Canadian Council on Health Services Accreditation

Conseil canadien d'agrément des services de santé

Accreditation Survey Report

Interior Health Authority

Kelowna, BC

June 4 - 9, 2006

CONFIDENTIALITY STATEMENT

The results of this accreditation survey are documented in the attached report, which was prepared by the Canadian Council on Health Services Accreditation (CCHSA) at the request of Interior Health Authority.

This report is based on information obtained from the organization, as well as from other sources. CCHSA relies on the accuracy of this information to conduct the survey and to prepare the report.

This confidential report is intended for the organization only. The information herein may be disclosed at the organization's discretion; however, CCHSA assumes no responsibility for its release or subsequent use. If the reader of this notice is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this report is strictly prohibited.

Any alteration of this report is strictly prohibited and could result in a criminal conviction for fraud pursuant to the Criminal Code of Canada.

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ABOUT THIS REPORT

This report provides guidance for future quality improvement initiatives by documenting the findings from the organization's recent accreditation survey. The report is divided into four main sections: 1) Survey Summary; 2) Survey Details; 3) Team Findings; and 4) Future Direction.

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

Leading Practices

Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.

Recommendations

Recommendations are areas highlighted for improvement due to low compliance with the criteria. Recommendations are tied to a criterion and are given a risk rating related to the likelihood and severity of a potential adverse event, and urgency of addressing the issue.

Key Recommendations

Key recommendations are recommendations that are rated high urgency and need to be addressed as a priority.

Repeat Key Recommendations

Repeat key recommendations are recommendations that are rated high urgency and cover areas/issues that were the subject of a recommendation in the previous accreditation survey.

Total Recommendations

Total recommendations are the total number of recommendations related to a team, a quality dimension or descriptor, or a standard sub-section.

Risk Ratings

Ratings assigned to a recommendation, which measure the degree of risk related to non-compliance with a standard, based on the surveyor's assessment. The surveyor assesses the likelihood of an adverse event occurring, the severity of the event should it occur, and how urgently the recommendation must be addressed in order to avoid the occurrence of that adverse event.

- **H** High
- **M** Medium
- **L** Low

Quality Dimensions

The dimensions define what CCHSA means by "quality". Please see the Appendix A for a full description of the Quality Dimensions and the corresponding descriptors.

- Responsiveness
- System Competency
- Client/Community Focus
- Worklife

SURVEY SUMMARY

The Accreditation Decision

Further to the survey held June 04 - 09, 2006, the Board of Directors of the Canadian Council on Health Services Accreditation (CCHSA) advises the Interior Health Authority that it has been granted:

Accreditation with Condition: Report and Focused Visit

Introduction

As part of the accreditation process, health services organizations take part in a self-assessment followed by a survey visit. The survey itself includes a review of documentation, team interviews, facility tours and focus group meetings with various stakeholders. This accreditation process allows CCHSA and the organization to evaluate the quality of the organization's services by comparing them to nationally accepted standards.

This summary provides a synopsis of the results of the third and final component of Interior Health's sequential accreditation survey. It is CCHSA's intention that the comments and recommendations in the report will help the organization improve the care and service it provides to its clients. The information can be shared with internal and external partners such as stakeholders, staff, visiting family, volunteers, the public, and the media.

Survey Profile

Interior Health (IH) is headquartered in Kelowna, BC. This third and final component of IH's sequential survey was conducted by six surveyors and included focus group interviews, team interviews, and onsite visits. Documentation from all teams was also reviewed.

The following sites were visited during this survey visit:

Royal Inland Hospital
Chase Health Centre and Adult Day Care
Shuswap Lake General Hospital/Bastion Place
Arrow Lakes Hospital
Kootenay Boundary Regional Hospital
Boundary Hospital
Invermere Hospital
East Kootenay Regional Hospital
Kelowna General Hospital
South Okanagan General Hospital
Vernon Jubilee Hospital
Reid's Corner
Enderby Community Health Centre
Penticton Regional Hospital
Integrated Health Centre
Vernon Renal Clinic
Kirschner Office

The following teams participated in this accreditation survey:

Information Management
Acute Care Medicine
Ambulatory Care Renal
Critical Care
Rehabilitation

Survey Objectives

The organization’s goal is to assess Interior Health's programs and services compliance with the Canadian Council for Health Services (CCHSA) Achieving Improved Measurement (AIM) standards.

The organization’s objectives for this accreditation survey are:

1) To evaluate the organization and identify areas for improvement.

2) To assist in the creation of IHA-wide integrated service delivery systems along the continuum of care in all sectors.

3) To provide frontline staff, physicians, volunteers, the public, and community partners the opportunity to assess the quality of care and service in an interdisciplinary team environment.

4) To increase understanding regarding the use of a population health approach for service improvement across the continuum of care.

5) To further involve its clients, community, staff, and partners in the planning, delivery, and evaluation of health care services.

6) To integrate the quality improvement framework into day-to-day operations.

7) To demonstrate accountability and promote public confidence in the IHA and the health system.

The surveyors’ response to the organization’s objectives is that the overall goal has been well-achieved.

1) The organization was assisted to identify areas for improvement and it is addressing them.

2) The organization facilitated progress on creating an integrated service delivery system. Interior Health recognizes that there are still some key decisions that need to be made about how integrated the region wants to be.

3) The accreditation process has provided this organization with a foundation to assess its services in an interdisciplinary team environment, and to further standardize processes across the HSAs.

4) There are areas where there is an opportunity to improve the understanding of population health in clinical areas.

5) The accreditation cycle has created some opportunities for community involvement. IHA is encouraged to continue looking for ways to increase meaningful community linkages and involvement.

6) The QI framework integration is being implemented.

7) The region will need to determine if this process has helped to enhance accountability and public confidence.

Organization Profile

Successes and Challenges

Successes

IHA continues to realize the benefits of a macro regional structure. By concentrating specialty services in a few areas, it has been able to achieve efficiencies of care and to take steps to maintain system sustainability such as adequate coverage of specialists and sub-specialists.

There are five key priority areas of focus including emergency services, senior care, quality and patient safety, surgery, and human resources.

It continues to work toward regional standardization in several areas such as ethics, consent policies, incident reporting, and monitoring the standardization of diagnostic procedures.

There is evidence of more communication and collaboration across the sites, within HSAs, and in some cases regionally such as the DI newsletter. There is growing evidence of more sharing and collaboration at the regional level in specific areas such as infection control. IHA needs to continue to enhance communication and collaboration in all areas to achieve more coordination of services and appropriate integration.

The organization is encouraging relationships between specialists and primary care physicians. It is mentoring new nurses. Staff and physicians report significant improvements in morale over the past two years in this HSA.

There has been an obvious emphasis placed on creating a culture of support for incident reporting and reporting. The no blame/no shame message has reached the frontline. Staff and physicians acknowledge that there has been a change in culture over the last two years in most areas. Air and oxygen outlets were identified as a root cause of a critical incident and the system was changed across the IHA as a result.

The IHA continues to have strong links with the province through the minister’s forum, the leadership council, and representation on over 250 provincial committees.

It continues to use a concept of hospitals within a hospital system that helps to define levels of care and the location of various levels of care. It provides services within a coordinated network of care that includes the entire continuum of care.

The organization is in the process of implementing "Pixelere", which is a method of recording wound observations that allows the wound nurse specialist to provide expert and timely advice in the treatment of difficult to treat wounds.

The IHA implemented a quality patient safety pilot project at the South Okanagan General Hospital, which consists of a six-phase approach conceptualized as the quality circle. A bar code armband for patient identification has been implemented. Bar code scanners are used for patient identification purposes during laboratory specimen collection. Hand held devices and mobile computer carts have been implemented to facilitate bedside information access and documentation by nursing staff, including an online medication administration record. Bar code scanning is again used for medication verification. Electronic physician order management and primary care linkages were recently implemented to complete the quality circle. Each phase of the pilot project has been supported and guided by an individual project charter, in keeping with the global project charter guiding the overall pilot. Commencing in October of 2004, each new phase was added at approximately six-month intervals. The pilot project provides a model for improved safety and systems implementation that can be used throughout the IHA and beyond.

Meditech and PACS have made a significant improvement in the effectiveness and efficiency of the radiology departments. The real time consultation with radiologists, access to verbal transcriptions, and ability to treat many patients closer to home has been very beneficial.

Staff are passionate, dedicated, and caring.

IHA is developing creative strategies to address human resource challenges. The rehabilitation staff vacancies have decreased from 30% last year to 9% this year.

There are some good relationships with the postsecondary institutions. Some services have adopted a policy to refuse no student and encourage placements in the organization that will hopefully lead to employment.

Infection control strategies appear to be very successful. A very good committee structure is in place and most practices are standardized. There are hand washing strategies at all sites. Screening for infections is done before scheduled admissions.

Other notable successes in IHA include:

Patients and families report that they receive good explanations of care.

There is auditing of access to electronic records and staff are aware.

Benzodiazepines are now handled in compliance with the federal targeted substances regulations.

Concentrated KCL is now a controlled substance in IHA and it has been removed from all of the nursing units.

There are some excellent examples of renal care in Kamloops, Kelowna, and Penticton.

There is a very good five-year strategic plan for information management in place for the IHA.

There has been some excellent work related to online library services. Communication and implementation strategies are needed to inform staff about this valuable support.

Challenges

Geography remains a huge challenge and travel by car can take over seven hours. Not all parts of the region are in the same time zone.

Two years ago, this recently formed health authority was struggling with a lack of standardization across many of its sites. At an HSA level, there has been considerable improvement in this regard, however standards and resources across the HSAs continue to reflect significant differences. This region could be described as a federation of HSAs.

