ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

NL Health Services – Eastern Zones

St. John's, NL

Sequence 2 of 3

On-site survey dates: November 26, 2023 - December 1, 2023

Report issued: April 1, 2024

About the Accreditation Report

NL Health Services – Eastern Zones (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 2023. 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

NL Health Services – Eastern Zones (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

NL Health Services – Eastern Zones'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 26, 2023 to December 1, 2023**

This on-site survey is part of a series of sequential surveys for this organization. Collectively, these are used to assess the full scope of the organization's services and programs.

- **Locations**

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

1. Bonavista Peninsula Health Centre
2. Burin Peninsula Health Care Centre
3. Carbonear General Hospital
4. Dr. G.B. Cross Memorial Hospital
5. Dr. H. Bliss Murphy Cancer Centre
6. Health Sciences Centre (General Hospital)
7. Health Sciences Centre - Cardiac Cath Lab
8. Health Sciences Centre - Endoscopy
9. Janeway Children's Health and Rehabilitation Centre
10. Lions Manor Nursing Home
11. Placentia Health Centre
12. St. Clare's Mercy Hospital
13. St. Patrick's Mercy Home
14. The Agnes Pratt Home
15. Waterford Hospital

- **Standards**

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

System-Wide Standards

1. Infection Prevention and Control Standards

Service Excellence Standards

2. Cancer Care - Service Excellence Standards
3. Critical Care Services - Service Excellence Standards
4. Emergency Department - Service Excellence Standards
5. EMS and Interfacility Transport - Service Excellence Standards
6. Inpatient Services - Service Excellence Standards
7. Medication Management (For Surveys in 2021) - Service Excellence Standards
8. Obstetrics Services - Service Excellence Standards
9. Perioperative Services and Invasive Procedures - Service Excellence Standards

- **Instruments**

The organization administered:

Indicators

1. 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)	21	1	0	22
 Accessibility (Give me timely and equitable services)	66	2	0	68
 Safety (Keep me safe)	545	6	9	560
 Worklife (Take care of those who take care of me)	67	7	0	74
 Client-centred Services (Partner with me and my family in our care)	279	3	0	282
 Continuity (Coordinate my care across the continuum)	72	1	0	73
 Appropriateness (Do the right thing to achieve the best results)	513	11	4	528
 Efficiency (Make the best use of resources)	46	0	0	46
Total	**1609**	**31**	**13**	**1653**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Infection Prevention and Control Standards	64 (98.5%)	1 (1.5%)	2	36 (97.3%)	1 (2.7%)	0	100 (98.0%)	2 (2.0%)	2
Medication Management (For Surveys in 2021)	95 (99.0%)	1 (1.0%)	4	48 (100.0%)	0 (0.0%)	2	143 (99.3%)	1 (0.7%)	6
Cancer Care	97 (99.0%)	1 (1.0%)	3	127 (100.0%)	0 (0.0%)	0	224 (99.6%)	1 (0.4%)	3
Critical Care Services	53 (88.3%)	7 (11.7%)	0	96 (91.4%)	9 (8.6%)	0	149 (90.3%)	16 (9.7%)	0
Emergency Department	69 (95.8%)	3 (4.2%)	0	107 (100.0%)	0 (0.0%)	0	176 (98.3%)	3 (1.7%)	0
EMS and Interfacility Transport	118 (99.2%)	1 (0.8%)	0	121 (100.0%)	0 (0.0%)	0	239 (99.6%)	1 (0.4%)	0
Inpatient Services	59 (98.3%)	1 (1.7%)	0	84 (98.8%)	1 (1.2%)	0	143 (98.6%)	2 (1.4%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Perioperative Services and Invasive Procedures	113 (98.3%)	2 (1.7%)	0	108 (99.1%)	1 (0.9%)	0	221 (98.7%)	3 (1.3%)	0
Total	**739 (97.8%)**	17 (2.2%)	11	815 (98.5%)	12 (1.5%)	2	1554 (98.2%)	29 (1.8%)	13

* 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: Communication			
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Unmet	2 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (EMS and Interfacility Transport)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Cancer Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The "Do Not Use" list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
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 (EMS and Interfacility Transport)	Met	5 of 5	3 of 3
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (EMS and Interfacility Transport)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (EMS and Interfacility Transport)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (EMS and Interfacility Transport)	Unmet	0 of 1	0 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1
Reprocessing (Infection Prevention and Control Standards)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

NL Health Services – Eastern Zones is to be commended for the ongoing commitment to the accreditation process. This survey was the second component of their 3-part sequential survey. The organization continues to demonstrate commitment to quality and safety as was evidenced throughout this survey. The focus of the review was primarily the clinical areas. The team met and interacted with an engaged group of caring and compassionate staff and physicians. We had many opportunities to meet with patients and families and heard consistently that the care received was excellent. It was evident from speaking with staff that they worked well together and were proud of the care they provided.

The organization will be transitioning to one health region. Throughout the survey visit staff spoke to the upcoming change and many were looking forward to it. The leadership team is encouraged keep staff abreast of changes. It will be important to ensure that while the transition takes place, key quality and safety practices, for example do not get pushed to the side. Staff will need support to continue their work and make the changes required within this transition.

Quality boards were visible in many of the units with ROP measurements evident. Staff spoke proudly of the gains they have made. We would encourage units to look at other quality indicators to reflect unit performance. Many of the quality boards were in the back hallways and not readily visible. Leaders may want to consider placing them in areas where patients and families can see their performance.

Documentation is hybrid with the majority being manual and paper based. Some units have a combination of components that are electronic. While there are staff who love their “papers”, many look forward to having an integrated electronic medical record (EMR). The organization is encouraged to move forward on this important project and ensure that staff are involved in the process and kept informed along the journey. Provincial programs will benefit significantly from an integrated EMR.

Policies are transitioning to a new platform. In the interim it was noted that many were outdated. We were assured that they were revised and updated but were waiting in the queue to be approved. The organization is encouraged to ensure that staff are working with the most current policy.

Most staff had a good understanding of how to address ethical issues and who to contact for help. However, many have not had ethics education since being hired. The organization may want to consider offering current updated ethics education.

The organization may benefit from the development of a facility master planning process to support the transition to one region. Signage in some facilities was not clear and paper based. Some older buildings were noted to be cluttered. Humidity and temperature were challenging to maintain in some sites. Elevator bulletin boards were often empty and could be used for public and staff updates. While there are patient flow policies and protocols, they are not being consistently followed in all sites. Performance reviews were not consistently completed for many of the staff.

NL Health Services – Eastern Zones' committed effort to integrate principles of people-centered care into the organization's daily operations was apparent in all the program areas visited. NL Health Services – Eastern Zones has multiple policies that reinforce the organizational commitment to people-centred care, in addition to many Client and Family Advisors who support teams on a local level in integrating feedback. There are strong examples of services being co-created with patients and family members across programs visited. The Care of the Elderly project is a fantastic example of the power of service-level engagement in improving outcomes in partnership with staff. The Client and Family Advisor's involvement was multi-modal, including reviewing documents, signage, speaking with patients, and participating in walkabouts. A team member concisely emphasized the value of engaging with patients and their families, illustrating how this positively impacts operations at NL Health Services – Eastern Zones: When we put patients in the center, the path forward becomes clear. This perspective resonated throughout the entire organization, showcasing the authentic embodiment of a strong people-centered care culture at NL Health Services – Eastern Zones.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Emergency Department 12.16
Patient Safety Goal Area: Infection Control	
Hand-Hygiene Compliance Compliance with accepted hand-hygiene practices is measured.	· EMS and Interfacility Transport 8.7

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Transport vehicles are configured to provide safe and effective EMS and interfacility transport. Annual checks of team members operating records are documented. Vehicle operators are participating in regular training procedures and as new transport vehicles are introduced. There is an electronic process to ensure compliance with all applicable legislation for operation of EMS and interfacility transport vehicles.

A fleet management program is in place that monitors safety and loading systems to operate in accordance with relevant organizational policy, legislation, and regulations. A preventative maintenance program is in place and a process to report, investigate and follow up on incidents involving transport vehicles is followed.

The physical layout of the operating room/invasive procedure areas have appropriate signage that indicate restricted access and outline the appropriate dress code. The flow of the areas supports appropriate patient flow.

