
7.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
7.13	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		
12.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
15.8	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		
17.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
17.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
19.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	

19.5	Quality improvement activities are designed and tested to meet objectives.	!
19.6	New or existing indicator data are used to establish a baseline for each indicator.	
19.7	There is a process to regularly collect indicator data and track progress.	
19.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
19.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
19.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
19.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients 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

The Assisted Reproductive Technology (ART) team practice is guided by Health Canada's Assisted Human Reproductive Act and Safety of Sperm & Ova Regulations. No IVF is performed in Newfoundland and Labrador (NL); however, the patients and families experiencing infertility can have investigation, testing and IUI performed at the ART Clinic at Major's Path.

The team has suffered some setbacks over the last 2-3 years. There have been some staff changes, and the team has been doing some team building. This has been necessary to ensure clarity around roles and responsibilities, respect for each other, and work done to help the team work more collaboratively. The team is in a good place now to move forward.

The team's main referral partners are Halifax, Ottawa, and Calgary. There is a good rapport with the referral partners, and the ART team works hard to remove barriers for their patients/families, particularly by doing as much prep work for IVF in NL and providing follow-up care in NL.

The documentation in the ART Clinic is on paper. An electronic record would likely reduce transcription errors and improve efficiencies in the clinic. For example, reception has to mail out appointments to their clients. This is tedious and expensive, may take longer to get appointments to clients and some patients voice they would prefer texts or emails. As the team shifts their focus from team building to working on quality issues again, this is something the team may wish to consider addressing early on. Person-centred other problems to tackle include adding bariatric equipment (chairs, exam tables) and having advisors participate in planning and monitoring at the clinic.

The team is currently monitoring trends in infertility, and a study is underway around the impacts of obesity/metabolic syndrome and infertility. A program has been implemented to support women who are obese and experiencing infertility to lose at least 5% of their body weight. Through the research, the clinic is learning that rather than focusing on the BMI, it may be more beneficial to focus on the cardio-respiratory health indicators and the overall relationship with infertility. NL has seen a significant increase in obesity in females.

The team is monitoring statistics now that they have emerged from the COVID-19 pandemic. They offer approximately 50% of in-person appointments and the other 50% virtual. The last patient satisfaction survey indicated that 83% prefer in-person appointments. The team believes that the timing of the survey may have led to results that may be no longer relevant. The team is encouraged to drill down into this and other results to find out more by either re-surveying or conducting focus groups with patients/families.

Priority Process: Competency

The reception staff are trained to clean the Trophon probes. It was noted through observation that the staff are well trained, competent, and proud of their contributions. Nurses, in addition to other duties in the clinic, monitor the provincial phone lines, following up on patient requests for information and direction. They do so with competence and compassion, recognizing that their clients struggle with loss and frustration and are anxious to move forward.
All staff have the required competencies, credentials, and liability protection. Managers verify credentials. In speaking with clinical staff, none had a performance appraisal in at least ten years. The team is encouraged to ensure that formalized feedback is completed regularly.

The security guard (Paladin) secures the clinic with a patrol hourly. The reception staff have plexiglass separating them from patients. They report feeling safe and have had no negative experiences with patients/families. There is a panic button to use on weekends with reduced staff numbers.

There are no smart pumps used at this site. The ROP for infusion pumps has been rated as not applicable. The team has been doing some work around how they collaborate. Staff/physicians report this has helped clarify roles and responsibilities.

One of the gaps expressed by staff is the lack of emotional support for patients/families. A psychologist or social worker could be an asset to this team.

Priority Process: Episode of Care

Many patients/families who come to the clinic are on a journey. Some patients may have suffered pregnancy loss, some may never have conceived, and others may wish to save eggs/sperm for various reasons (e.g., undergoing cancer treatment). Patients and families can be emotionally labile, and the team is mindful that the journey is sometimes difficult. Physicians provide options and then discuss the pros and cons of these options. The discussions are open, transparent, and with the most up-to-date information available. Patients/families appreciate the honesty and compassion they experience at the clinic.

For obstetrical care, those who need to go out of province for care (e.g., IVF) are followed up until they leave and continue their care immediately upon return. Often the time out of province is reduced because of the clinic's care.

There is a laboratory on site which can provide excellent services, reducing wait times and expanding the menu of testing available.