Human resource issues pose a continuing and growing challenge for the region. The organization has struggled with turnover in some key positions and has had difficulty recruiting competent staff in several disciplines such as ultrasound technology, transcription staff, critical care, management, and leadership positions. There are no workload measures and ensuring adequate staffing is a problem in areas such as critical care.

Some programs and services are completing performance appraisals regularly, while many others have not even begun to address this issue. Lack of recognition could be a significant factor in the ongoing staff morale issues. The East Kootenays health service area has made significant progress on the completion of performance appraisals.

The Legacy facilities pose environmental challenges to staff and present safety risks to patients such as the Vernon Jubilee Hospital medication rooms, diagnostic imaging (DI) area, and pharmacy. The pharmacy at Vernon presents high risks that should be addressed immediately. The space is small and cluttered that increases the risk of dispensing errors. The chemotherapy area presents health and safety risks for staff. The fume hood is not physically separated from the rest of the pharmacy, thereby exposing pharmacy staff to possible contamination without appropriate protection. The organization is providing services at several acute care facilities that are undergoing renovations.

There are some significant professional practice issues affecting the renal services in this region, which require action. These affect medical care to patients and the scope of practice issues for nursing. These will be addressed in detail in the team report and will be accompanied by recommendations.

Response to Previous Survey Recommendations

2005 Report

The new consent forms for emergency surgery, and policies for physician responsibility and nurse verification have been developed and are in final draft. The timelines for implementation across the region have been delayed after initial feedback indicated that there were still areas of confusion and unanswered questions. This work is happening over the summer, and staff education sessions are planned in the fall of 2006.

The emergency response management system has been an area of focus over the past year. There has been progress in this area, although it is still somewhat inconsistent across the IHA. There has been progress made on fire and evacuation drills in several facilities, and disaster fan out lists are in place. A tabletop exercise was conducted last year and the organization found it helpful.

There is support from the board to make patient safety a priority. IHA has developed the Interior Health Quality and Safety model that outlines the roles of the various players in the organization, an incident reporting algorithm, sentinel event algorithm, and a description of root cause analysis principles and process. Senior management is familiar with this model. The managers are somewhat aware, and information has not yet reached the frontline. The organization is encouraged to pursue strategies to disseminate this information as planned. It is including this model in orientation for new staff.

The corporate director of performance management is responsible for quality improvement and risk management and a new person is in the position of director of quality and patient safety. The quality and safety committee has been reconstituted with more strategic leadership to focus on excellence in quality, patient safety, and care through patient focused leadership, innovation, and shared responsibility. Each HSA has a quality and safety leader position.

A quality bulletin has been developed to communicate broadly about QI initiatives. They are in the process of establishing quality service teams.

Overall, the organization has embraced the concept of patient safety as a priority and staff acknowledge a philosophy of no shame/no blame. However, reporting of incidents is still lower than would be expected and in some areas, incidents are not being identified such as when medications are missing from pharmacy. A rural ICU reported no incidents since 1988. Patients in the focus groups were aware of medication errors. The senior executive team has approved an incident reporting process and each HSA has an incident reporting system although it is not standardized across the region. Recently the medication error reporting system was standardized across the pharmacies using the Analyze system. In all other instances, predominantly manual systems are used. The organization is planning to move to an electronic provincial system in 2007.

There have been some sentinel events this past year, which have been reviewed. The knowledge gained from these reviews has resulted in system wide changes such as air and oxygen valves.

The pharmacy department is using the Analyze system.

The organization continues to participate in the provincial initiative related to incident management.

The accreditation teams have identified several opportunities for quality improvement during the second component of the sequential survey and they are encouraged to continue with the work that has been started.

A regional clinical ethics committee (CEC) has been established and each health service area (HSA) has at least one ethics committee. There is widespread awareness of the ability to access ethics consultation, but this resource appears to be underutilized and teams are still struggling on their own. Further work is needed to encourage consultations and provide experience with the committees.

Progress is being made to implement standardized infection control practices across the region.

Work is underway in some areas related to the development of outcome indicators.

There is a process for complaints to be filed in the region and there is access to patient representatives. There is very little communication of these vehicles to patients and families.

October 2004 report

The organization began work on the values in the fall of 2005. It is committed to a bottom up process that includes staff and physicians. It began staff forums in January 2006, however it suspended activities due to a potential job action. That situation has been resolved, and it is planning staff forums to complete the values work in September 2006 and will include in person and online opportunities for input. A final draft of the values statement is expected in November 2006 that will be presented to the board at a strategic planning session.

There is a process to reduce overtime and address the ratio of casual positions. There has been some progress in increasing the number of permanent positions.

Watson and Wyatt completed a survey of staff and it shows marginal improvement over the results achieved three years ago. There are some pockets within IHA, such as the East Kootenay health service area, where there has been marked improvement in staff morale and worklife satisfaction. IHA needs to look at the factors that contributed to the fairly dramatic shift in this area over the past 21 months.

IHA is now compliant with the requirements for benzodiazepine and concentrated electrolytes.

Work is in progress to address the many challenges with communication in this region. Progress is being made but sustained effort is required to ensure that key messages are communicated sufficiently throughout the organization.

Leading Practices

- The IHA implemented a quality patient safety pilot project at the South Okanagan General Hospital, which consists of a six-phase approach conceptualized as the quality circle. A bar code armband for patient identification has been implemented. Bar code scanners are used for patient identification purposes during laboratory specimen collection. Hand held devices and mobile computer carts have been implemented to facilitate bedside information access and documentation by nursing staff, including an online medication administration record. Bar code scanning is again used for medication verification. Electronic physician order management and primary care linkages were recently implemented to complete the quality circle. Each phase of the pilot project has been supported and guided by an individual project charter, in keeping with the global project charter guiding the overall pilot. Commencing in October of 2004 each new phase will be added at approximately six-month intervals. The pilot project provides a model for improved safety and systems implementation that can be used throughout the IHA and beyond. Information Management team. (Information Management, Standard 5.0)

List of Recommendations

Required Organizational Practices

Goal Area # 1: Culture

Quarterly Reports — Rating: D

Recommendation

It is recommended that the organization implement a full safety reporting system to the board including the implemented changes and improvements following the investigation of serious incidents.

Reporting Adverse Events — Rating: D

Recommendation

It is recommended that the IHA move forward with its plan to consolidate the HSAs' multiple reporting systems and begin to implement training to address adequate reporting.

Disclosure — Rating: D

Recommendation

It is recommended that IHA develop and implement its own regional disclosure policy. The region has been waiting for provincial work on a disclosure policy.

Prospective Analysis — Rating: N

Recommendation

It is recommended that the organization implement a process to define and implement a patient safety prospective analytical process every year.

Goal Area # 2: Communication

Verification Processes — Rating: D

Recommendation

It is recommended that the organization educate staff and reinforce the routine use of verification methodologies including consistent verification of patient identification using armbands, and verification of patient medications at each medication transaction. The organization participated in a pilot project aimed at improved patient quality and safety at the South Okanagan Health Centre. It is recommended that the IHA expand this pilot strategy to other areas.

Goal Area # 4: Worklife/Workforce

Patient Safety Training — Rating: D

Recommendation

It is recommended that the organization provide education on patient safety to all staff this fiscal year and develop a mechanism for tracking.

Patient Safety Plan — Rating: D

Recommendation

It is recommended that the organization assess the region's safety issues to guide the development of a detailed action plan for implementation this fiscal year. Start implementation with targets and methods to monitor. Report the plan to senior leadership and the board.

Roles & Responsibilities — Rating: D

Recommendation

It is recommended that the organization implement its plan to use the high-level delineation document to help support all staff to have an awareness of and be able to consistently articulate their roles and responsibilities in safety.

Goal Area # 5: Infection Control

Hand Washing/Hygiene — Rating: D

Recommendation

It is recommended that the organization educate the physicians about hand washing and monitor compliance. Hand washing in physicians needs some attention as staff and clients have to remind them. This does not apply to surgeons.

Recommendations by Quality Dimensions

R Responsiveness

Ambulatory Care Renal — Criterion 12.3 — Descriptor: *Timeliness*

Recommendation

It is recommended that the team involve the entire team, including the nephrologist, in family conferences, and that this be standardized across the region.

Organization Rating	Survey Rating	Risk Rating
5	4	Likelihood **M** Severity **M** Urgency **M**

Potential Adverse Event

Without input from all relevant providers, patients and family members may not understand the problems or goals fully to make informed decisions about their care. Health care providers may not have all the information to base to build an appropriate care plan.

Reason for Urgency

All members of the team need to be present to set and communicate a truly integrated care plan.

Critical Care — Criterion 1.1 — Descriptor: *Availability*

Recommendation

It is recommended that the team work with the information available at the regional, provincial, and national level and use population health data to determine future needs and guide planning.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

The ICU team and the region may not be aware of the ongoing needs and demands for services and the resource allocation necessary to meet the needs.

Reason for Urgency

This recommendation should be addressed in a planning and budgeting cycle as part of the strategic directions for the ICU team.

Rehabilitation — Criterion 1.1 — Descriptor: *Availability*

Recommendation

It is recommended that rehabilitation services develop and implement a strategic plan.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

Inappropriate use of resources and ongoing fragmentation of services may result.

Reason for Urgency

This has been an ongoing issue and it is essential to high quality service delivery. The team has very ambitious plans and objectives. It needs to exercise caution, prioritize efforts, and collectively develop a series of reasonable steps.

Rehabilitation — Criterion 1.2 — Descriptor: *Continuity*

Recommendation

It is recommended that the team implement appropriate administrative structures for rehabilitation services at both the HSA and IHA levels.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

The group may be voiceless and the rehabilitation services team may not be able to come together.

Reason for Urgency

Studies and documents were produced at the HSA level in the past few years that have dealt with this issue, but no action has yet been taken.

System Competency

Acute Care Medicine — Criterion 4.3 — Descriptor: *Effectiveness*

Recommendation

It is recommended that the team work with leadership in the organization to increase its efforts in prevention and early detection.