Regulation of humidity levels at Dr. G. B. Cross Memorial Hospital is very challenging during the summer months. The current solution is to raise the temperature of the operating room area which results in achieving the appropriate humidity level, however, makes the working environment very challenging for the surgeons and nursing staff. Investment in an upgrade to the ventilation system is encouraged to support ongoing surgical services at the Dr. G. B. Cross Memorial Hospital and to avoid future service disruption, mitigate the risk of surgical site infections and the loss of health human resources related to working conditions.

All medical gas pipelines are certified and checked annually, ducts have microbic filters and the surgical and invasive procedure rooms have at least 20 complete air exchanges per hour. The operating room has a restricted access area for sterile storage of supplies and there is a comprehensive cleaning schedule for the operating room/minor procedure room in a place that is accessible to all team members.

Some of the rural sites of NL Health Services – Eastern Zones were constructed approximately 40 years ago and reflect aging infrastructure that requires updates to floors and walls.

Tape is used to support signage and should be replaced with an infection control friendly substitute and some consideration should be given to replace paper signage with a wipeable surface such as laminate to provide sustainable signage solutions. Wooden surfaces cannot be cleaned appropriately and future consideration to replace wooden surfaces should be considered. There is tape on the ceiling areas that does not support appropriate infection control practices and the issue that required the initial use of tape should be addressed.

Space is an ongoing challenge for storage which has resulted in equipment storage in the hallway. This results in a cluttered presentation and may impact infection prevention and control practices as well as fire codes legislation. Consideration to finding alternative to storage space is encouraged.

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)

Emergency response planning is vital in organizations, and requires collaboration of a diverse stakeholder group, including EMS and Infection Prevention and Control (IPC). Simulation exercises are extremely effective in identifying potential concerns with set plans and validate processes that are relevant and support the team's ability to respond to critical events in an efficient and effective manner. The Paramedicine & Medical Transport program regularly participate in mock, or tabletop sims related to disaster planning coordinated by the local hospitals, police, and the Airport Authority. There are clear team roles, responsibilities, and expectations. There are clear guidelines and protocols available to staff responding to incidents with hazardous material or infectious diseases. Staff are comfortable using an all-hazards approach to minimize potential risk and exposure.

The IPC team participates in emergency response committees and internal quality councils at NL Health Services – Eastern Zones. Through these committees, IPC supports the planning, policy, and process development of pandemic/outbreak management within the organization as well as with community partners such as Personal Care Homes. The IPC team is also responsible for supporting the execution of the developed processes during an outbreak, ensure the appropriate communication and reporting is completed, and act as a guide for frontline teams. During and post outbreak events, IPC will evaluate their effectiveness and identify opportunities for improvement.

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: Critical Care Services		
8.3	Goals and expected results of the client's care and services are identified in partnership with the client and family.	
8.15	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.	!
Surveyor comments on the priority process(es)		

NL Health Services – Eastern Zones' committed effort to integrate principles of people-centered care into the organization's daily operations was apparent in all the program areas visited. The organization has multiple policies that reinforce the organizational commitment to people-centred care, in addition to many Client and Family Advisors who support teams at the local level to integrate feedback.

Conversations with patients and families at all locations highlighted the depth of the integration of people-centred care principles with staff. Most patients and family members described their experience of receiving care as a true partnership. However, patient and family member involvement in the development of goals of care and care plans is not always happening.

Many programs across the organization have dedicated Client and Family Advisors, in addition to the numerous facility-based advisory councils. Although there are ongoing difficulties with recruitment, the cohort of client and family advisors has grown since last surveyed in 2017. The collective impact on the organization is palpable and should be celebrated.

There is incredible strength in the Client Relations Office. The staff has a passion for not only integrating Client and Family Advisors into work at all levels of the organization but also utilizing all feedback as opportunities for NL Health Services – Eastern Zones to be better. Client and Family Advisors express appreciation for the extensive staff assistance provided to them, especially on initiatives backed by the People-Centred Care Manager. The Client Relation office houses a wealth of information about patient and family experiences that could be further utilized. The organization may want to consider investing in an up-to-date tracking system for the Client Relations Office. This would allow the program to grow towards its full potential. Investing in such a tool would allow the staff to track more accurately, understand themes, analyze, and be more agile in responding to feedback provided by patients and family members.

There are strong examples of services being co-created with patients and family members across the programs visited. The Care of the Elderly project is a fantastic example of the power of service-level engagement in improving outcomes in partnership with staff. The Client and Family Advisor's involvement was multi-modal, including reviewing documents, signage, speaking with patients, and participating in walkabouts.

Program areas also use additional service-level engagement methods to collect patient and family experience through surveys like the “one thing” initiative and experience of care surveys. Utilization of feedback collection methods, such as experience of care surveys, was not consistent which presents an opportunity for programs to begin collecting this information to inform new quality initiatives.

There is room for growth related to patients' and family members' understanding of the various avenues to provide feedback and more specifically the Client Relations Office. Most patients the surveyors spoke with did not know how they could bring a concern or complaint about their experience forward.

Although there is an organizational family presence and general visitation policy, there is not consistent implementation across locations, leaving family members and patients confused and frustrated. It would be beneficial to ensure all program areas are consistently honoring family presence.

A team member concisely emphasized the value of engaging with patients and their families, illustrating how this positively impacts operations at NL Health Services – Eastern Zones saying, “When we put patients in the center, the path forward becomes clear”. This perspective resonated throughout the entire organization, showcasing the authentic embodiment of a strong people-centered care culture.

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)

NL Health Services – Eastern Zones is significantly challenged with maintaining effective patient flow throughout the zones. The current demand consistently exceeds the capacity that the acute care facilities can comfortably tolerate. The organization has attempted to address some of their current challenges by identifying bottlenecks and developing and executing surge and overcapacity plans on a constant basis. Managing flow and capacity is extremely complex and requires taking the lens from an organizational, provincial systems perspective and requires a multipronged approach to effect sustainable improvement.

Some key symptoms of poor flow throughout the organization includes high EMS offload delays, extended wait times, high 'left without being seen' rates, large count of Emergency Inpatients and high hospital alternate level of care (ALC) count. The organization is encouraged to consider patient flow as a high priority as it severely impacts the patient and family experience, increases the risk and liability to the organization, increases costs, and contributes to negative staff experiences. There are several external factors that significantly impact the acute care flow, such as lack of primary care providers and availability of mid-level providers, and increased need for ALC spaces in the community. The organization is strongly encouraged to build the relationships with the external key stakeholders to work together to resolve some challenges.

The organization is encouraged to evaluate every flow segment of the patient journey to support the identification of potential improvement opportunities. The organization is encouraged to explore internal opportunities that would support better flow throughout the zones.

Surgical wait times also continue to be a challenge, and the organization is encouraged to continue to implement the existing strategies in place to reduce the waiting period (such as providing additional orthopedic hip and knee surgeries in Carbonear General Hospital).

Lastly, the oganization requires development of key metrics to focus on, frequent monitoring, and a clear evaluation plan to assess the effectiveness of any flow improvement put in place.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Infection Prevention and Control Standards		
11.2	Areas for reprocessing flexible endoscopes are physically separate from client care areas.	!
11.3	Endoscope reprocessing areas are equipped with separate cleaning and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
Standards Set: Perioperative Services and Invasive Procedures		
4.11	Immediate-use (or "flash") sterilization is used in the operating/procedure room only in an emergency, and never for complete sets or implantable devices.	!

Surveyor comments on the priority process(es)

Medical devices and equipment are reprocessed at five sites in NL Health Services – Eastern Zones with shared oversight. Satellite sites under the medical device reprocessing (MDR) oversight include the cancer clinic, cardiac catheter lab, and endoscopy at Health Sciences Centre, and endoscopy and the Ears, Nose and Throat (ENT) clinic at St. Clare's Mercy Hospital. Reprocessing done in the operating room and diagnostic imaging units at both sites are not overseen by MDR. Reprocessing is not contracted out to external providers.

MDR standard operating procedures (SOPs) as well as policies and procedures are standardized across the organization. SOPs are developed in a standardized format and incorporate necessary regulations and industry best practices. An SOP detailing the recall procedure was not available for review at the time of survey. A comprehensive instrument management system is in place allowing tracking of instruments in the event of a recall.