The intake process at the clinic is comprehensive, with excellent documentation. A range of options is provided. One gap noted is that no psychologist or social worker exists on the team. That could add value as many patients/families experience emotional turmoil during their journey.

While there is no evidence of ongoing training on ethics, ethical issues are proactively identified and dealt with. The ethics committee has been asked to provide advice on numerous occasions. A physician provided an example of a woman whose cardiometabolic health is compromised but is seeking fertility assistance. Knowing that the client is getting on in years, is in poor health, and consequently, a high risk for a negative outcome presents a dilemma, particularly for the medical staff.

The team is early in its journey to being patient or person-centred, and they are encouraged to focus on that aspect for this next cycle.

Priority Process: Decision Support

The staff work hard to protect the confidentiality of their patients/families. Record policies and procedures are followed. Currently, all records are on paper. This is not ideal, and moving to an electronic medical record would be beneficial and create efficiencies.

Much information must be shared within the clinic and outside the province. The staff uses great care in transferring and safeguarding patient information. Some laboratory tests can be time-sensitive, and staff work hard to ensure the appropriate data gets to where it is needed on time. Currently, there is no involvement of patient and family advisors in work around record keeping.

There can be forms and consents to complete throughout the process, and staff are mindful that this is a stressful and sometimes frustrating time for their patients/families. They support their clients throughout the journey and provide education and training as required.

Priority Process: Impact on Outcomes

The team provided nearly 9,000 visits last year and has excellent statistics on the types and reasons for visits. They performed a satisfaction survey in February of 2022 with some interesting results.

The team has developed a collaborative team based on mutual respect and trust. They appear to be in an excellent place to turn their efforts toward developing quality plans. It will be important to make this quality work visible to patients, families, and staff. Looking at the satisfaction survey, some good projects could be developed to drill down and understand some of the responses, such as overall satisfaction (58.7%) and emotional needs not met in 61.5% of respondents. Some assumptions have been made about these results, and it would be good to test them to ensure you can improve.

Statistics kept by the clinic are primarily manual due to the lack of an electronic medical record (EMR). A strong EMR could create efficiencies and allow better tracking for the team.

Integrating patients/families into the team will be important going forward. There are approximately 90 individuals who have expressed a desire to participate in the team in whatever way they can. Several standards in this section require input from patients/families, so integrating their voices will help the team achieve these standards.

Priority Process: Medication Management

Medication teaching occurs both at the clinic and partner sites. As IVF is not performed in Newfoundland and Labrador (NL), some teaching is performed at the partner sites (usually Halifax, Ottawa, and Calgary). The team in NL supports the clients up to and post their IVF and is available for questions or to address concerns about medication.

There is no medication administration on site. A few medications (Benadryl, Cytotec, Lidocaine, and an epi-pen) are in a locked room in a locked cupboard. The epinephrine expired one year ago, in October 2021, and the saline vials have also expired. As a quality improvement, the team could examine the medications they stock, determine if they are necessary to stock and manage the inventory by checking expiry dates monthly, ensuring the shelves are well labelled.

Priority Process: Infection Prevention and Control

The team follows regional policies on hand hygiene and infection prevention & control broadly. Hand hygiene audits are performed regularly. In 2021 the rates ranged from 57-98%, and in 2022 the rates increased to 92-100%. The team is to be congratulated on these results. Hand Hygiene training is completed annually via LEARN.

The reception staff cleans trophon vaginal probes. The staff take training and demonstrate competency. There is a bio-indicator with every probe, and the staff verifies these. Every probe is tracked, and the probe number is attached to the patient. The records are well done. Hazardous waste is managed well. The contact sites are cleaned with Accel.

Standards Set: Assisted Reproductive Technology (ART) Standards for Laboratory 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.	
Priority Process: Competency		
5.11	A code of conduct is followed by the team.	
Priority Process: Episode of Care		
3.5	There is separate office space for administrative functions such as record-keeping and data entry.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.3	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.8	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.9	Quality improvement activities are designed and tested to meet objectives.	!
16.10	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The assisted reproductive technology (ART) laboratory services are part of the fertility clinic at EH. The fertility clinic has recruited a world-class scientific director, a pioneer in the fertility field. This edition of the scientific director has increased quality and staff confidence tremulously. The laboratory was part of the biochemistry laboratory until April 2022, when it became a separate entity of the EH laboratory structure. This recognition permitted them to attain dedicated laboratory fertility Medical Laboratory Technician (MLT) positions. The services provided currently meet the needs of the clients. There has been renewed leadership in the clinic and the laboratory over the last few years. The focus was on team building and establishing respect and clear roles and responsibilities, which has helped the team to where they are now.