Organization Rating	Survey Rating	Risk Rating
3	3	Likelihood L Severity L Urgency L

Potential Adverse Event

The growing burden of illness and disease may lead to capacity issues for acute care and community care.

Reason for Urgency

The team is engaged in some prevention and monitoring activities. Having stronger involvement in early detection strategies, as well as stronger awareness and linkages to the region's prevention strategies will assist the acute care medicine programs in continuing to reduce readmissions, length of stay and other key indicators.

Acute Care Medicine — Criterion 10.1 — Descriptor: *Legitimacy*

Recommendation

It is recommended that the organization finalize and disseminate the informed consent policy throughout IHA.

Organization Rating	Survey Rating	Risk Rating
5	3	Likelihood M Severity H Urgency H

Potential Adverse Event

A patient may receive an unwanted medical intervention. There may be risk to IHA for legal action and loss of public credibility and trust.

Reason for Urgency

The organization needs to protect the patients' rights and reduce its financial risk.

Ambulatory Care Renal — Criterion 3.1 — Descriptor: *Effectiveness*

Recommendation

It is recommended that the team conduct formal patient satisfaction surveys.

Organization Rating	Survey Rating	Risk Rating
3	3	Likelihood M Severity M Urgency M

Potential Adverse Event

The team may lack knowledge of patient dissatisfaction and ways to improve care.

Reason for Urgency

The team needs to identify and address areas for improvement to improve the patient experience.

Ambulatory Care Renal — Criterion 3.3 — Descriptor: *Effectiveness*

Recommendation

It is recommended that the team develop a process to determine the relationship between infections, septicemias and the access type.

Organization Rating	Survey Rating	Risk Rating					
3	**3**	Likelihood	**M**	Severity	**M**	Urgency	**M**

Potential Adverse Event

Staff may be unable to discover ongoing or episodic problems.

Reason for Urgency

The team needs to be able to monitor these key indicators, protect patient safety and identify areas for improvement.

Ambulatory Care Renal — Criterion 12.2 — Descriptor: *Appropriateness*

Recommendation

It is recommended that the nephrologist be present in the dialysis units at reasonable intervals. Telemedicine could be used in distant units for bimonthly or monthly sessions with the patients and the multidisciplinary teams.

Organization Rating	Survey Rating	Risk Rating					
5	**1**	Likelihood	**M**	Severity	**H**	Urgency	**H**

Potential Adverse Event

A patient could develop a problem and there could be poor understanding by the staff.

Reason for Urgency

The patients need nephrology involvement, visits and plans.

Ambulatory Care Renal — Criterion 13.1 — Descriptor: *Appropriateness*

Recommendation

It is recommended that the team increase the frequency with which long distance patients are seen by the physician to at least every two months. This could be done by telemedicine.

Organization Rating	Survey Rating	Risk Rating					
6	**3**	Likelihood	**M**	Severity	**H**	Urgency	**H**

Potential Adverse Event

Without regular and timely contact with the physician, patient and care problems may be missed and the patients may be dissatisfied with the lack of nephrology care.

Reason for Urgency

The organization needs to ensure that appropriate and adequate nephrology care is provided. Patients have expressed concern with the frequency of visits by some nephrologists.

Ambulatory Care Renal — Criterion 14.1 — Descriptor: *Safety*

Recommendation

It is recommended that the team access a pharmacist, possibly by telemedicine.

Organization Rating	Survey Rating	Risk Rating
3	3	Likelihood **M** Severity **M** Urgency **M**

Potential Adverse Event

Staff may lack understanding of side effects, which could interfere with care or lead to other more serious health complications.

Reason for Urgency

A pharmacist is needed to support safe medication practices. The team is fully aware of the need for a pharmacist on the team and of the human resource challenge they are facing.

Critical Care — Criterion 7.1 — Descriptor: *Appropriateness*

Recommendation

It is recommended that the team work with management to develop a workload measurement tool to assess the level of staffing needed in the ICU environment.

Organization Rating	Survey Rating	Risk Rating
6	3	Likelihood **M** Severity **M** Urgency **M**

Potential Adverse Event

Staffing levels may be inappropriate resulting in over or understaffing in the ICU areas.

Reason for Urgency

The nurse to patient ratio for ventilated patients should be one-on-one and this is not always the case throughout the region.

Critical Care — Criterion 15.3 — Descriptor: *Effectiveness*

Recommendation

It is recommended that the team monitor patients following discharge to determine the outcomes including mortality, morbidity, adverse events, average length of stay, and readmission rates.

Organization Rating	Survey Rating	Risk Rating
4	3	Likelihood **M** Severity **M** Urgency **M**

Potential Adverse Event

The team is uncertain outcome data for the ICU population in the region and this may result in misallocation of resources.

Reason for Urgency

Better awareness of outcomes will assist this team in better overall operational and strategic planning.

C Client/Community Focus

Ambulatory Care Renal — Criterion 10.4 — Descriptor: *Participation and Partnership*

Recommendation

It is recommended that the team ensure that the consents include all advance directives.

Organization Rating	Survey Rating	Risk Rating
4	3	Likelihood **M** Severity **M** Urgency **M**

Potential Adverse Event

Events or treatments may occur without patient or family input. Patients' wishes may be missed causing unwanted or harmful care.

Reason for Urgency

A standardized process will assist all in ensuring that all aspects of care are discussed with the patient, and that the patient's wishes are both documented and respected.

Ambulatory Care Renal — Criterion 11.6 — Descriptor: *Participation and Partnership*

Recommendation

It is recommended that the team ensure that patients are made aware of the complaint process and assured that the process will be confidential.

Organization Rating	Survey Rating	Risk Rating
4	3	Likelihood **M** Severity **H** Urgency **M**

Potential Adverse Event

Patients may not bring ideas or problems forward, and may not know how to have their concerns addressed in an efficient and timely manner.

Reason for Urgency

Once patients bring their complaints forward, the team and the organization will be able to watch for trends much more effectively.

Recommendation

It is recommended that the team inform patients and their families about the availability of the complaint process and how they can express concerns about their care.

Organization Rating	Survey Rating	Risk Rating					
5	**3**	Likelihood	**M**	Severity	**H**	Urgency	**M**

Potential Adverse Event

Patients and families with concerns about their care may not be aware of the mechanisms that are in place. Patient and family concerns are not being addressed.

Reason for Urgency

Increased patient awareness of the complaints process will ensure that complaints are addressed in an efficient and timely manner.

SURVEY DETAILS

Accreditation Decision Details

The Accreditation status informs the organization whether it has met the CCHSA eligibility requirements for accreditation, and gives the details on the conditions of that status, if any. This status, together with the findings from the self-assessment and the content of the report, give the organization a reference point from which to focus their continuous quality improvement efforts for the next three years.

As granted by the Board of Directors of CCHSA, the Interior Health Authority has achieved the following Accreditation Recognition decision:

Accreditation with Condition: Report and Focused Visit

A report is due in 6 months and should focus on the following areas:

Implement a full safety reporting system to the board including the implemented changes and improvements following the investigation of serious incidents (Patient Safety Goal 1: Culture, Required Organizational Practice 2).

Move forward with its plan to consolidate the HSAs' multiple reporting systems and begin to implement training to address adequate reporting (Patient Safety Goal 1: Culture, Required Organizational Practice 3).

Develop and implement a regional disclosure policy (Patient Safety Goal 1: Culture, Required Organizational Practice 4).

Implement a process to define and implement a patient safety prospective analytical process every year (Patient Safety Goal 1: Culture, Required Organizational Practice 5).

Educate staff and reinforce the routine use of verification methodologies including consistent verification of patient identification using armbands, and verification of patient medications at each medication transaction (Patient Safety Goal 2: Communication, Required Organizational Practice 3).

Provide education on patient safety to all staff this fiscal year and develop a mechanism for tracking (Patient Safety Goal 4: Worklife/Workforce, Required Organizational Practice 1).

Assess the region's safety issues to guide the development of a detailed action plan for implementation this fiscal year; start implementation with targets and methods to monitor.; report the plan to senior leadership and the board (Patient Safety Goal 4: Worklife/Workforce, Required Organizational Practice 2).

Implement the plan to use the high-level delineation document to help support all staff to have an awareness of and be able to consistently articulate their roles and responsibilities in safety (Patient Safety Goal 4: Worklife/Workforce, Required Organizational Practice 3).

Educate the physicians about hand washing and monitor compliance; this does not apply to surgeons (Patient Safety Goal 5: Infection Control, Required Organizational Practice 2).

Please use the online follow-up template, as indicated in the Future Direction section of this report, to follow up on these areas of review.

A Focused Visit is due to occur in 12 months and should address the following areas:

Increase the frequency with which long distance patients are seen by the physician to at least every two months. This could be done by telemedicine (Ambulatory Care Renal team, Ambulatory Care Standard 13.0, criterion 13.1).

Ensure that the nephrologist is present in the dialysis units at reasonable intervals; telemedicine could be used in distant units for bimonthly or monthly sessions with the patients and the multidisciplinary teams (Ambulatory Care Renal team, Ambulatory Care Standard 4.0, criterion 4.3).

Finalize and disseminate the informed consent policy throughout IHA (Acute Care Medicine team, Acute Care Standard 10.0, criterion 10.1).

Please refer to the “Guidelines for Preparing for a Focused Visit as a Condition of Accreditation” information sheet or contact your Accreditation Specialist for more information on how to prepare for this focused visit.

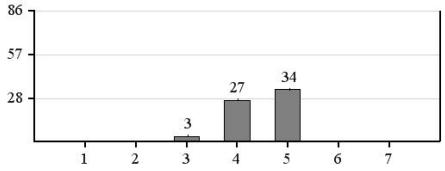
Please note that the remaining recommendations will also need to be addressed by your next survey visit in three years.