Six of approximately 118 sterile supply technicians were certified (Medical Device Reprocessing Technician) at the time of survey. The departmental goal is to pursue certification for all staff and the organization is prepared to cover the cost of the certification course. Staff undergo standardized in-house training and are required to demonstrate competency on an annual basis.

The MDR facility at Health Sciences Centre allows appropriate separation of contaminated and clean/sterilized items with temperature and humidity monitored regularly. However, the area for reprocessing flexible endoscopes is not appropriately physically separate from client care areas. There is not appropriate separation of clean and contaminated items. Contaminated items are transferred near client service and high-traffic areas. There are plans for renovations to the existing area which will allow for appropriate spacing. This is expected to be complete by Fall 2024.

At St. Clare's Mercy Hospital, the ENT scope reprocessing area (Clinic D area) is not adequately ventilated. A floor fan is used by staff to cool the room.

At Janeway Children's Health and Rehabilitation Centre, the disinfecting and cleaning of endoscopes are done in separate rooms. However, the room where the clean scopes are kept has a staff fridge and a coffee maker. The team is encouraged to have the clean scopes stored in a dedicated area.

Prostheses are still stored in MDR (identified as an issue at the last survey). It is suggested again that alternate, appropriate storage be located.

Immediate use steam sterilization (IUSS) was noted to take place in the OR at Health Sciences Centre, St. Clare’s Mercy Hospital, and Janeway Children’s Health and Rehabilitation Centre. Reprocessing also takes place in diagnostic imaging (ultrasound probes). The MDR department does not provide oversight for either of these areas and is in fact in the process of rescinding the policy previously in place providing such oversight to the OR.

It is recommended that MRD expert staff review the processes and staff training in each of these areas to ensure best practices are in place and to minimize unnecessary risk to patients and to the organization.

At Dr. G. B. Cross Memorial Hospital, contaminated items are appropriately contained and transported to the reprocessing unit or area using a visual colour coding system. Green to indicate clean and red to indicate dirty. Flash sterilization is not done at this site. Clean and sterile surgical equipment, medical devices and supplies are stored in separate areas from soiled and contaminated equipment.

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: Cancer Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
8.11 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Provincial Cancer Care Program (PCCP) serves the people of Newfoundland and Labrador through population-based screening, oncology clinics, systemic therapy, radiation therapy, cancer surveillance and data reporting. The Newfoundland Cancer Care Registry (NCCR) includes tumor registry, cytology registry, breast, colon, and systemic therapy data repository. Data is provided to the Canadian Cancer Registry and to the North American Association of Central Cancer Registries.

Provincial population-based programs are in place for breast, colon, and cervical cancer. Four breast screening centres are located throughout the province. Pediatric systemic cancer treatment occurs at the Janeway Children's Health and Rehabilitation Centre while radiation for children is at the Dr. H. Bliss Murphy Cancer Centre.

Chemotherapy in rural areas falls to the medicine program however the linkages are strong with the Cancer Program for protocols and best practice. Some of the smaller sites are challenged to maintain services due to lack of consistent staff.

Priority Process: Competency

Nurses are required to complete the certification for oncology. The team is multidisciplinary and consists of Nurses, Nurse Practitioners, Social Workers, Physicians, Pharmacist, Nutritionists and Oncology Coordinators. For adult patients, there are Pharmacists and Pharmacy Technicians, Radiation Therapists, Dosimetrists, Medical physicists, Medical Physicist Assistants, and Biomedical Engineering Technologists. The pediatric program has a dedicated clinical pharmacist. Support is provided to the teams in the ambulatory care units outside of St. John's, in terms of providing the chemotherapy certification for their nurses, as well as sharing policies, procedures, and well-established pre-printed orders. The physicians that work within these centers are also supported by oncologists. The multidisciplinary team are knowledgeable, caring, and compassionate, and demonstrate a culture of pride and teamwork. Many have been in their positions for a considerable period of time. Human resource challenges impact the program and long-term planning strategies are being developed.

Priority Process: Episode of Care

Regional cancer centres provide adult systemic therapy to the residents of Newfoundland and Labrador across 4 sites in St John's, Gander, Grand Falls, and Corner Brook. Systemic therapy delivery occurs at the four regional sites as well as in 11 peripheral ambulatory care units, under the management of the medicine program. Radiation therapy is currently only offered at the Dr. H. Bliss Murphy Cancer Centre in St. John's with plans to open a site in Corner Brook in June 2024. Satellite sites that provide services closer to home are supported by the Provincial Cancer Care Program (PCCP).

The Dr. H. Bliss Murphy Cancer Center, which opened in 1994, is adjacent to the Health Sciences Center in St. John's. The site provides chemotherapy treatment, as well as radiation therapy to both adults and children. Systemic therapy for children only takes place at the Janeway Children's Health and Rehabilitation Centre.

Radiation therapy will be expanded to Corner Brook in June 2024 providing great support to those residents. When children need radiation therapy, they come to the Cancer Center. The staff do a great job of modifying the area to accommodate children plus provide recovery space. The staff from pediatrics accompany the patient.

The teams are integrated and meet on a regular basis. The multidisciplinary team is knowledgeable, caring, and compassionate, and demonstrates a culture of pride in their teamwork. Regular meetings held include monthly Staff Meetings, Integrated Safety Meetings every 2 months, monthly Leadership Meetings, and monthly Managers Meetings.

The Patient Passport is useful for new patients to familiarize themselves with the system. Pediatric patients receive a Protocol Book Journey.

There are two Quality Screens in the waiting areas of the Dr. H. Bliss Murphy Cancer Centre to raise awareness around hand hygiene audits, healthy eating, smoking cessation, importance of exercise, Know Your Medications, and access to mental health resources. The Medical Ambulatory Clinic at the Janeway Children's Health and Rehabilitation Centre is situated in a small space and is used for more than oncology services.

Your Medications, and access to mental health resources. The Medical Ambulatory Clinic at the Janeway Children's Health and Rehabilitation Centre is situated in a small space and is used for more than oncology services.

Adult Cancer Care has five Patient Navigators. The Cancer Care Navigators connect with NL Health Services Indigenous Navigator when needed. There are processes in place for pediatric patients to access services on the weekend or in emergencies. The two Pediatric Oncology Coordinators (navigators) work with the family and child to understand how to manage their course of treatment. Considerable time is spent with them prior to their treatment to prepare them and their family. There were no chemotherapy services scheduled during my visit and I was unable to speak with patients and families. Services available to support patients include patient navigation, social work, a clinical nutritionist, and smoking cessation. The Dr. H. Bliss Murphy Cancer Center has volunteers to help support waiting patients.

The success of the program is built upon the internal and external partnerships that are developed to help deliver an efficient, high-quality service. Benchmarks include, wait times to ensure that patients are receiving treatment in a timely manner. Pediatric patient protocols and standards are based on national standards. It is estimated that 90% of all pediatric treatments can be completed at the Janeway Children’s Health and Rehabilitation Centre.

Both the adult and pediatric program have active involvement from patients and family. On the adult side, a Patient Advisory Council has been in place since 2017 that meets four times a year. Members include previous patients, patient caregivers, and staff. The council members were involved in planning the new facility. Advisors also participated in the experience care survey in 2021. Feedback was provided on the care they received in the Provincial Cancer Care Program (PCCP). In pediatric oncology a Youth Advisory Council is active.

Patients spoke positively about the care they received. They appreciated the staff and felt very fortunate, even when they had to travel to receive treatment.

There are regular quality assurance meetings. Audits are performed monthly on required organizational practices (ROPs). A failure mode and effects analysis was completed at the Janeway Children's Health and Rehabilitation Centre looking at how to address safety issues. Other quality improvement initiatives for pediatrics have been looking at improving communication between the inpatient and outpatient units.

NOONA, introduced in 2022, is a patient facing app that allows patients to report their symptoms into their EMR. Currently it is only available in the St. John’s catchment area.

The systemic therapy program has rolled out new infusion pumps, implemented a pre-assessment nurse to support the completion of the best possible medication history, and the transition of hematology with a new chemotherapy suite. A new state of the art chemotherapy suite for adults opened in 2023 with point of care stations, medication pyxis and satellite pharmacy with the intention to improve efficiencies and workflow.