There is a plan to increase services, requiring additional equipment and physical space. The new scientific director is at the forefront of the standardization of routine semen analysis in the province, where the fertility laboratory would be the reference to guide all the other sites. There are discussions to explore the possibility of offering IVF to the population of Newfoundland. This will require significant investments in equipment, physical space, and the requirement of specialized staff such as embryologists. Careful planning and consideration will have to be made if this project could move forward.

Rigorous inventory control is in place to ensure adequate supplies, media, and solutions to offer high-quality and safe services.

The laboratory has established informal goals and objectives that are not formalized and documented. They are at the beginning of establishing a quality plan and program. Objectives are recommended to be clear, have measurable outcomes and success factors, and are realistic and time specific. Goals and objectives are meaningful to the team. They are reviewed annually or as needed, and their achievement is evaluated. Services are reviewed through client surveys, but no action plan exists to remove barriers or bring improvements.

Priority Process: Competency

The assisted reproductive laboratory offers services for semen analysis, and the staff has the required qualifications. The Canadian Society of Medical Laboratory Science (CFAS) code of conduct could be part of the quality program. A proper training program has been established, which is supported by the scientific director. Competencies are assessed. The scientific director offers continuing education, met with great appreciation from staff. The quality of services has increased by completely revising all the standard operating procedures using best practices. Aspiration benchmarks and KPIs have been introduced for sperm washing which the laboratory attains established targets. Position descriptions exist but could be reviewed since they date from 2016, and with the arrival of the new scientific director, some changes might be warranted.

Priority Process: Episode of Care

The laboratory maintains appropriate environmental conditions, monitored daily along with equipment and gamete storage. Records are well-kept and complete. A proper alarm system ensures the storage of gametes. The alarm system is tested regularly, which guarantees sample integrity. Complete inventory control and proper documentation, labelling, and supplies validation are in place.

The current physical space is adequate, but the layout does not permit a separate administrative space. It would be beneficial to have a physical separation between administrative and testing areas.

Reorganization of the current space could permit such a separation. The laboratory is exploring the possibility of increasing its service, which will require more physical space to purchase equipment. The collection room is located off a busy public hallway which does not leave much privacy. The furniture in the collection room does not meet the IPC codes and could be replaced. The drop-off and pick-up window in a busy public hallway does not permit confidentiality. Explore the possibility of relocating the collection room and providing more confidentiality for the client at the laboratory drop-off window.

Double identification is performed from beginning to end of every procedure and process. All the proper documentation and consents are in place for every service offered. A procedure is in place for the reception of donor sperm, and adequate documentation is maintained.

Proper and complete SOPs are in place for every procedure performed. The laboratory participates in two external proficiency programs for staff competencies.

Priority Process: Decision Support

The staff is very conscientious of patient confidentiality. The laboratory process and procedure to maintain accurate and secure records are well respected. There is some integration of pertinent documents in the client record. Currently, many documents or data are all paper-based. The laboratory and clinic do not have dedicated fertility software. The addition of this valuable software would permit complete integration of the clinic and laboratory and permit the extraction of important data to increase its services, quality of services, statistics, and indicators. Currently, this is not possible since most are paper-based.

Priority Process: Impact on Outcomes

The laboratory has completed a risk assessment using the Qmentum ART laboratory standards to identify gaps and improvement opportunities. A biological risk assessment was done along with an FMEA for the reception of sperms sample from external providers, where an action plan was developed and completed. The laboratory measures quality indicators such as aspiration benchmarks and KPI for sperm washing which the laboratory attains to the established targets. These indicators are focused on specific fertility indicators. The laboratory would benefit from establishing indicators to align with objectives or identify needed improvement areas.

Client satisfaction surveys were performed, and information and statistics were gathered. Analysis was performed, but no improvement opportunities have yet been identified and deployed. The organization is encouraged to include clients in improvement opportunities to increase their experience. The input of clients and families is crucial in the fertility setting since you mostly deal with clients and families that already have high expectations to realize their dreams.