Overview by Quality Dimensions and Descriptors

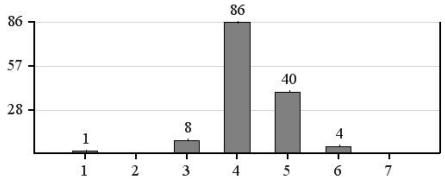
The table below provides information on recommendations and ratings organized according to quality dimension and descriptor. For each quality dimension the following information is supplied:

- a frequency distribution showing how often each rating was given by surveyors for each quality dimension
- a listing of the number and type of recommendation for each quality descriptor if a recommendation was written or if the average rating was below 4.5
- the average rating for each applicable quality descriptor

The frequency distribution of ratings for each dimension is particularly useful when quality dimensions have averages that are very similar because it shows how ratings at different levels can result in similar means. This increased specificity provides greater detail of how the organization was rated at particular levels of compliance between quality dimensions. Please see Appendix A for more information on quality dimensions and descriptors.

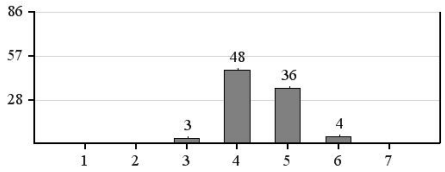


Responsiveness	R			TR	Avg. Rating
Availability	2			2	4.5
Continuity	1			1	4.3
Timeliness	1			1	4.4
Dimension Total	4			4	



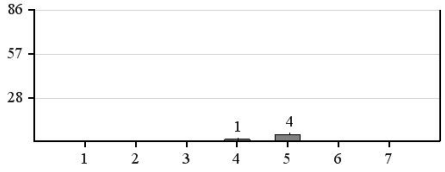
System Competency	R			TR	Avg. Rating
Appropriateness	1	2		3	4.4
Competence					4.0
Effectiveness	4			4	4.1
Efficiency					4.0
Legitimacy		1		1	4.6
Safety	1			1	4.3
Dimension Total	6	3		9	

Client/Community Focus



	R		PR	TR	Avg. Rating
Participation and Partnership	3			3	4.2
Dimension Total	3			3	

Worklife



	R		PR	TR	Avg. Rating
Open Communication					4.0
Dimension Total					
Recommendations Total	13	3		16	

Patient Safety

The accreditation process evaluates the organization's performance on key issues of patient safety in two ways:

1. Patient Safety Goals and Required Organizational Practices (ROPs)
2. Patient Safety Criteria

This section of the accreditation survey report provides an overall assessment of the organization's performance in these two areas. It provides a guide to the organization in terms of areas of excellence and improvement in patient safety. In these ways, CCHSA has made patient safety an essential element of the accreditation program, reinforcing that health services cannot be of high quality unless they are safe.

Section 1: Patient Safety Goals and Required Organizational Practices

The table below displays the organization's performance with the 21 ROPs according to the 5 patient safety goal areas: culture, communication, medication use, worklife/workforce and infection control. For a complete list of the patient safety goals and required organizational practices, please refer to Appendix C on Patient Safety Goals and Required Organizational Practices.

The table indicates that the organization has 1 of the ROPs not in place, 8 of the ROPs in development and 12 of the ROPs fully implemented. The organization is encouraged to focus attention on the patient safety goal areas of Culture , Communication , Worklife/Workforce and Infection Control and to implement the associated ROPs.

Following the table, is a detailed summary of the organization's performance on each of the 21 ROPs. The summary provides the rating, comments and recommendations, where applicable, for each ROP.

Table 1.0 Required Organizational Practices

	Not in place	In development	Fully implemented	Leading Practice	Non Applicable	TOTAL
Culture	1	3	1			5
Communication		1	4			5
Medication Use			3			3
Worklife/Workforce		3	1			4
Infection Control		1	3			4
TOTAL	1	8	12			21

Not in place (N): *The organization has no activity related to the required organizational practice.* **• In development (D):** *The organization has some activity but the organization has not implemented the practice throughout the organization.* **• Fully implemented (I):** *The organization has operationalized the practice throughout the organization.* **• Leading Practice (L):** *Leading Practice are noteworthy practices carried out by the organization. These practices demonstrate innovation and creativity. Leading practices are notable for what they could contribute to the field.* **• NA (Non-Applicable):** *The practice does not apply to organization.*

Required Organizational Practices

Goal Area # 1: Culture	*Rating*
1. Adopt patient safety as a written, strategic priority/goal.	**I**
2. Provide quarterly reports to Board on patient/client safety, including changes /improvements following incident investigation and follow-up.	**D**
Recommendation: It is recommended that the organization implement a full safety reporting system to the board including the implemented changes and improvements following the investigation of serious incidents.	
Comments: A plan has been developed but it is not yet implemented.	
3. Establish a reporting system for actual and potential adverse events, including appropriate follow-up. This should be in compliance with any applicable legislation; and within any protection afforded by legislation.	**D**
Recommendation: It is recommended that the IHA move forward with its plan to consolidate the HSAs' multiple reporting systems and begin to implement training to address adequate reporting.	
Comments: There are multiple adverse event reporting systems. There is no capacity for organizational analysis and trending.	
4. Implement a formal (transparent) policy and process of disclosure of adverse events to patients/families, including support mechanisms for patients, family, and care/service providers.	**D**
Recommendation: It is recommended that IHA develop and implement its own regional disclosure policy. The region has been waiting for provincial work on a disclosure policy.	
Comments: There is no IHA-wide standardized policy for the disclosure of adverse events. Many teams disclose adverse events but this is carried out by individual providers.	
5. Carry out one patient safety-related prospective, analytical process per year (e.g. Failure Modes and Effects Analysis), and implement appropriate improvements/changes.	**N**
Recommendation: It is recommended that the organization implement a process to define and implement a patient safety prospective analytical process every year.	
Comments: At present there is no process in place to do a prospective analysis, such as FMEA.	

Goal Area # 2: Communication	*Rating*
1. Inform and educate patients/clients and/or family about their role in patient safety, using both written and verbal communication.	**I**

Comments: Written and verbal information regarding the client and family role in safety is evident in a number of areas. The organization has developed a patient information booklet that is available online and in a magazine format for the public. Patient responsibility information is displayed in a number of areas. The organization is encouraged to continue develop and implement strategies across the HSAs to consistently inform clients and families of their role and responsibilities related to their own safety including written handouts, posters, and a standardized checklist for verbal interactions.

2. Employ effective mechanisms for transfer of information at interface points, including shift changes; discharge; and, patient/client movement between health care services and sectors, and implement improvements.	**I**

Comments: The organization has implemented a number of processes to ensure appropriate information exchange at care transition points. The implementation of the Meditech system has provided clinical information throughout the region at point of care to ensure that discharge summaries, medication, and lab data is readily available. These strategies are acknowledged, however improvements need to continue in care transition communications in some areas.

3. Implement verification processes and other checking systems for high risk care/service activities, including ordering and receiving results of critical tests; administering surgical or other invasive procedures; diagnostic testing; medication use, and implement improvements.	**D**

Recommendation: It is recommended that the organization educate staff and reinforce the routine use of verification methodologies including consistent verification of patient identification using armbands, and verification of patient medications at each medication transaction. The organization participated in a pilot project aimed at improved patient quality and safety at the South Okanagan Health Centre. It is recommended that the IHA expand this pilot strategy to other areas.

Comments: Processes are in place to appropriately identify patients and ensure appropriate medication administration. However, staff, patients, and families indicate that these practices are inconsistently applied. In some areas, the number of pharmacy re-dispensing requests for medication are incongruent with the number of incident reports filed.

4. Reconcile the patient's/client's medications upon admission to the organization, and with the involvement of the patient/client.	**I**

Goal Area # 2: Communication (Continued)	*Rating*
5. Reconcile medications with the patient/client at referral or transfer, and communicate the patient's/client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	**I**

Comments: Medication reconciliation occurs regularly throughout the organization facilitated by the region-wide electronic health record. Some clinical areas are less consistent in reconciling medications with patients, and some clinical areas reinforce safety as a shared responsibility. The organization is encouraged to develop and implement strategies to identify good practices in this area and apply those practices consistently across Interior Health.

Goal Area # 3: Medication Use	*Rating*
1. Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient/client care units.	**I**
Comments: There are no concentrated electrolytes in patient care areas.	
2. Standardize and limit the number of drug concentrations available in the organization.	**I**
Comments: The pharmacy controls doses.	
3. Provide ongoing, effective training for service providers on all infusion pumps.	**I**
Comments: Training is provided on infusion pumps.	

Goal Area # 4: Worklife/Workforce	*Rating*
1. Deliver at least annual education/training on patient safety to all staff, including targeted patient safety focus areas within the organization.	**D**

Recommendation: It is recommended that the organization provide education on patient safety to all staff this fiscal year and develop a mechanism for tracking.

Comments: Some training on patient safety was noted with some pockets of training excellence. New staff orientation includes patient safety training.

2. Develop and implement a plan and process to assess patient safety issues within the organization, and to carry out improvement activities.	**D**

Recommendation: It is recommended that the organization assess the region's safety issues to guide the development of a detailed action plan for implementation this fiscal year. Start implementation with targets and methods to monitor. Report the plan to senior leadership and the board.

Comments: A high level strategic plan for quality and safety is in place and has been recently approved, but not implemented. There is no evidence of a detailed action plan to guide full implementation.

3. Delineate clearly the roles, responsibilities, and accountabilities of staff and other providers for patient/client care and safety.	**D**

Recommendation: It is recommended that the organization implement its plan to use the high-level delineation document to help support all staff to have an awareness of and be able to consistently articulate their roles and responsibilities in safety.