Priority Process: Decision Support

While the Provincial Cancer Care Program has had an electronic medical record since 2015, there is no EMR at the Janeway. Other systems that are used in the cancer program such as HEALTHe NL and Pharmacy Network do not connect to the hospital information system. The team have built in safety checks to ensure documentation is complete but there is still a risk of error. The Janeway Children and Rehab Centre is encouraged to move forward on acquiring and implementing an EMR given the regional nature of their program. For the Provinical Cancer Care program, policies and procedures are in the process of being updated and transitioned to the new policy system, however many are in the queue waiting approval.

Priority Process: Impact on Outcomes

In the past year there have been challenges with staffing which has impacted wait times. As a result, some clients are triaged and sent to Toronto for radiation therapy. There is no waitlist for pediatric patients. Long term follow-up clinics in pediatrics may follow with patients beyond their 18th birthday. For those youth who are close to their 18th birthday when they begin treatment the challenge is which is the best site to provide ongoing care and support. The Provincial Cancer Care Program (PCCP) fosters a culture of quality and safety to reduce risk. There are many safety checks built into the system. A retreat held this fall for the pediatric group was seen as beneficial with good discussion about goals and priorities. A team member who participated referred to the retreat as patient and family centric.

Priority Process: Medication Management

The pharmacy and Chemotherapy Mixing System meets all the requirements of NAPRA (National Association of Pharmacy Regulatory Authority). Although everything is done manually, they have implemented a system to ensure patient safety. Several Lean projects have been completed focusing on efficiencies, such as distribution flow. As there is no CPOE (computerized provider order entry), so medication orders are typed by the pharmacists. In pediatric oncology, the pharmacist has put in numerous double sign off check points to ensure that chemotherapy orders are accurate before being filled. This process takes a considerable time away from their clinical duties. Other areas of focus for pharmacy include attending the pediatric clinics, rounding with the team, and acquiring special access medications when required.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.9	A universally-accessible environment is created with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
7.15	Clients and families are provided with information about their rights and responsibilities.	!
Priority Process: Decision Support		
13.8	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		
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Critical care services provide critical care to various client populations including neonatal, pediatric, and adult clients. The team is knowledgeable and committed to person-centered care and providing the best possible care to each client.

Information is collected from clients and families, partners, and the community to inform service design. Service-specific goals and objectives are developed, with input from clients and families.

The Critical Care units at the Janeway Children's Health and Rehabilitation Centre and Burin Peninsula Health Care Centre are challenged with their physical space, leading to tight spaces that do not support patient mobility and rounding at the bedside. Patient mobility is something that physicians feel is a priority for recovery and bedside rounding is a priority for clients and families.

The team is urged to consider other options for bedside rounding, such as the family being virtual into the room for bedside rounding. This would ensure real time discussion when goals are being discussed. Another option would be to review goals with the client before rounds.

Input from team members, clients, and families, where appropriate, around work design, job roles and responsibilities is encouraged. This will highlight the client and families' perspective.

The surge capacity plan for critical care units needs to be strengthened to manage a high number of clients during times of increased volume. A process should be defined as to who gets priority for in hospital beds. Patient flow should be clearly outlined and monitored to ensure timely access to the right type of care, in the right place.

Priority Process: Competency

Staff have the required training and education to do their work and their credentials are monitored.

Performance appraisals are not completed on a regular basis. They have not been done, in some cases, for a very long time. Managers shared that they are working on a new process; however, in the interim, performance appraisals would be beneficial for the staff.

Staff have a good orientation and then are provided annual, mandatory education virtually, using the Learn Platform. Staff like it as they can do it virtually from their homes.

Staff have access to ongoing professional development, like attending conferences.

Infusion pump training is completed and documented. The organization has standardized the infusion pumps - going with Alaris across the system.

Standardized communication tools are used to share information about a client's care within and between teams. The tool they use to transfer information is called Share. A different communication tool is used in the long-term care homes for shift change and transfer.

The team works in collaboration with clients and families to ensure their voices are heard and that they provide person-centered care.

Priority Process: Episode of Care

The critical care services are delivered by knowledgeable, caring, and skilled individuals who strive to provide the best possible care to their clients. They provide person-centered care that fully involve clients and families. Many teams consist of patient care coordinators, nursing, respiratory therapist, dietician, nurse practitioners, social workers, pharmacy, physiotherapists, medical specialists, students, etc. The team felt some of their strengths included teamwork, a good culture, collaboration, and support.

The plan for allocating beds to clients who no longer require one-to-one care in critical care services should be defined. This will ensure beds are always available for those requiring reduced acuity and that they get the right care in the right place, leaving critical care beds for others.

Bedside rounding is encouraged however at some hospitals, there is limited space at the bedside to support this. The team are encouraged to consider options to include the client and families in the rounds, such as virtual attendance from their beds. Another option would be to have the discussion with clients and families before the rounds.

The rounds are interactive, and decisions are made using a collaborative approach. It is encouraged that advance care directives be completed on all clients as per the policy.

It was noted in the critical care unit at the Health Sciences Centre, the falls risk assessment was not completed which is also a requirement. If falls risk assessments cannot be completed on admission, this should be documented on the record.

The bedside space at the Health Sciences Centre and Carbonear General Hospital does not support mobility easily for some clients and alternate approaches should be considered. Physicians feel that mobility is a priority for recovery.

Client and families are happy with the care they receive. They would prefer that their loved ones are sent to appropriate units for recovery when they are ready, rather than waiting on the Critical Care Unit.

At the Health Sciences Centre families also shared that the staff should not be eating and drinking in the unit when some patients cannot have anything (NPO). Another comment from families is that it is too noisy for clients trying to rest. The teams are encouraged to consider options for eliminating food and drink at the desk, as well as noise level. White noise may help some patients.

The critical care teams are encouraged to review their quality standards and the outcomes to ensure they meet the pre-determined targets. If these are not met, steps should be taken to improve the outcomes.

Client records are paper based. The team like the flow charts, however the organization would benefit from an overall electronic health record to include eMAR, support CPOE, and data collection.

The units have pyxis in place. They also have a standardized infusion pump, Alaris across the system.

PICU and NICU has a family presence at rounds, at codes, and during procedures. The teams for PICU and NICU are engaged and multidisciplinary. They referenced debriefing processes, both from a clinical and emotional perspective. They are aware and have used the ethical consultation process in the past.

Families spoke positively about both areas and the care and compassion they demonstrate. The team members are trained specifically for the areas of NICU and PICU and are required to maintain their certifications.

Priority Process: Decision Support

Each client has a complete record that is paper based. They do not have an electronic health record (EHR) but they are working on it. They use Meditech EHR software for order entry.

The organization would benefit from an EHR, eMAR, and an enabled computerized physician order entry (CPOE) to compliment the Pyxis system they do have in place.

There was no clear evidence how privacy breaches are monitored in the paper-based and electronic-based charting system. The organization is encouraged to consider processes to monitor record-keeping practices, designed with input from clients and families.

Training and education about legislation to protect client privacy and appropriately use client information are provided at orientation and then annually through the LEARN platform.

Priority Process: Impact on Outcomes

There is a quality improvement plan in place with a number of quality coordinators across the system. The team is encouraged to actively recruit patient/family representatives to the group.

Quality indicators are defined and measured however the outcomes don't always meet the targets, indicating that this must be reviewed to ensure the standard of care delivery is maintained.

At Carbonear General Hospital, the service is encouraged to implement an overall quality improvement plan, defining their indicators and benchmark monitoring. This was not evident during the visit to the site.

Data is currently being manually captured which creates some challenges with data quality. This can create challenges in being able to perform sound, data-driven decision making.

Quality improvement opportunities are identified, discussed, and actioned at the program level. The team is encouraged to look for ways to bring quality improvement to the frontline, discussing the same topics at the local level. This creates an opportunity to engage frontline team members in defining quality initiatives.

The teams are encouraged to regularly perform quality activities including hand hygiene audits to measure their compliance, complete the falls risk assessment on all clients, ensure High Alert medications are double checked with two signatures, and other ROP compliance that may apply.