Quality improvement activities are the actions undertaken to initiate improvements and are part of the larger quality improvement plan. The laboratory has many elements of a quality improvement program, but certain elements are missing examples of defined, measurable objectives and indicators.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
1.3	The resources needed to support the IPC program are regularly reviewed.	
2.4	There is an interdisciplinary committee to provide guidance about the IPC program.	
8.5	Reminders are posted about the proper techniques for hand-washing and using alcohol-based hand rubs.	
9.3	There are policies and procedures for cleaning and disinfecting the physical environment and documenting this information.	!
9.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	
9.7	When cleaning services are contracted to external providers, the quality of the services provided is regularly monitored.	
14.3	Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The IPAC team was integral to responding to the COVID-19 pandemic and providing support and safety to the population and employees. The IPAC team, with the arrival of the COVID-19 pandemic, was, attributed to additional programs such as correctional services, personal care homes, primary health, and long-term care homes. The IPAC resources were increased with five temporary positions to provide support. The term of these temporary positions is coming to term. The IPAC program has requested that three positions become permanent to continue supporting those additional programs that will remain under their jurisdiction. There are issues with the availability of human resources where the organization is recommended to provide immediate attention. Due to the large geographical distances between rural and community sites, more resources are required to maintain the current level of presence and to be able to do preventive instead of reactive in IPC. The scenario in the largest establishment is mostly due to the volume of activities where additional resources are needed. Many projects were sidelined during the COVID-19 pandemic, and without those extra resources, the deployment of those projects will be further delayed. The mandate of the IPAC is to prevent outbreaks by protecting the community and staff. Additional resources would be a consideration to allow the team to continue fulfilling this mandate.

The IPAC team is very involved and present in all the activities in all establishments. Any IPAC activities do not support certain establishments under the EH jurisdiction such as the five faith-based facilities. The IPAC teams would ideally be present in all EH establishments to provide a safe environment for residents and staff. It is recommended that IPAC work with these facilities. They are in the process of finalizing a cleanliness policy which will include 17 EVS policies which include the participation of patients. To further increase patient and staff safety every external contractor must follow an in-person mandatory IPC orientation course. IPAC surveillance is rigorously done. All the statistics, except for hand hygiene compliance, are done manually. The current computer system is not able to extract statistics to make reports. This is a major issue when dealing with IPC not being able to generate reports in real time. The organization could consider purchasing a system or finding a solution to generate these very important statistics to increase patient safety and prevent unnecessary outbreaks due to unavailable data.

Hand hygiene compliance has increased from 84% in 2020 to 93% in 2022. Hand hygiene audits are performed, and results are available to all staff, patients, residents, and visitors, with television screens on each unit. Staff auditors have been trained to perform hand hygiene audits to communicate the importance of hand hygiene further. Currently, hand hygiene education is mandatory in the hiring of new staff. To stress the importance of hand hygiene, education on hand hygiene could be mandatory at a defined frequency as other mandatory sessions. It is recommended to conduct audits on patients and visitors to decrease infection spreading further. Reminders on the proper handwashing techniques and alcohol-based techniques are not consistently posted in washrooms or near alcohol-based hand rub dispensers. Further promotions as a reminder for hand hygiene could be placed in strategic areas to be constantly viewed by patients, staff, and visitors.

Some facilities are aging and create challenges in providing a safe environment. The Health Science Centre has challenges with many rooms and server cabinets that are not up to IPC code, and the proximity of soiled and clean linen rooms is challenging. Some facilities still have wooden surfaces or fabric chairs that are sometimes difficult to clean. These could be looked to be replaced.

Each site has different run sheets, and standardization of these run sheets is recommended. Only the Pte. Josiah Squibb Memorial Pavilion had signed and documented run sheets. Pte Josiah Squibb Memorial Pavilion and Caribou Memorial Veterans Pavilion perform cleanliness audits and include residents' input. Compliance with cleaning and disinfection, such as surface swabbing is done in some of the establishments and is in the process of being deployed eventually in all sites. There is very limited interaction between the EVS and the IPAC to evaluate the services the contracted services provided. The EVS performs several audits which are not currently shared with IPAC.