Comments: A high level role delineation document was recently developed. Some staff and physicians can articulate their roles. The overall plan has not yet been implemented and there is no evidence of a detailed action plan to guide full implementation.

4. Implement an effective preventive maintenance program for all medical devices, equipment, and technology.	**I**

Comments: Equipment appeared safe and operational. There is a preventive maintenance program for equipment. Some recent staffing challenges were noted in biomedical. However, the organization is recruiting a QI lead for this area along with three new staff.

Goal Area # 5: Infection Control	*Rating*
1. Adhere to federal and/or provincially-developed infection control guidelines such as Health Canada's Infection Control Guidelines: Hand Washing, Cleaning, Disinfection and Sterilization in Health Care.	**I**

Comments: The organization has clearly demonstrated adherence to infection control guidelines. An infection control committee consists of the infection control lead for the region and four HSA managers. It reviews relevant regulations on a regular basis.

2. Deliver education and training for staff, other providers and volunteers on hand washing/hygiene.	**D**

Recommendation: It is recommended that the organization educate the physicians about hand washing and monitor compliance. Hand washing in physicians needs some attention as staff and clients have to remind them. This does not apply to surgeons.

Comments: There is a focus on hand washing stations, posters, education, and training.

3. Monitor infection rates and share this information throughout the organization.	**I**

Comments: There is clear evidence of the monitoring of infection rates. The ICU team is a Canadian leader in VAP with monitoring over a several year period. Excellent data has been developed in the East Kootenay region to illustrate the commitment to using data to support patient safety.

4. Examine, and where indicated, improve processes for sterilization of equipment and facilities.	**I**

Comments: The infection control team has implemented a process to ensure that sterilization of equipment is effective.

Section 2: Patient Safety Criteria

In addition to the specific ROPs, the accreditation process includes a focus on patient safety through the examination of a broader set of patient safety criteria. The table below displays the organization's ratings on these 74 patient safety related criteria. Following the table are the organization's Areas of Strength and Excellence, Areas of Caution and Recommendations. For a complete list of the patient safety criteria, please refer to Appendix B on Patient Safety Criteria across Themes.

Rating	No. of Patient Safety Criteria Rated	Percentage of Patient Safety Criteria Rated	No. of Patient Safety Recommendations
N/A	2	3%	0
1-3	1	1%	1
4	39	53%	0
5-6	32	43%	0
7	0	0%	0

Areas of Strength and Excellence:

Of the 74 criteria related directly to patient safety, the organization received 32 rating(s) of good to excellent compliance. Ratings of 5 or 6 indicate areas of strength and ratings of 7 indicate areas of excellence. Please refer to individual team findings throughout the accreditation report for details on these areas.

Areas of Caution:

The organization received a rating of 4 on the following 39 of 74 patient safety related criteria.

A rating of 4 indicates to the organization that the organization should focus attention on strengthening its compliance with the criteria. Please refer to the individual team finding throughout the accreditation report for further details related to these criteria.

Team Name	Criterion	Patient Safety Theme
Information Management	8.2	Documentation
Acute Care Medicine	3.4	Managing Risks
Ambulatory Care Renal	3.4	Managing Risks
Acute Care Medicine	6.5	Managing Risks
Critical Care	6.5	Managing Risks
Acute Care Medicine	8.2	Medication Use & Diagnostic Tests
Ambulatory Care Renal	8.2	Medication Use & Diagnostic Tests
Ambulatory Care Renal	8.3	Equipment Use
Acute Care Medicine	8.3	Equipment Use

(Continued)

Team Name	Criterion	Patient Safety Theme
Critical Care	8.3	Equipment Use
Rehabilitation	8.3	Equipment Use
Acute Care Medicine	8.4	Medication Use & Diagnostic Tests
Ambulatory Care Renal	8.4	Medication Use & Diagnostic Tests
Acute Care Medicine	10.3	Documentation
Rehabilitation	10.3	Documentation
Rehabilitation	13.2	Managing Risks
Acute Care Medicine	13.2	Managing Risks
Ambulatory Care Renal	13.2	Managing Risks
Ambulatory Care Renal	13.3	Managing Risks
Acute Care Medicine	13.3	Managing Risks
Acute Care Medicine	13.4	Disaster/Emergency Preparedness
Ambulatory Care Renal	13.4	Disaster/Emergency Preparedness
Acute Care Medicine	13.5	Managing Risks
Critical Care	13.5	Managing Risks
Rehabilitation	13.5	Disaster/Emergency Preparedness
Rehabilitation	13.6	Managing Risks
Critical Care	13.6	Equipment Use
Rehabilitation	13.7	Equipment Use
Critical Care	14.1	Medication Use & Diagnostic Tests
Acute Care Medicine	14.1	Medication Use & Diagnostic Tests
Acute Care Medicine	14.2	Medication Use & Diagnostic Tests
Ambulatory Care Renal	14.2	Medication Use & Diagnostic Tests
Ambulatory Care Renal	14.3	Medication Use & Diagnostic Tests
Acute Care Medicine	14.3	Medication Use & Diagnostic Tests
Critical Care	14.3	Medication Use & Diagnostic Tests
Rehabilitation	14.3	Medication Use & Diagnostic Tests
Critical Care	14.5	Medication Use & Diagnostic Tests
Acute Care Medicine	14.5	Medication Use & Diagnostic Tests
Ambulatory Care Renal	14.5	Medication Use & Diagnostic Tests

Recommendations

The organization received 1 recommendation(s) related to the following patient safety related criteria.

Team Name	Criterion	Patient Safety Theme
Ambulatory Care Renal	14.1	Medication Use & Diagnostic Tests

Focus Group Feedback

During the accreditation survey, the surveyor(s) met with focus groups representing clients, staff, and community partners. The surveyor(s) asked specific questions to each group to help assess how the organization is meeting the standards, as well as allow for comments about the overall experience. This report section provides a summary of the comments from each of the focus groups.

Client Focus Group

Focus groups were held in each of the region's HSA's and included patients and family members. The participants included representatives from hemodialysis, rehabilitation renal, medical patients, and stroke.

Participants felt that the hospitals in the region provides very good service. The general tone of the group was that the hospital staff cared.

Rehabilitation clients know their medications and their purpose. This was well explained.

The occupational and physical therapy team in inpatient and outpatient rehabilitation is excellent.

The social worker is helpful in discharge planning. Another patient said that the discharge process is well organized.

Nursing care is excellent and the nurses really care for people.

The responses were mixed but generally, the patients agreed that there was good communication about patient safety and their related roles.

IHA provides some information on smoking cessation and other educational materials.

Satisfaction with services is variable. Clients have to be strong and serve as their own advocates.

More explanations of the care could be provided. Participants stated that the major problem was lack of explanations. In two cases, the family and the patient were not informed of why they required a biopsy or about the various possibilities arising from the biopsy. The patient and the family felt information was withheld. In both situations, after the diagnosis was made they felt that the team was excellent in helping them cope. One of the patients was provided good information on admission or subsequently. The hemodialysis group stated they would like more opportunities to see or talk to their doctors.

Access to care and services was discussed. Access to care is phenomenal. Access from Fort Nelson was direct and immediate using air and ground ambulance. A brain injury client entered through the emergency department quickly. A client was transported from Williams Lake and had quick and easy access to surgery. A trauma client accessed the system easily by ambulance through the emergency department to ICU. In the step-down unit, the client found the nurses are very busy and do not have enough time to care for clients. One family member waited considerable time in emergency and the patient was on a stretcher overnight and the next day before getting a bed.

One of the clients in the group was not seen by a surgeon preoperatively or for one month postoperatively and had no information about the procedure or what to do. The client called the office several times but the physician did not return the call.

Client Focus Group (Continued)

Information about tests and procedures is inconsistent and depends on the staff involved.

Many departments were moved to Kelowna and it now takes longer to make decisions.

Access to specialist services in Kelowna is expensive for clients and they need to travel through Vancouver.

The dialysis clinic staff are very responsive, but are not available nights or weekends.

One participant expressed concerns about the mixing of alert patients with Alzheimer patients.

One participant wondered why there are not more specialists and support for travel when convalescence is completed in other centres.

There is one nephrologist situated in Trail. The participants stated there should be a nephrologist and service available in East Kootenay. Patients requiring acute care must go to Calgary or Trail.

Many of the participants expressed concern the lack of continuity in care and the transfer of care between units. There is a lack of communication between sites. Physiotherapy in the hospital is excellent but when discharged to the community it is not covered and is two-tiered medicine. When clients are sent by air or by ambulance to the center, there are no provisions made for their return trip. Patients who experience a number of moves in the hospital may miss some of their medications.

Care is disjointed and there does not seem to be anyone in control. There is poor communication when a client moves from service to service. There is poor communication with the patient and the patient does not feel empowered.

It is recognized that there are inappropriate placements due to the lack of community support and long term care.

Follow up care seems to be good following discharge.

Medication administration was briefly discussed. One patient said they missed warfarin dosing for three days due to lack of communication during several transfers between units. Other patients received the wrong pills but realized before taking them that they were incorrect.

The ICU nurses explain medications and procedures thoroughly. Medication changes take some time to get the new dose from pharmacy, especially on weekends.

Patients can bring in their own medications from home and have supervised self-medication. The nurses are excellent at explaining new medications and changes.

Staff wash their hands and encourage visitors to wash their hands. Hand washing and the use of gloves is extensive. ICU visitors must wash their hands. One family feels that hand washing for the peritoneal dialysis clients is inadequate.

Client Focus Group (Continued)

Participants touched on their relationship with IHA. The clients need to be more involved in decision-making. More community consultation and involvement would be welcome. The participants did not feel that the organization listens to the community in a meaningful way. The IHA does not seem to act on issues or suggestions because of the intrusion of politics. The theme of politics affecting health care delivery decisions is very evident. A patient required placement due to Alzheimer disease and needed an emergency admission. The patient received support from a private agency after trying valiantly to obtain help from the IHA with no helpful response.