Priority Process: Organ and Tissue Donation

Organ & Tissue donations are not prevalent across NL Health Services – Eastern Zones; however, it is discussed when appropriate and there is an increased awareness. Relationships exist with other hospitals where they would send a procurement team to the organization to complete the harvesting of organs as required.

There are established policies and protocols surrounding donation, supports in place to guide staff though the process, education provided to staff to manage the organ & tissue donation process, and education provided on how to support families. Some staff wear buttons in support of Organ and Tissue Donation.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
7.1	Entrance(s) to the emergency department are clearly marked and accessible.		!
9.14	Clients and families are provided with information about their rights and responsibilities.		!
12.16	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	12.16.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	12.16.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			
Priority Process: Organ and Tissue Donation			
The organization has met all criteria for this priority process.			
Surveyor comments on the priority process(es)			
Priority Process: Clinical Leadership			

There are a total of 11 emergency departments (ED) within NL Health Services – Eastern Zones, of which six are considered Category A sites which provide expanded 24/7 services, and five Category B sites

serving smaller rural communities with some limitations to services during off hours. The total bed count of the 11 departments is 126 beds which attempts to serve a large catchment area of approximately 300,000 people which results in 52,000 ED visits/year. There is a dedicated pediatric ED in the city of St. John's, and outside of the city, the remaining departments are considered mixed. The necessary equipment, supplies, policies & procedures are currently available to support the care of the pediatric population where needed. Service-specific key performance indicators are identified and tracked at a programmatic level and a monthly site-based report card is shared with each site.

Priority Process: Competency

Outside of the pre-established required organizational learning requirements upon hire and annual maintenance, all the required training and education specific to the emergency department (ED) is established at the program level. This is extremely valuable as it ensures consistency of education across NL Health Services – Eastern Zones for all ED staff. There is a strong orientation process by which all new hires from across the organization come together and attend a three-week program-specific orientation with the educators in St. John's, including a full week of focused simulation-based learning to reinforce the two-week didactic learnings. The staff are then sent to their respective hospitals and receive an on-the-floor transition period before working independently in the care area. New staff feel well supported through this process, as well as feel they are given ample opportunity to pursue continual educational opportunities and certifications such as ENPC, TNCC, PALS and ACLS. The nature of the ED requires a constant evaluation and reevaluation of workload to maintain safe and efficient care in the department. The team members express feeling psychologically safe to ask for help as required and regularly work in a collaborative manner to support each other, especially during high volume/high acuity times. Although performance and feedback may be frequently provided on an informal basis, it has been noted that there are multiple locations that have not performed and documented formal staff performance appraisals since before the COVID-19 pandemic. The team is encouraged to complete these for all staff on a more consistent and frequent basis.

Priority Process: Episode of Care

There are inconsistencies found among the various sites related to ease of patient access, visibility of ED signage, adequate visibility of patients in the waiting room, and practicality of the physical layout across the organization. Each individual site is encouraged to evaluate their own care spaces, including waiting room areas to ensure they are safe, clearly marked, and patient focused. There are great, patient-facing posters developed by the ED program that are posted in each of the locations of the department with a brief description of what to expect in their stage of their ED care journey. Accurate and consistent triage assessment for adults and pediatric patients was validated as well as consistent standardized assessment documentation use. Patients express a positive experience in the care being delivered and feel well supported during care delivery. Discharge teaching sheets are available to many of the common ED presentations/diagnoses to support the patient education teaching. There are clear documentation tools being utilized for transfer of information when ED patients leave the department, but there is an internal shift handover gap. An opportunity for improvement is to review how information transfer can be completed in a standardized manner during the ED shift handover to ensure all appropriate and pertinent

information is relayed to oncoming team members. At multiple locations, registration is performed in a public area with the patient on one side of a window in the waiting room and staff on the other side. The organization is encouraged to find ways to improve on patient privacy during the registration process. There are multiple locations that sometimes have significant delay between registration time and triage time. The time between a patient entering the hospital (regardless of walk in or EMS offload delay) to being triaged should be minimized/eliminated.

Priority Process: Decision Support

There is a hybrid charting system in the ED, where most patient health records are captured on paper, but orders and results are on Meditech. The hybrid charting system can be a challenge and opens the possibility to making errors and have missed/delayed patient interventions. The organization is encouraged to explore ways to investigate solutions to this current process. There are standardized documentation forms (including triage, assessment records, procedural sedation, and discharge) available across the organization. This is extremely helpful in supporting consistent charting and documentation processes across all 11 EDs. The ED program is commended for maintaining their intranet site that is the home for all clinical guidelines, tools, and policies applicable to the care area. Staff expressed how beneficial they find this resource to be and would like to see this continued and maintained. The majority of existing policies and procedures related to the ED, as well as organizational policies are outdated and require review.

Priority Process: Impact on Outcomes

The ED program holds a monthly multidisciplinary quality council where patient safety events are evaluated, policies and protocols are developed and approved, key quality indicators are reviewed, and information sharing occurs across all 11 EDs. Multiple medical directives and care algorithms that support standardized best practice have been developed through this collaborative process. The team is encouraged to continue with this value-add council and continue to actively find patient/family representation to join the group. Data is currently being manually captured which creates some challenges with data quality, which in turns creates challenges in being able to perform sound data-driven decision making. Quality improvement opportunities are certainly identified, discussed, and actioned at this level. The team should look for ways to bring quality improvement to the frontlines, discussing the same topics at a local level as an opportunity to engage frontline team members and obtain grass roots feedback and suggestions. The teams are encouraged to perform quality huddles daily (ideally around a quality board) where program quality indicators, other metrics such as hand hygiene compliance, new best practices, and patient feedback is reviewed.

Priority Process: Organ and Tissue Donation

While Organ & Tissue donations is not prevalent across NL Health Services – Eastern Zones, there are established policies and protocols surrounding donation, supports in place to guide staff though the process, education provided to staff to manage the organ & tissue donation process, and education on how to support families.

Relationships exist with other hospitals where they would send a procurement team to the organization to complete the harvesting of organs as required.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
5.20 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	
Priority Process: Infection Prevention and Control	
8.7 Compliance with accepted hand-hygiene practices is measured.	ROP
8.7.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example: • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions).	**MAJOR**
8.7.2 Hand-hygiene compliance results are shared with team members and volunteers.	**MINOR**

8.7.3	Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.	**MINOR**

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Paramedicine & Medical Transport program is currently transitioning into a single provincially run program through the absorption of private and community-based EMS services, as a larger strategy to better coordinate patient flow, call response, and coverage across the province. To best leverage the benefits of resource centralization, the organization is encouraged to complete this not only for ground EMS, but also for air ambulance as well. The team consists of a mix of advanced care practitioners, primary care paramedicine, and medical flight specialists. The team is undergoing the hiring process to include new positions focused on quality assurance and improvement. Connections are also made with NL Health Services – Eastern Zones stroke team to develop a comprehensive strategy for hyperacute strokes, provide outreach education for stroke risk factors, and improving community stroke awareness. EMS also provides community education related to available services provided, such as the community & palliative care program. There is engaged 24/7 medical oversight to not only support the program, but also to improve the quality and efficiency of care delivered to patients. Staff express feeling strongly supported by their clinical leadership team and have a sense of pride to say they work for the organization.

Priority Process: Competency

There is standard orientation for all new hires. In addition to the organizational learning modules from NL Health Services – Eastern Zones, program specific education is provided. Due to recent staffing shortages, the didactic education hours have decreased but they have maintained a mentorship model for at least seven shifts and additional partner feedback and signoff for the following three months. For the different areas of specialization in EMS, there are set hours required on a bi-annual basis as well as annual recertifications required to maintain competency and be in good standing. There is currently limited to no in-house educational opportunities, but the team has the vision that the newly created positions would help to fill this gap.

During the mentor period they are provided with the training to appropriately use, maintain, clean, store and secure all equipment used for patient care within the applicable scope. Staff feel adequately prepared to practice following the onboarding process. Although performance and feedback are robust during the probationary period, formal staff appraisals are not completed and documented on a regular basis. Informal conversations are completed with staff ad hoc and may not be documented. The team is encouraged to complete these for all staff more consistently and frequently, as well as have a plan in place to ensure no staff are missed. Supporting the mental wellbeing of staff is very important and goes beyond education on stress and fatigue identification. The current Employee and Family Assistance Program and Rapid Response Team available within the organization may not be meeting the psychological needs of staff that are constantly placed in high stress traumatic situations. The organization is encouraged to evaluate the effectiveness of current mental wellness resources available.