The IPAC current committee does not include interdisciplinary representation. A new committee will be deployed shortly, consisting of a broader representation of interdisciplinary participation, including two client advisors, OHS, HR, OTR IPAC leadership and IPC from a different program. Other services such as EVS, nutrition, laundry, and infrastructure could participate in this committee. It would also be beneficial for each site, specially in the community and rural setting to form a small-scale comity to address specific issues to their establishments.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.10	The interdisciplinary committee shall develop and implement standardized protocols and/or coupled order sets that permit the emergency administration of all appropriate antidotes, reversal agents, and rescue agents used in the facility.	!
4.3	The interdisciplinary committee reviews and updates the formulary at least every four years.	
13.7	Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	!
14.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	!
15.11	The organization uses regular, documented audits to assess the accuracy of medication order documentation and makes improvements as needed as part of a continuous quality improvement program.	!
16.1	The pharmacist reviews each medication order prior to the first dose being administered	!
17.3	There is a separate negative pressure area for preparing hazardous medications, with a 100 percent externally vented biological safety cabinet.	!
17.4	Sterile products are prepared in a separate area that meets standards for aseptic compounding.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

Since the last survey, the team has implemented compounding standards, implemented technologies such as Omni-Assistant Software, Inspect Rx, and PharmacyKeeper, expanded clinical services and scopes of practice, implemented three oncology projects to reduce waste/increase efficiencies/better utilize resources, and added the Pharmacy Residence Program which attained Accreditation in 2020.

The pharmacy team has a Regional Quality committee. The terms of reference are up to date (2021) and have been added in the retail pharmacy partners where appropriate (e.g. Dr. Albert O'Mahony Memorial Manor). The local pharmacy director oversees and monitors that the SLA is being met. The pharmacist has been integrated into the long-term care team and is viewed as an asset.

There is a regional Drugs & Therapeutics (D&T) committee. The D&T establishes criteria to add, restrict, and remove medications from the formulary. The D&T also reviews and approves policies and procedures. It is multidisciplinary and has added a physician since the last survey. The terms of reference were updated in 2021.

One quality initiative the pharmacy team is forming is a Regional Smart Pump committee (2021). Currently, the organization uses at least four smart pumps, which will be phased out so that all are using a single pump.

The Antimicrobial Stewardship committee is interdisciplinary and, in addition to pharmacy, includes a microbiologist, infection prevention and control resource, physicians, and nursing staff. The organization and pharmacy team have developed an Antimicrobial Formulary for Acute Care. The team is seeing success in reducing antibiotic use in hospitals but is seeing higher antibiotic use in the community, particularly around upper respiratory viruses.

The pharmacy team has been working with the organization to ensure that all sites have negative pressure hazardous storage rooms and are currently in the process.

Concerning high-alert medications, the policy was last updated in 2021. Quarterly audits are performed, and results are shared. One area that has been identified as being challenging is insulins. During the survey, two vials of Rocuronium were noted in the fridge at the Dr. Leonard A. Miller Centre (2 South) and not labelled high alert. The pharmacy team has addressed this already.

Heparin safety continues to be an area of focus. Heparin vials of 10,000 units are now dispensed per patient via pharmacy. Sites (e.g., dialysis) can complete ROP exception forms to store these on-site and not be patient specific. The team is working with cardiology towards other alternatives to storing high-potency heparin.

Narcotic safety is another area of focus for the team. Efforts have been made to educate prescribers and those who administer high-potency narcotics on narcotic safety. Again, the drugs are segregated, and high potency is only kept in stock when ROP exception forms have been submitted and approved.
Regular reviews of concentrated electrolytes are performed, and these products are “signed out” similar to narcotics in places like cardiac units. Otherwise, there are no vials or mixing in nursing units.

Annual audits on Do Not Use Abbreviations (DNU) are conducted with 1,000 prescriptions per year in larger sites, and 500 prescriptions per year in smaller sites are reviewed. Signage was available throughout medication areas. The signage at the Dr. Albert O’Mahony Memorial Manor Medication Room is from 2006 and could be updated. The two main focus areas are “daily” and “units.” The team has ensured that all schools (medicine, pharmacy, and nursing) are educating their students about the DNU within their programs and offering a session on Prescription Writing within each program.

There is a good culture of reporting and reviewing incidents. Aggregate data comes to the D&T quarterly. An example of a quality improvement related to incident reporting was related to methadone incidents. The pharmacy has changed the labels they apply to methadone, which appears to have been effective.