Most of the participants were not aware of the process for making a complaint. The clients do not understand the complaint procedure and are not aware of the presence of a patient advocate. One patient did make a complaint about the food and received two follow up calls.

It is difficult to know staff on the wards. The nametags need to be worn more consistently and staff need to be encouraged to dress more professionally.

Staff check the identification bracelets most of the time, but this needs to be more consistent.

The nurses are fabulous and provide information but it is difficult to catch physicians who are very busy. Some meetings with a specific physician were conducted in the corridor rather than in a private area.

There is the perception that, "Health care runs as a business so it cannot take the time to make patients comfortable". Nurse staffing is inadequate and there is a lack of trained nurses. The staff are tired and overworked.

The inpatient rehabilitation nurses may need to be more client focused. A family member complained to the nurse manager who did not respond to the issue.

Accountability appears to be lacking from physicians and nurses. Concerns expressed to the managers are not addressed or are brushed aside.

Most feel the food is poor, although it has been good for the last week. The diabetes diet is particularly bad. It is the same every day for those who require special diets. There are good dieticians.

Transportation was identified as an issue for patients who are referred out. There is no special parking for hemodialysis patients. Security does not enforce drop off or handicapped zones.

A renal patient reported difficulty with transportation to hospital by Handidart and taxis that cannot stop at the front door, which requires patients to walk a distance from the back of the hospital.

The participants offered the following list of general suggestions for IHA:

Recruit more doctors.

Provide more specialty care closer to home.

Increase the equipment and facilities.

Client Focus Group (Continued)

Provide more staff at all levels.

Address the cleanliness of the hospitals. They understand that there is construction but believe that cleanliness has been sacrificed for computers.

Improve housekeeping services. A coffee spill in one room remained there for three days.

Provide more beds.

Improve food services.

Ensure that the there is special funding for medications for seniors.

Staff Focus Group

Thompson Caribou Shuswap Health Service Area Staff Focus Group

The staff focus group consisted of nine staff from information management, medicine, rehabilitation, and the renal programs. The clinical staff included nurses, occupational therapy, physical therapy, and respiratory therapy.

This is a friendly, open health service area (HSA) and all staff know each other. They are enthusiastic despite the massive changes that are occurring. The challenges are related to the widespread nature of the region. Help is always available and there is cooperation between the floors. Collaboration is the hallmark of the organization.

Information management has recently noted increased recognition of their efforts and improved communications. This area now focuses more on the quality of project work, rather than simply the number of completed projects.

IHA, the health service areas, and individual staff strive to provide a safe environment for patients and staff. Staff cited the universal no lift policy and the increasing availability of mechanical lifts as excellent. Safety checks occur on a regular basis, and occupational health and safety is involved in the assessment of new products, such as slider sheets. There is a good amount of safety information and education available to them.

The electronic health record has improved patient safety by making pertinent information readily available throughout the IHA including allergies. A new emergency module tracks patient movement and has improved access from rural areas after hours. Online lab results from the rural areas have been particularly beneficial.

The staff values the local leadership and managers. A dedicated staff group supports one another. There is a good work ethic and good morale in certain areas. They appreciate autonomy, the advancements in information technology, and the focus on patient safety.

There are positive opportunities for education in professional development.

The HSA is more responsive than the region in many cases. Many benefits are identifiable at the IHA level where issues are integrated. The province micromanages in some areas which further complicates developments.

All identified needs are considered. Changes begin with a task force that identifies the overall needs of a new or modified program. It is a team approach as opposed to a single individual. The unit council process enhances inclusiveness.

Errors and adverse events are used as a means of driving change.

Ancillary services are involved in the education of staff in their area of expertise. There is complete comfort with reporting and investigation of mistakes. There is a process for incident and adverse event reporting and follow-up including critical incident review.

There are increased tools for communication.

Education programs have been encouraged.

Construction is being done to build modern space suited to safer practice.

Staff Focus Group (Continued)

A food safety audit has been undertaken and will be done annually as a provincial initiative.

MRSA/VRE numbers are increasing. A tracking system is in place and patients are identified.

Allergies and other alerts are on the electronic record. A falls risk assessment is done on all patients.

There is an employee assistance program (EAP).

The referral pattern to Calgary is working well.

The communication is continually improving. Strategies are in place and need to be embraced given the geography and the complexity of the region. Communication is done via e-mail and workshops. There are meetings in some departments to review relevant communications. Communication books, bulletin boards, and memos are used on some units. Morning report is used for communication. Rehabilitation has a new web page for communication purposes. PACs and MediTech are also used as tools for communication. Communication with physicians is sometimes difficult.

The necessary steps are taken to rectify unsafe situations when they arise. Unsafe conditions are reported to the manager or physician and an incident reporting process is used regularly.

Mortality reviews are sporadic and mortality rounds do not occur. There are very few autopsies.

Staff who have ethical questions or concerns rely on their managers, colleagues, and the local chaplain for guidance. They recognize the availability of ethics consultation through their professional bodies. An ethics committee primarily focuses on research reviews.

They recalled the completion of the employer of choice survey approximately four years ago and recognized that the organization has taken steps to address the findings. The most significant ongoing issue identified is frontline staff involvement in decision-making. While significant improvements have been seen in some work areas, many staff perceive a lack of awareness, knowledge, and ability to influence decision-making.

The organization has an increased number of management layers with fewer managers available locally, therefore creating a sense of distance from decision-making.

Nurses highlighted issues with staff morale stemming from workload, and increasing overtime required due to nursing staff shortages. IHA is attempting to address the issue through new recruitment and retention strategies, including the reestablishment of local recruitment staff. Despite these efforts, the nurses are not optimistic that IHA will be able to address the issue in the end. The nurses are likely to retire as soon as they are eligible due to the working conditions.

There have been few opportunities for advancement to management in Kamloops and this requires relocation to Kelowna. Staff see a change in this practice with more opportunities available locally.

Staff Focus Group (Continued)

There is a lack of communication in many areas and a lack of opportunity for their concerns to be heard. Some areas have regular and effective staff meetings, but others have infrequent staff meetings once or twice per year and rely heavily on e-mail for communication. Rehabilitation staff noted that staff meetings are regular and frequent in their area. Staff use the staff meetings and local managers to make their concerns and issues known, but are not aware of what happens with their information and they do not routinely receive feedback.

Staff expressed concern over a perceived lack of collaboration between the health service areas in the region. While many areas such as renal and information management are working more closely with colleagues throughout the IHA, other areas perceive an inability to influence decision-making in Kelowna. These staff are concerned that their work and initiatives are not valued by the organization and that regional colleagues often duplicate initiatives rather than consider practices that are working well in Kamloops.

They are concerned with the safety of wheelchairs at the Royal Inland Hospital, as many are missing parts, are in poor condition, and do not routinely receive preventative maintenance.

The IHA does not have a disclosure policy, but there is inconsistent practice in terms of disclosure of adverse events to patients. A local patient representative is available for patients.

Staff engage patients and families in the care process by beginning discharge planning on admission. A discharge planning pilot project involving social work is underway and staff report that families feel very involved and consulted. Rehabilitation areas always involve the patient and family, typically through the family conference process. Treatment goals are jointly set with the patient. Renal patients are also very involved in their own care and patients are given many choices. Family conferences are used.

Only three of eight staff present reported having a formal performance evaluation or review within the past year.

They perceive inequities in the distribution of resources, such as inconsistencies in the number of wound care nurses available in each health service area.

The most significant issue the organization is facing is a bed capacity crisis with overcapacity patients in hallways and the majority of emergency department spaces used for admitted patients with no beds. Staff perceive that the actions taken by IHA are short term reactive solutions. Their input into longer term solutions to the issue is not being heard, and there needs to be an increased focus on long term care and assisted living beds, meaningful use of MCAP data, and patient flow strategies.

Participants offered the following comments as general areas for improvement:

There should be a better risk identification and management system to proactively address emerging issues.

More beds in ICU and more physical space in general are needed. Staff would appreciate staff lounges and meeting rooms.

There should be an aboriginal healing room and an aboriginal discharge planner.

More staff are needed in some areas. Staff do not necessarily expand in concert with the workload. The organization needs to increase the respiratory therapy staff.

Staff Focus Group (Continued)

There are bottlenecks in the system, particularly in the community.

Prevention programs need to reach into the community and a geriatric program is needed.

East Kootenay and Kootenay Boundary Health Service Area Staff Focus Groups

The focus group included staff from information management (IM), pharmacy, health information management, laboratory, clinical resource nurse, SLP rehabilitation, intensive care nurses, physiotherapy, social work, renal unit, dialysis, IM field support, respiratory therapy, and medicine. There were nine managers, five physicians, and seven frontline people from the East Kootenay Health Centre.

There was staff training on patient safety. One attended a few years ago and two others attended a recent session on quality management systems. They have the feeling that patient safety is more important now.

There are great ideas and expertise in the frontline staff if the organization would only leverage this resource.

In lab and health information management, there is a strategic focus on quality improvement. IM feels that Meditech the best thing that has happened to IHA.

Since the restructuring, frontline staff does not feel their input is asked for or valued. They are able to give some input in the critical care area. They feel isolated from the strategic and operational planning. Staff is interested in participating but when they tried to bring forward ideas, the good ideas stopped at their managers. Staff are aware of changes and decisions made in IHA through a memo but they may not be told the reasons for the change. Sometimes they are told that the managers made the decision. The organization needs to invest in the employees before implementing changes such as the new computerized medication system.

In Kootenay Boundary, staff would like to see more of the COO for Castlegar. Until there was a crisis related to a death of relative, one staff reported they had rarely seen senior management. There is a perception that senior management do not appreciate the transfers in geographical areas.