Priority Process: Episode of Care

The Medical Communications Team uses a standard process to obtain the relevant information required to dispatch the most appropriate or closest available crew to respond to service requests. All the call information is documented and sent to the responding transport team to provide the team with pertinent details prior to scene arrival. There are established guidelines through Provincial Medical Oversight (PMO) to guides practitioners in all activities from standard care practices to management of exceptional situations (e.g., triaging mass casualties). If there are any questions or additional supports required, teams have 24/7 access to the Online Medical Command to receive further clarity and support potential ethical concerns or specific directions of care. There are robust existing guidelines, policies, procedures, and directives currently in use by the Paramedicine & Medical Transport team. Many of the existing policies have not been reviewed recently, and the team is encouraged to review, update, and maintain them on a more regular basis.

Along with some outdated policies, many PMOs are outdated and should be updated as they contain the 2015 Heart and Stroke Foundation ACLS guidelines and has been updated in 2020 with best practice changes, not limited to but including the bradycardia algorithm medication dose change from 0.5mg to 1mg.

Patients and families are involved in their care, and express feeling well cared for.

Priority Process: Decision Support

All health records are complete, kept confidential and up to date. There are policies and procedures in place detailing what patient information needs to be collected, to maintain consistency among all patient care records. The team is encouraged to continue with the process of transitioning NL Health Services – Eastern Zones entirely to electronic charting to better support information transfer. Charts are regularly reviewed and audited for completeness, and irregularities. Charts are also retroactively reviewed in safety and complaint situations.

Priority Process: Impact on Outcomes

The Paramedicine & Medical Transport program regularly track key quality metrics (such as red alert frequency, off load times, time on scene, shoot time) specifically related to services delivered. This information is well utilized for data driven decision making for managing capacity/demand for service and strategic program planning and design. The information is also used to identify opportunities for improvements through internal process changes as well as collaborating with other departments and services for cross-departmental process changes. During the transition to one service, the team is encouraged to closely monitor the quality of services, as well as the existing defined metrics delivered by legacy private/community-based services to ensure appropriate education, training, remediation is completed as appropriate. The full implementation of electronic charting will also support the evaluation of service delivery. The team is encouraged to explore ways to obtain more formal patient and family feedback, for every call/mission performed.

Priority Process: Medication Management

The Paramedicine & Medical Transport program has a clear process in place for managing medication procurement, storage, administration, and proper wastage as appropriate. There are minimal high-dose narcotics stocked or available for use in the program's care areas (only available for air ambulance). The NL Health Services – Eastern Zones policy for high-alert medications is available and followed by staff.

Priority Process: Infection Prevention and Control

There is access to all the required personal protective equipment (PPE) in the vehicle for staff to safely care and transport patients. Team members are well versed at knowing when it is required to utilize the appropriate PPE, complete point-of-care risk assessments, notify receiving areas, and how to correctly don and doff their PPE. All equipment and vehicles are cleaned and disinfected immediately after use. Supplies, equipment, linen, and devices are all properly handled, maintained, and stored. Hand hygiene practice compliance is not measured utilizing direct observation for this service. The team is encouraged to work with the Infection Prevention and Control team to develop ways to appropriately audit the team members in this program that meets the needs of the specialized services delivered. These results should then be shared and used to inform improvement opportunities.

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

Unmet Criteria	High Priority Criteria
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: Infection Prevention and Control

The Infection Prevention and Control (IPC) program at Health Sciences Centre and St. Clare's Mercy Hospital is currently staffed by three coordinators and 14 Infection Control Practitioner (ICP), all of whom have their certification in infection control except for one. These ICPs also provide support to other hospitals in the region.

There is concern by the team that three temporary full-time employee positions will end after March 2024, leaving the team unable to maintain their current level of service. IPC leadership is encouraged to review best practice guidelines (e.g., PIDAC) for IPC staffing based on number of beds, acuity, etc., to establish appropriate staffing levels for each of their facilities.

There is medical, administrative, and laboratory support for the program with appropriate reporting to the senior leadership team.

There is a multidisciplinary committee to support and guide the efforts of the team with ad hoc membership by key partners as required. The team has engaged two client/family representatives to the IPC Quality Committee. These committee members have provided invaluable input on items such as program policies as well as patient information materials.

The IPC team is well embedded within the organization and consult appropriately on issues such as the selection of disinfectants, equipment purchasing, and construction and renovation projects. The profile of the team has been elevated significantly during and after the COVID-19 pandemic. The team feels recognized as a valuable resource to the organization and their input is often sought.

The team has developed a comprehensive education program which is delivered to staff at onboarding and on a regular basis thereafter. The modules are reviewed annually to ensure content is appropriate and current.

Not all policies are current in terms of last review date, however, many have been submitted to the policy review group and are pending review. Policies are developed based on evidence review and reflect best practices.

Although hand hygiene compliance rates are monitored, there is opportunity to monitor compliance with other IPC policies (e.g., appropriate use of PPE).

One site, St. Patrick’s Mercy Home long term care facility, has initiated a 'Cleanliness Project' targeting high touch areas with good results. The plan is to roll this successful initiative out more broadly across the organization.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical and administrative leadership dyad in Medicine is visibly collaborative and effective in the design and delivery of inpatient services. Information is collected from clients and families, community partners, and internal partners to inform service design and delivery. There is a strong emphasis on designing 'senior friendly' services to meet the needs of older adults served by this program. Service-specific goals are developed by some teams (e.g., neurology and stroke), selected to align with corporate goals and objectives. Indicators are selected by the team to monitor their success in achieving their goals and findings are shared broadly via their quality board. Teams have developed strategic partnerships to meet the needs of their clients and community (e.g., March of Dimes post-stroke support program, Dr. Leonard A. Miller Centre rehabilitation facility, Community Service Program, supportive housing shelters). A multidisciplinary team including (but not limited to) an occupational therapist, physiotherapist, speech language pathologist, recreation therapy, social work, and dietitian as well as medical and nursing staff provides comprehensive care to clients. Although clinical pharmacists are not embedded into the team, the team has access to central pharmacy expertise when needed. Information on palliative and end-of-life care includes information for clients and families as well as resources for the team.

At the Janeway Children's Health and Rehabilitation Centre pediatric unit visited during survey, the unit was noted to be tidy and well laid out. A dedicated team provided care to pediatric inpatients, and charge nurse roles were recently developed to better support the team. Standardized assessment and communication tools were used. Quality initiatives were visible, and staff were able to speak to them during the onsite visit.

Priority Process: Competency

Multidisciplinary team members are appropriately credentialed and maintain competency to ensure safe and effective service delivery. Education and training are provided by the organization to support staff in care delivery within the organization.

Although performance appraisals are to be completed on an annual basis as per organization policy, they are often not completed in a timely manner according to staff. Staff generally report being supported by the organization in pursuing their professional development goals. There is opportunity to improve upon timely completion of performance appraisals.

Staff are trained on a number of organizational clinical policies such as 'least restraints' and can speak to the details of the policy as it applies to care delivery. Standardized communication tools are regularly used by the team and compliance is monitored.

Although some staff were aware that support was available for handling ethical issues, the details of that support were not clear to most staff, nor did most know about or receive education and training on the organization's ethical decision-making framework. There is opportunity for the organization to raise awareness of both the framework and the available training.

Priority Process: Episode of Care

Accreditation Canada Required Organizational Practices (ROPs) were in place at the time of survey and charts reviewed onsite included the required supporting documentation.

Binders provided to patients at hospital admission provide standardized orientation information with the option to include service-specific information. They are written in plain language and were developed with input from clients and families.

The team has put a considerable effort into standardizing practices across the region to improve care and reduce risk. A number of evidence-informed clinical guidelines have been developed or adopted by the interdisciplinary team and incorporated into practice (e.g., acute coronary syndrome, deep vein thrombosis/pulmonary embolism, antimicrobial stewardship).

The team has timely access to diagnostic testing and specialist consultation with the exception of rheumatology consultation which is not as readily available due to limited personnel. Palliative and end-of-life care is available to clients and supported by the team as indicated/requested.