Pharmacy technicians require college level education/training, write national exams, require ongoing continuing education credits, and liability protection. Their pay scale is marginally larger than a pharmacy assistant who does not have the same requirements. This may be contributing to a shortage of pharmacy techs.

There are several challenges that the pharmacy team is addressing. Ensuring they review and update the formulary at least every four years is recommended to be addressed; however, with the single health authority formed on April 1st, it seemed prudent to wait. Developing and implementing standardized protocols and/or coupled order sets that permit the emergency administration of all appropriate antidotes, reversal agents and rescue agents used in facilities is a work in progress.

There was no evidence of audits of medication order documentation being completed. Most of the sites are using paper Medication Administration Records (MARs). The use of paper MARs means that you miss out on many safety features that are available when you use Computerized MARs. The organization is encouraged to accelerate the work of moving to CMARs.

Finally, during the survey, the surveyor reviewed the medication cupboard in the ART clinic. The epinephrine expired in 2021, the saline vials expired, and the staff do not believe they have ever needed the medications contained there. The organization may wish to review the site and review the stock. The pharmacy team is to be commended for their quality work and projects. An example is the Chemotherapy Vial Optimization Program. With this program, the pharmacy can realize $1.75 million in savings annually. Some of these savings could be used to reinvest in additional human resources and to review pay scales for pharmacy techs.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Organ and tissue donation is part of the organization's strategic priorities.	
1.4	Policies for both organ and tissue donation are developed with input from clients and families.	
1.5	A policy on donation after cardio-circulatory death (DCD) is developed with input from clients and families.	
1.7	Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency		
5.11	Education and training are provided on the organization's ethical decision-making framework.	
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		
17.3	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
17.4	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
17.7	There is a policy on ethical research practices that outlines when to seek approval, developed 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 Organ Procurement and Exchange Program (OPEN) has experienced recent retirement and two staff who had been re-deployed left their positions. New staff have since been hired, and one more position has been posted. These are highly specialized roles with at least three months of orientation required. Consequently, the program had to be paused from March to October 2022 due to the need to hire and train new staff.

Leadership in the team includes a medical director from the Intensive Care Unit (ICU) and a new manager. The nurses who coordinate the program require a background in ICU. This provides a strong linkage to the ICU, where the majority of organs are procured.

The team's focus has been on staffing, achieving competency, and reactivating the program. Once the last positions are filled, the team can look to developing their goals and objectives for the coming year. One of these goals will be to continue incorporating the voices of clients/families.

The OPEN Program, situated in Eastern Health, serves the entire province of Newfoundland and Labrador (NL). There is access to a coordinator 24/7 via pager/phone. The team is connected to the Canadian Transplant Registry and follows the Health Canada Guidelines and the Canadian Standards Organization. There is a regional donation committee.

The team has comprehensive Standard Operating Procedures (SOPs) that are up-to-date and easily accessible to the team.

Transplants are not performed in NL; however, teams from Nova Scotia and Ontario (2 main partners) do come to retrieve organs when a match is found. NL does procure frozen tissue for transplant, and the team monitors the dedicated freezers at Health Sciences and St. Clare’s Hospitals.

One of the things staff are most proud of is that former staff assisted in developing the standards that Accreditation Canada uses. They are also proud of their resilience: after the long break due to the COVID-19 pandemic, they have regrouped and are ramping up the OPEN, with a first donor this year just last weekend.

Some of the plans for the future include understanding the impacts of Medical Assistance in Dying (MAID). With the potential for MAID to be used by individuals with persistent mental health disorders, it may open up an opportunity for organ donation. Currently, the team uses NDD (Neurological Declaration of Death) but hopes to include DCD (Donation after Circulatory Death) in the future. They also plan to increase organ and tissue donation awareness in the broader community. The upcoming move to a single health authority may reduce barriers across regions. As air and road ambulance services improve, this could improve donor accessibility.

Priority Process: Competency

There is an extensive orientation to the coordinator role in the OPEN. Staff are trained on the program's Standard Operating Procedures (SOPs), program-specific policies and procedures, and the relevant Eastern Health policies and procedures.

There are position profiles for the different roles; the position profile for the coordinators is very comprehensive, and the staff have reviewed it.

There is very little equipment to learn. There is a thermometer for checking frozen tissue temperature and freezers used to store frozen tissue. Preventative maintenance is performed monthly, and annual inspections are completed.