The corporate office in Kelowna needs to look at urban and rural differences or consider the need for adaptation to the smaller centres.

The IHA needs to focus on retaining and recruiting staff. The region is losing new registered nurses because of the workload, which is influenced by higher patient acuity. There are more vacancies in middle management which seem to be filled by new staff members who may not be as qualified, as some seasoned frontline staff.

There are morale issues. Participants stated that some staff feel "powerless, invisible, and undervalued".

Some concerns were raised regarding the new computer medication system. Staff stated that the new computer medication system looks good and will reduce medication errors. However, when the equipment for this system was brought in to be implemented right away, there was little or no training provided for the pharmacists and the company training was inadequate. The nurses had no input into this change. In the past, the ICU nurse could assist in emergency for critical cases, but now can not run the new computer medication system.

Staff Focus Group (Continued)

Participants suggested there is a need to build processes to identify and solve problems before the media is involved. There is no clear process to report problems and staff does not know how to take issues forward.

Participants suggested that IM needs more advance notice on new initiatives, such as the changes implemented in the lab. The lab implements changes that affect IM and IM may hear about it just two weeks before going live. The departments are still working in isolation.

Participants shared the following comments as general areas for improvement:

They would like to see bar codes on the armbands in all areas. There is a pilot with bar codes.

The organization needs to provide more community services to offer discharged patients.

The organization needs to provide expertise onsite for palliative care.

They need more acknowledgement and attention to psychosocial aspects.

The organization needs to increase the frontline staff and improve staff retention.

The staff would like more opportunities for effective communication with upper management.

Staff need a better understanding of what each department is doing. The region needs to enhance the team approach.

More training is needed for new staff and casual staff.

There should be more value placed on long-term employees. The IHA seems to value new employees more.

In Kootenay Boundary, security needs improvement on the Trail hospital site.

Improvements in emergency to address the backlogs need to be made.

The organization needs to address the downtime on the server.

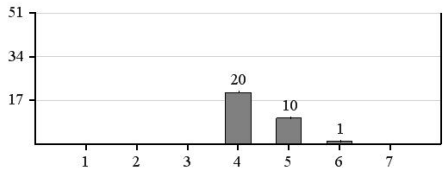
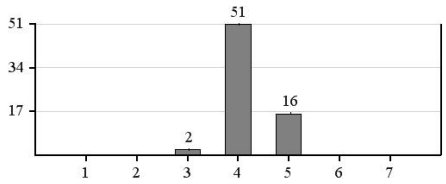
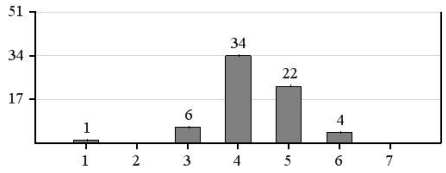
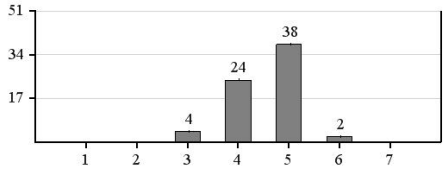
TEAM FINDINGS

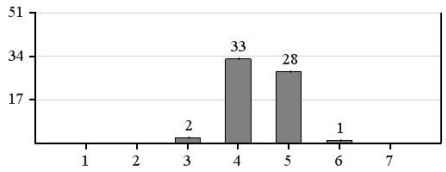
Overview by Teams

The table below provides information on leading practices, recommendations and ratings organized by team, with the following information:

- a frequency distribution showing how often each rating was applied within a team
- a table listing the number and type of recommendation for each team
- the average rating for each team

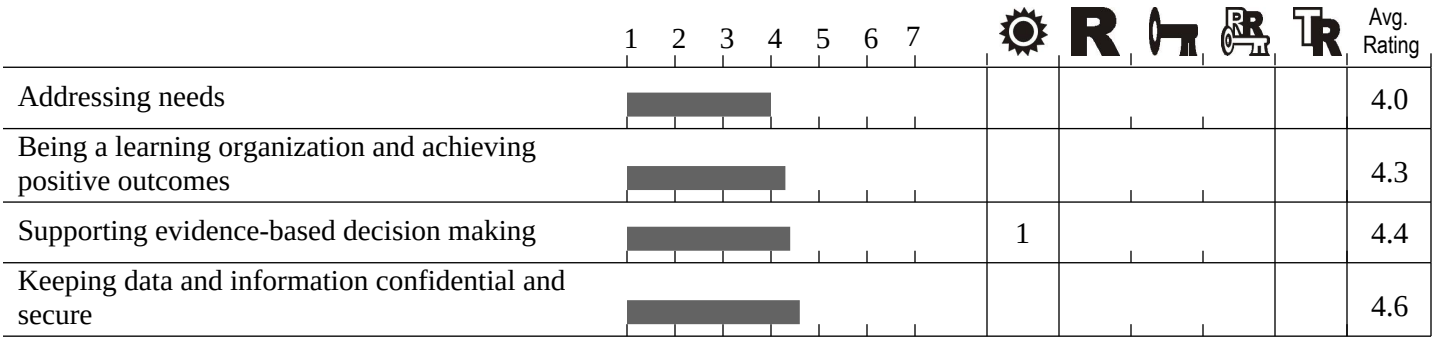
The frequency distribution of ratings is particularly useful when teams have means that are very similar because it shows patterns that are not always evident using averages. Using this graph the organization can compare how often a team was rated at a particular level of compliance.

						Avg. Rating
Information Management		1					4.4
Acute Care Medicine			1	1		2	4.2
Ambulatory Care Renal			6	2		8	4.3
Critical Care			4			4	4.6

							Avg. Rating
							
Rehabilitation			2			2	4.4
	Total	1	13	3	0	16	

Information Management

Rating at the Sub-section Level



Leading Practices

The IHA implemented a quality patient safety pilot project at the South Okanagan General Hospital, which consists of a six-phase approach conceptualized as the quality circle. A bar code armband for patient identification has been implemented. Bar code scanners are used for patient identification purposes during laboratory specimen collection. Hand held devices and mobile computer carts have been implemented to facilitate bedside information access and documentation by nursing staff, including an online medication administration record. Bar code scanning is again used for medication verification. Electronic physician order management and primary care linkages were recently implemented to complete the quality circle. Each phase of the pilot project has been supported and guided by an individual project charter, in keeping with the global project charter guiding the overall pilot. Commencing in October of 2004 each new phase will be added at approximately six-month intervals. The pilot project provides a model for improved safety and systems implementation that can be used throughout the IHA and beyond. Information Management team. (Information Management, Standard 5.0)

Recommendations

There are no recommendations for this team.

Key Findings

Addressing needs	Criteria	Organization Rating	Survey Rating
1.0 The organization's information management processes meet current and future information needs and enhance its performance.	1.1	4	4
	1.2	4	4
	1.3	4	4
	1.4	4	4

Key Findings (Continued)

Strengths:

IHA developed and executed a three-year information and technology plan. As completion of that plan approached, the team used a four phase approach in the development of a five year strategic plan for information management that is closely aligned with the organization's health service plan and balanced scorecard. User/stakeholder input into the strategic planning process was gained through focus groups and surveys targeting physicians, nurses, health records, and other clinical areas with a good response. The strategic planning process was conducted by the information management steering committee with the collaboration of an external consultant. The process included a thorough analysis of potential strategic directions to establish priorities and marginal value. Five major goals were established in keeping with the guiding principles of the planning process. Twenty individual initiatives have been identified to achieve the strategic goals.

The information management steering committee reviews the strategic plan on a yearly basis. It combines that information with the needs assessment information from users and health service areas to develop a one-year prioritization recommendation for upcoming projects. The recommendation is reviewed by the senior management and endorsed by the governing body. It forms the basis of the annual information management tactical plan.

Implementation of the Meditech system universally across the region has been approached using a change management philosophy with the engagement of stakeholders and with particular emphasis on clinicians and their training needs. Currently 82% of physicians access the Meditech system from within IHA facilities and 60% of physicians access the system from their home or office.

A single master patient index has been implemented with policies and procedures governing duplicate records and for merging records when necessary.

Based on feedback from users, ongoing system support and system implementation functions have been separated within the past year. A five-person implementation team was established to focus on minor implementation projects, with specific project teams struck for major implementations. This strategy has provided more consistent and available user support for the existing software.

The organization has begun a major implementation of the Inter-RAI tool for residential care as mandated by the BC Ministry of Health. Building on the successes and opportunities for improvement identified through the previous implementation of Inter-RAI in complex home care, the organization has developed a decentralized implementation strategy consisting of five concurrent implementations in 65 facilities. This represents one for each health service area. A core trainer and super user group has received training and an e-learning tool was selected. A basic computer training strategy is being implemented first.

The organization has recognized the need for staff training in the reporting and use of the generated data, which is planned for February.

Information management leadership has set an expectation that information managers are accessible and visible to users throughout the region. Leaders travel a few weeks a year to meet with users.

The organization has a computer education strategy in place that has modified curriculum and course materials to align with IHA standard practices. Through the course calendar and registration system, the team is able to monitor and analyze training activities.

Key Findings (Continued)

IHA has modified and extended its ongoing communication plan to the current fiscal year. The plan includes a comprehensive set of strategic objectives targeting internal and external communications including media relations, government reporting, and health marketing and promotion. The plan includes an evaluation and performance measurement component.

IHA has produced a health services guide for consumers that is available online or in magazine format. The guide includes health tips, general information about interior health, service descriptions, and contact information.

Areas for Improvement:

Improve communication strategies and user awareness of information management strategies across IHA. Users are involved and informed about projects directly affecting their services.

Ensure that the region's health service plan is well disseminated to staff throughout the region and implement strategies to increase awareness of this plan.