Information is collected and communicated during care transitions using standardized tools, and the effectiveness of communication is evaluated. The discharge process is also standardized and includes a discharge summary and any medication changes.

At Dr. G. B. Cross Memorial Hospital, there was a high rate of readmission to the unit visited. Follow-up appointments with physicians are challenging to arrange due to the lack of community physicians and the lack of an urgent care or walk in primary care clinic. The primary care clinic only accepts walk-ins on weekends between 1-4 pm. Weekday visits are by appointment only. Improvements to this process may be considered (e.g., book primary care follow-up appointments prior to discharge for those without a regular primary care physician)

A 'One Thing' patient survey identified that patients had a lot of time on their hands and were often bored while in hospital. This led to a pilot project introducing a recreation therapist and assistant to the team. Feedback to date has been very positive. The team is encouraged to follow up on their plan to repeat the survey to evaluate any change in patient response and satisfaction.

At St. Clare's Mercy Hospital workflow was described as "inefficient" and a number of barriers to patient flow were identified. For example, it can take up to one week to obtain an EEG; neurology and cardiology consultations take longer to obtain than other consults; CT scans, PICC line insertions, and occupational therapy, physical therapy, and Social Work consultations are not available on the weekends. On many occasions, patients are kept in hospital only waiting for these investigations or consultations to take place. The organization is encouraged to consider options for expanding access to necessary services to facilitate timely discharge/transfer. Repatriation to peripheral centres was also identified as a barrier to patient flow.

Some clinicians were of the opinion that timely access to diagnostic testing (e.g., cardiac catheterization, CT, EEG) is inequitable between the Health Sciences Centre and St. Clare's Mercy Hospital with the former having preferential access.

Priority Process: Decision Support

Hybrid (paper and electronic) medical records were in use at the time of survey. There are plans to transition to an electronic medical record in future.

Comprehensive, standardized assessments are conducted on each client and documented well in the medical record. Compliance with organizational documentation standards is audited and results are shared with staff.

Staff and physicians met during the survey could speak to organizational policies regarding privacy and disclosure of health information.

Priority Process: Impact on Outcomes

Evidence-informed guidelines are selected for use by the team and are reviewed on a regular basis. A Research Ethics Board is available to support the research activity of the team when required. Staff are comfortable using the incident reporting system (Clinical Safety Reporting System, CSRS) and processes are in place for review of incidents by appropriate clinical leaders. The team has undertaken a number of quality initiatives, identifying opportunities for improvement and implementing actions to support change (e.g., compliance with VTE prophylaxis, improving hand hygiene rates, 'One Thing' survey).

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

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
9.3 A policy for when and how to override alerts by the pharmacy computer system is developed and implemented.	!
Surveyor comments on the priority process(es)	
Priority Process: Medication Management	

The pharmacy team is an integrated, collaborative, and interdisciplinary group. The team includes pharmacists, pharmacy technicians, and support staff.

In some areas Lawton's Drugs are contracted with full access to a pharmacist. Those receiving services from Lawton's Drugs are very satisfied with their delivery, clinical expertise, and education. They provide the required audits and complete medication reconciliation. They also circulate information, education and updates through their Clinical Connection for staff.

There is a regional Pharmacy & Therapeutics (P&T) Committee. The P&T establishes criteria to add, restrict, and remove medications from the formulary. The P&T committee also reviews, updates, and approves policies and procedures, Standards of Practice, and education and training.

The P&T Committee is multidisciplinary and is made up of a number of health professionals including a physician. The terms of reference are reviewed on a regular basis.

One quality initiative the pharmacy team completed was implementation of a Regional Smart Pump Committee used to standardize from four different infusion pumps down to one. The IV infusion system, Alaris has been well accepted across the organization.

The Antimicrobial Stewardship Committee is interdisciplinary and in addition to pharmacy, includes microbiology, infection prevention and control, physicians, and nursing staff. One pharmacist is assigned as the lead. The organization, under the leadership of the pharmacy team, has developed an Antimicrobial Formulary for Acute Care. The team is seeing improvements in reducing antibiotic use in hospitals.

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

Audits are performed quarterly around high alert medications (Insulins), medication incidents, chart reviews, compliance with Best Possible Medication History (BPMH). The results are shared and posted on quality boards. The teams are encouraged to ensure all sites receive the quality updates and that they are reviewed at staff meetings.

The local pharmacy director oversees and monitors that the Service Level Agreement (SLA) is being met. Efforts have been made to educate prescribers and those who administer high-potency narcotics on narcotic safety. Regular reviews of concentrated electrolytes are performed, and these products are "signed out" similar to narcotics in the cardiac units. There were no vials or mixing noted on the nursing units.

Annual audits on 'Do Not Use List of Abbreviations' are conducted. Signage was noted throughout medication areas and staff had good awareness of the list.

The team has ensured that all schools (medicine, pharmacy, and nursing) are educating their students about the Do Not Use List of Abbreviations within their respective programs. They also offer a session on Prescription Writing for students.

There is a good culture of reporting and reviewing incidents. Data is collected and comes to the Pharmacy and Therapeutics Committee quarterly. An example of quality improvement related to incident reporting was around methadone incidents. There is also attention to de-prescribing and monitoring of progress.

There are several challenges that the pharmacy team are addressing. They are committed to reviewing and updating the formulary at least every four years however, with the single health authority forming it was delayed. During the survey, surveyors were informed that it is now underway and will be reviewed and updated at least every four years, per the standard.

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, but it is underway. I would encourage the P&T Committee to monitor progress on the work with regular reporting to leadership.

There are some audits on medication order documentation being completed. Most of the sites are using paper Medication Administration Records (MARs). The use of paper MARs may cause missed opportunities on many safety features that are available when you use electronic MARs. An eMAR would complement the pyxis system and provide timely data.

Computerized physician order entry (CPOE) would also be very beneficial to support safe, quality patient care by reducing incomplete orders, reducing time spent by nurses clarifying orders, reducing overall costs, and increasing safety.

The organization is encouraged to accelerate the work of moving to an electronic health record (EHR).

Paper-based documentation is challenging in the pharmacy as they work to ensure safety and mitigate risk manually. It is time consuming and takes pharmacists away from the clinical work.

There is attention given to shortages of drugs and ways to manage this.

It was noted that some medications like PEG (Polyethylene Glycol) are covered in acute care but not in long term care. This can lead to residents not getting this medication. Further discussion is encouraged to consider other options to address and manage this.

The pharmacy team is to be commended for their quality initiatives and projects. An example is the Chemotherapy Vial Optimization Program. This has the potential to realize savings annually. The pharmacy team would utilize some of these savings to reinvest in additional human resources to support pharmacists in the clinical areas.

Some clinical and rural areas do not have pharmacists available on their units. Multidisciplinary teams benefit greatly from the expertise of pharmacists, resulting in improved patient care and new efficiencies.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There are many services provided under the umbrella of Obstetrics Services in NL Health Services – Eastern Zones. Some of these include prenatal ambulatory care for pre-admission assessment, monitoring of women booked for cesarean sections, and monitoring health concerns such as gestational diabetes, anemia, and hypertension. The Maternal Fetal Assessment Unit provides assessment and surveillance of the fetus.

Some challenges that the teams face include rural staffing of physicians and nursing and maintenance of competencies due to the low volume of deliveries in some sites. The obstetrician at Carbonear General Hospital is working to improve the awareness in the community of the local obstetrical clinic. Due to a recent lack of OB/GYNs many expectant mothers were referred to clinics in St. John's.

Priority Process: Competency

Management is currently supporting performance evaluations and ongoing education for their staff. Managers have committed to ongoing performance evaluations. From the performance appraisals staff are taking training courses in Fetal Health Surveillance and Neonatal Resuscitation Program. Participation in the Just Culture system has allowed managers to coach team members or determine an alternate approach for action if needed. LEARN modules are used to assist in keeping learnings up-to-date and 'just in time' training is used for multiple initiatives and for equipment and devices training.