The team has ongoing training and education to maintain competency and to keep up in their area of expertise. They recently used the SIM lab at the medical school and used actors to practice obtaining consent from donor families and performing “medical-social screening.” The staff found this helpful.

In the last survey, it was identified that there is no policy regarding the maximum consecutive work hours. The policy is still outstanding, and it is recommended the team consider a policy that specifies if there is/is not a limit to the consecutive hours a staff member could /could work.

Priority Process: Episode of Care

Standardized tools are used to gather information about potential donors. Once identified, there is a rigorous testing and information gathering. Coordinators go through a thorough consent process and medical-social history to look for “red flags” or barriers.

As the program has rebooted, the team is working on educating staff and the general public to increase awareness of organ and tissue donation. The team has a webpage on the Eastern Health website. A family member has been helping to review brochures and pamphlets. The family member may be interested in public speaking engagements to increase awareness.

The Acronym GIVE (grave prognosis, injured brain, ventilator dependent, and end-of-life discussion) reminds people about organ and tissue donation could opportunities arise.

Priority Process: Decision Support

The team collects data on all organ donations. They have decreased since the last survey, mainly due to the impacts of the global pandemic. In 2020 there were two donors; in 2021, there were six, and to date, in 2022, there has been one. The team does have an electronic data tracking system.

The team performs monthly audits of deaths in the ICU and the emergency department (ED) in Eastern Health for missed referrals. They contact the ICU and ED to follow up on missed opportunities to see how they can assist.

As per regulations, organ donor records are retained for 30 years. The records are very comprehensive. Again, a shared electronic record would improve access for the team.

A satisfaction survey is conducted annually, and results are used to improve the program.

Priority Process: Impact on Outcomes

Most of the Organ & Tissue Donation team has been new within the last 12 months, including the manager in his third week on the job. In addition, the program was paused for five months this year to allow staff to attain competency, and for most of the two years before this (during the COVID-19 pandemic), the program was on hold as staff were re-deployed to critical care. Consequently, the quality improvement work has had to be paused. The team is currently regrouping and ready to develop its goals and objectives for the coming year, including identifying the quality projects they wish to initiate. They are working on improving awareness that the program is up and running again with the staff in the health authorities and the general public.

The team monitors the number of deaths in the ICU and emergency departments to see if there are missed donation opportunities. They/the medical director approach teams if they identify any deaths where the opportunity to donate was not offered. Education and training are provided, and barriers are addressed. The team has begun to offer public education and plans to do some remotely with other areas of the province. Working with high schools will be a focus in 2023.

The team does survey families of donors and uses this information to strengthen their program. Families of donors are extremely appreciative of the work and support of the coordinators. In speaking with four families of donors, the words “very compassionate,” “very professional,” and “extremely helpful” were used to describe the nursing support from the coordinators. One woman remarked that donating her family member's organs “put a light down in a dark situation.”

Priority Process: Organ and Tissue Donation

As NL does not perform organ transplants, the retrieval teams come from other parts of Canada. The team has worked most closely with Halifax, Toronto, and Ottawa. Special privileges are identified and provided for retrieval teams. Identifications are identified once they arrive in NL.

Rigorous screening of potential donors is completed. It begins with an NDD or neurological determination of death. Once this has been completed, the transplant coordinators perform a physical examination of the potential donor and conduct a medical-social history with the person who knows the potential donor the best: family member, partner, or friend. If there are no red flags, the coordinators begin a consent process while partners are notified of potential organs for donation. At this point, rigorous serum and tissue testing begin.

Family members have reported that there is a great deal of work during the consent process, but they understand why. The transplant coordinators notify them that it could take days to complete testing, identify matches and then arrange transport to other parts of Canada. This is a difficult time for waiting; however, family members have reported that the coordinators are in constant communication to keep them up to date. Family members also appreciated the kindness and compassion of the ICU staff as they continued to provide expert nursing care to their loved ones awaiting organ donation.

The record keeping is comprehensive and quite well done. All Health Canada guidelines are followed and reported as required.

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: February 15, 2021 to February 28, 2021**
- **Number of responses: 1**

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: November 15, 2020 to December 5, 2020**
- **Minimum responses rate (based on the number of eligible employees): 371**
- **Number of responses: 940**

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

Priority processes associated with service excellence standards

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

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