At the Janeway Children's Health and Rehabilitation Centre Obstetrics unit all nurses are trained in delivery and OR. The manager ensures the least experienced RN on the unit will attend cesarean sections with a senior staff person. The unit works with the rural sites to spend time in the unit to hone obstetrical skills. At this time the staff are stable and 50% of them have less than two years of obstetrical nursing so keeping up clinical skills is the highest priority.

Priority Process: Episode of Care

There are four labour and delivery units at four facilities across NL Health Services – Eastern Zones, of which two were assessed during this survey visit. The Janeway Children's Health and Rehabilitation Centre is the tertiary care site for the province and provides care for individuals greater than 20 weeks' gestation. This birthing unit is one of the few in Canada that is attached to the Neonatal Intensive Care Unit. The Dr. G. B. Cross Memorial Hospital is located in Clarenville and is a combined Obstetrical and Gynecological Unit. Women greater than 26 weeks gestation who present to emergency are sent directly this this unit. They will be assessed and sent onto St. John's as needed. The team is able to deliver premature infants and can provide temporary NICU services until the ground transport team arrives. Urgent cases will call for assistance from the "Cougar Helicopters" – a private acute care transport team. Caesarian sections are done by the operating suite team with support for the infant provided by the obstetrics unit.

There is a need for staff education on how to transport infants in distress to the resuscitation rooms. Both sites visited described in emergency situations as "picking the infant up and running to the resuscitation room". There are definite policies on the transport of infants, and it is strongly encouraged that teams review and follow these policies, which apply to staff and parents.

At the Janeway Children's Health and Rehabilitation Centre, patient rounding for transitions is done each day on the maternity unit. The physiatrist is part of this and will follow up with those she thinks may have a need rather than a referral from the nursing staff. This has had a positive result from patients for follow up.

The Janeway Children's Health and Rehabilitation Centre OB/Maternity units were built in 2000 but there are no labour/delivery room suites. This is encouraged for any future improvements to the OB/Maternity units. Currently, the maternity patients are in four person rooms and have their infants with them. The rooms are shared between mothers who have given birth and expectant mothers. This physical environment does not suit the current standard of care. The organization is encouraged to consider how to provide single room occupancy for new mothers.

The final opportunity for the obstetrics program is to have centralized fetal heartrate monitoring. This would benefit monitoring within the site for the OB/Maternal tertiary program and the rural sites.

Priority Process: Decision Support

Charting is done with a mix of paper and the Meditech system. In the current system there is no standardized method to documentation. The organization is encouraged to implement a provincial electronic medical record to enable the smooth access to patient information and data.

Although the Janeway Children's Health and Rehabilitation Centre is the tertiary obstetrical service in the province there is no centralized fetal heart rate monitoring. This would be significant move towards best practice to have this implemented as soon as possible and then expanded to the maternity room where women are placed if they are greater than 20 weeks gestation. The system could then be spread to the rural sites with support from St. John's if there were concerns about the monitoring of a fetal heartrate.

Priority Process: Impact on Outcomes

The team is currently actively onboarding family/parent/caregiver advisors for committees with a focus on the MoreOB committee. The organization is encouraged to continue to expand the MoreOB program and to continue to expand and create care-paths and policies. The provincial Educators for the program utilize monthly meetings to ensure standardization and the use of best practice. One team member stated with regards to patient advisors, " You wouldn't know they were not staff!".

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.6	Education and training are provided on the organization's ethical decision-making framework.	
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Information at all sites is collected from clients, families, and partners to inform perioperative program design and service appropriateness. Renovations have been completed with input from the patients and families with a recent example being demonstrated in the St. Clare's Mercy Hospital site as they continue with their renovation process. The organization is encouraged to continue with partnering with patients and families to support the perioperative program.

Priority Process: Competency

There are standardized educational training requirements to work in the perioperative area. Annual mandatory education and training is provided and there is ongoing education and training to support

perioperative professional development. Some inconsistency is noted between sites for access to ongoing perioperative professional development and NL Health Services – Eastern Zones is encouraged to provide a consistent approach to providing educational support. Staff are aware of having an ethics policy in place but have not received any education on the ethical decision-making framework. In order to facilitate increased awareness of the ethics resources available, the organization is encouraged to consider providing education on the ethical decision-making framework for team members.

Priority Process: Episode of Care

Information is gathered during the day of surgery to support the delivery of appropriate surgical service and nursing care. Clients and families are actively engaged in a respectful, transparent manner to involve them in their care. Information and education are provided to prepare them for the procedure, protect them from infection, and relay the importance if following instructions. Post-operative information sheets and brochures are provided for reference. Standardized assessment tools from NL Health Services – Eastern Zones are utilized to mitigate risk and provide a consistent approach to pre- and post-operative care. The medication reconciliation process is completed upon admission, discharge, and transfer of care to support safe medication management. An assessment of fall risk, applicable pressure ulcer prevention and venous thrombosis prevention strategies are implemented as appropriate.

A pre-anaesthetic assessment is completed prior to the surgical procedure on the day of surgery. There is no clinical assessment of other services prior to the day of surgery. This may result in the cancelation or rescheduling or a surgical procedure. Consideration to developing a surgical pre-assessment clinic or process by a healthcare professional is encouraged to support a safe patient centered approach.

A two person-specific identifier process is utilized to confirm a patient's identity and information relevant to the care of the client is communicated effectively during care transition using a standardized process. A surgical safety checklist is used, and appropriate perioperative policies are in place to support perioperative care. Many perioperative policies are outdated and an opportunity to implement a standardized cadence to policy review for the perioperative program should be considered.

Standardized documentation tools are available to support all surgical services and guide appropriate documentation to support pre- and post- operative procedures. Observation of the client is completed as per organizational policy and evidenced-based best practice. Written instructions are provided to the client upon discharge as well as how to follow up if any concerns arise. There currently is no formal process for discharge follow up. Future consideration to implementing strategies to support follow up patient care (e.g., such as a 24-hour post-op phone call) is encouraged.

Priority Process: Decision Support

An accurate up-to-date and complete perioperative record is maintained for each client. A standardized approach to the collection of health information is completed utilizing NL Health Services – Eastern Zones perioperative forms. Policies and procedures are in place to support client access to health information, the use of electronic communication and technology, and the disclosures of health information for secondary use are developed and followed.

The flow of client information is completed and coordinated among team members to facilitate the transfer of patient care with a safe and transparent communication process. Evaluation of the record keeping process by clients and families would be completed through the Quality Committee. Training and education to protect client privacy and appropriate use of client information are provided.

Priority Process: Impact on Outcomes

The perioperative program utilizes best practice guidelines to support the delivery of high-quality surgical services. Patient and family advisors participate on the Quality Committee, with two representatives specifically supporting the perioperative program. The Quality Committee is responsible for reviewing standardized processes, evidence-based guidelines, patient safety incident reports, and protocols for the perioperative program.

Quality improvement strategies for the perioperative program are developed at the program level and do not reflect initiatives for each perioperative site. There are no posted indicators to support quality improvement strategies and therefore staff are not aware of their baseline or if any improvement has been demonstrated. To support quality improvement engagement and awareness for staff, patients, and families, the program is encouraged to consider posting indicators on the quality boards to increase awareness and promote engagement. The quality committee analyzes data specific to patient experience and corporate indicators, but the information is too inconsistently disseminated to the frontline to support a culture of quality improvement.

The Cardiac Cath Lab is located at the Health Science Centre and is the only cardiac services provider for Newfoundland. This cardiac program provides access to care for many cardiac invasive procedures and this program has seen a demonstrated demand that continues to grow. The Heart Force One program was introduced one year ago and should be recognized for the implementation of a cardiac service that provides efficient, effective prioritized transfer of low-risk cardiac patients in groups for procedures that are completed same day. This program is very patient centered by providing critical services to a patient population that would otherwise be waiting for extended periods of time to access services individually.

By providing return-trip transportation in groups on the same day, the wait times are significantly less, access to care is increased and the impact to positive patient outcomes are demonstrated.

Priority Process: Medication Management

Medication for the perioperative unit is stored and secured in a locked area according to the organizational policies. All medications are validated verbally and visually by two team members. Medications provided in the sterile field are delivered using an aseptic technique, and are labelled, documented, and retained until the procedure is completed. The utilization of multi-use vials is minimized, antidotes and emergency lifesaving equipment are available to support the delivery of safe medication practices.

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 20 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