Continue with the current process of developing and implementing a strategic plan for public health information.

Continue to implement the action plan items and develop a mechanism to monitor the achievement and completion of the action items. The team developed a quality improvement action plan to address areas for improvement identified through the self-assessment.

Key Findings (Continued)

Being a learning organization and achieving positive outcomes	Criteria	Organization Rating	Survey Rating
2.0 The organization regularly evaluates and improves information management processes to achieve the best possible results.	2.1	5	4
	2.2	5	5
	2.3	4	4

Strengths:

The organization has made some positive steps in providing staff education though traveling education fairs.

IHA successfully implemented the business components of the Meditech system ahead of schedule and under budget. It has generated $4.3 million in annual savings through the associated operational efficiencies.

Transcription services have initiated a quality improvement process and achieved a 97.8% accuracy rate.

Users throughout the region have expressed their satisfaction with the help desk services. The help desk monitors, records, and analyzes a number of data points regarding help desk calls, including the nature of the call, inquiry, time, and resolution. The knowledge gained through the analysis of data has been used to modify processes and education.

The professional practice office has completed a student capacity analysis to assess and inventory IHA capacity to increase student numbers generated by post-secondary institutions. It wants to maximize student placement opportunities and staff satisfaction, through increased placements in rural areas and the adoption of a computerized placement management and monitoring tool.

The organization developed comprehensive guidelines on the release of clinical information to provide consistent and standardized practices regarding the release of confidential personal and clinical information. These guidelines aim to safeguard health information from unauthorized access, protect privacy, guide client access to their information, and support the continuum of care.

The organization completed an information technology risk assessment in 2003, which identified and prioritized 29 risks. It has produced a one-year follow up report outlining the progress on mitigation strategies.

An authority-wide strategic plan has been developed by the library services with the identification of a decentralized collection of reference materials and tools that is centrally managed and electronically accessible to staff throughout the region or from their home computers. A library website has been developed that includes a number of search engines and mechanisms and allows an electronic borrowing from the collections.

All BC electronic health libraries have worked together in a consortium on a sharing initiative. Users can access reference materials from university libraries through this web page. The web page also includes access to more than 800 patient handouts on various conditions. These are accessible online and fully customizable.

Key Findings (Continued)

Areas for Improvement:

Continue with the plans to develop an advisory committee to guide the library service online, and continue with the deliberate communications strategy to increase region-wide awareness of this valuable tool. The communication strategy includes e-mail news flashes, inclusion in skill fairs and orientation, and presentation at internal conferences. The library has begun to monitor user requests and has noted an increase in requests from users outside facilities.

Develop and implement an IHA-wide strategic plan for education services.

Continue to address the human resources software and electronic processes. They are currently not achieving the desired results and strategies for replacement are under development.

Continue to develop evaluation mechanisms early in the project development process and formally evaluate the projects using measurable indicators of success. The information management team tends to review projects after their completion and it relies on anecdotal data as evidence of success. The director of research and evaluation is offering a workshop on evaluation mechanisms and has had a good response from approximately 60 interested participants.

Continue analyzing areas of redundant and duplicate data entry to streamline processes and enhance efficiency and data accuracy and consistency.

Key Findings (Continued)

Supporting evidence-based decision making	Criteria	Organization Rating	Survey Rating
3.0 The organization collects and reports relevant data and information in a way that is timely, efficient, accurate, and complete.	3.1	4	4
	3.2	5	5
	3.3	4	4
	3.4	4	4
4.0 The organization has a comprehensive, integrated information management system.	4.1	4	4
	4.2	5	5
5.0 Staff, service providers, clients, and families have access to information to support decision-making and improve knowledge.	5.1	4	5
	5.2	5	5
	5.3	5	5
	5.4	4	5
	5.5	4	4
6.0 All users receive adequate education, training, and support to generate, collect, analyze, and use data and information.	6.1	4	4
	6.2	4	4
	6.3	4	4
	6.4	5	4

Strengths:

The organization has made considerable strides in terms of computer access for staff at all levels of the organization and at all locations.

The organization is well aware of the issues surrounding the use of the hybrid paper and electronic patient record and it has deemed the paper record the official source. The management of the hybrid record is additionally challenging due to the current provincial moratorium on the destruction of records despite their age.

The privacy office regularly audits patient care inquiries and mental health report access to electronic information and takes steps to investigate questionable access. Staff education and disciplinary action have been used to reinforce confidentiality requirements regarding access to information.

The organization has carried out a pilot project in the East Kootenay health service area to make specific lab results directly available to chronic disease management clients.

The information management help desk routinely tracks calls and resolution using the Task+ software. The knowledge gained through the analysis of call data has led to changes in the set up of the software so that users signing on to a new computer now automatically log on to Outlook rather than setting it up manually. A student has been hired to do an in depth analysis of the help desk data.

The organization has a well-developed balanced scorecard in place.

A skills fair has been adopted to make standardized inservice and education readily available in a convenient way to staff throughout the region. Currently skill fairs are available on a demand basis.

Key Findings (Continued)

IHA implemented a quality patient safety pilot project at the South Okanagan General Hospital. It consists of a six-phase approach conceptualized as the quality circle. A bar coded armband for patient identification has been implemented. Bar code scanners are used for patient identification purposes during laboratory specimen collection. Hand held devices and mobile computer carts have been implemented to facilitate bedside information access and documentation by nursing staff. There is an online medication administration record. Bar code scanning is used for medication verification.

Electronic physician order management and primary care linkages have been recently implemented to complete the quality circle.

Each phase of the pilot project has been supported and guided by an individual project charter in keeping with the global project charter. Each new phase has been added at approximately six month intervals and this pilot project provides a model for improved safety and system implementation that can be used throughout IHA and beyond.

Areas for Improvement:

Continue to select physician office solutions from those identified through the province-wide RFP process to facilitate clinical information continuity between IHA and the physicians' offices throughout the region. The organization has linked Meditech and the local physician office system electronic medical records in a number of communities. This strategy has produced high user satisfaction and effective information sharing. There is improved availability for clinical decision-making and continuity of care. IHA is a participant in a current provincial strategy to access primary health care transition funding to more broadly link physician office systems with Meditech.

Continue with the plan to implement strategies for clinical data similar to those used for financial data. The team has expressed concern with the consistency of data quality and integrity related to clinical systems. The emphasis to date has been focused on system implementation and is now being focused more on home and community care data. The team has recognized that the strategies used for stewardship and ownership of financial data have been successful in ensuring data integrity and quality.

Monitor and facilitate the timely development of downtime procedures by all areas. Development of downtime procedures for clinical systems has been delegated to each facility. Regional guidelines for downtime procedures have been developed, and a strategy to make unique patient identifier numbers available off line via the data repository during downtimes has been established.

Review the posters related to the privacy officer. Information posters are displayed throughout the region identifying contact information of the privacy officer for patients and families. The lack of contacts received by the privacy officer suggests that a review of the effectiveness of these posters would be beneficial.

Re-institute the planning process to achieve an organizationally acceptable strategy to standardize forms wherever possible and rationalize any exceptions to forms standardization. A project plan has been developed to standardize all forms across the region, however some resistance has been encountered, and the plan is currently not moving ahead. The organization has successfully standardized the majority of its business related forms across all of IHA as well as a select number of clinical forms.

Key Findings (Continued)

Keeping data and information confidential and secure	Criteria	Organization Rating	Survey Rating
7.0 The organization protects the confidentiality, security, and integrity of data and information.	7.1	5	4
	7.2	6	6
	7.3	4	4
	7.4	4	4
8.0 The clients' files are current, accurate, comprehensive, and secure.	8.1	6	5
	8.2	3	4
	8.3	5	5
	8.4	6	5
	8.5	4	4

Strengths:

Interior Health has well developed strategies and tactical mechanisms to keep data and information confidential and secure.

Processes are in place to monitor access to electronic and hard copy information.

Appropriate disaster and recovery plans are in place.

Appropriate mechanisms are in place to facilitate accuracy, currency, and content of clinical records.

Key Findings (Continued)

Areas for Improvement:

Encourage standardization across the region in terms of acceptable symbols and abbreviations for the clinical record. The current site-specific approach to accepted standards and abbreviations puts the organization at risk if a client is seen at more than one site.

Develop a procedure manual for quick reference by staff completing the admitting function.

Complete the plans for the relocation of the Kelowna data centre. The region uses two data centres in order to replicate data, which is done on a daily basis. Currently, a significant portion of the Kelowna data centre has been lost due to building structural issues.

Acquire standardized confidential document destruction services, including electronic document destruction through the RFP process. The team has recognized inconsistencies in the processes for the removal and shredding of confidential documents by contracted service providers. In tact documents are removed by the service provider in many areas and destroyed off site. The staff have no mechanisms to ensure that the documents are handled appropriately and confidentially after leaving the facility. As a result, a number of areas have purchased shredders to destroy documents.

Develop and implement targeted strategies to facilitate compliance with chart completion in a timely manner and to address the issue of incomplete charts. There is evidence that clinical records are not completed within accepted time frames in a number of areas.

Develop, monitor, and analyze performance measures and indicators specific to information security and access. This will more appropriately inform decision-making regarding these strategies and aid in the evaluation of their effectiveness. An information privacy officer ensures audits of data access to patient care inquiries and mental health reports. The privacy officer also conducts privacy impact assessments on all significantly sized implementations, though more attention should be paid to the privacy impact of minor software implementation as well. The privacy officer recognizes the most common security breaches anecdotally and develops strategies to reduce the prevalence.

Acute Care Medicine

Rating at the Sub-section Level

Being a learning organization and achieving positive outcomes					4.3
Achieving wellness		1		1	3.7
Being responsive					4.3
Addressing needs					4.2
Empowering clients			1	1	4.1
Setting goals and monitoring achievements					4.3
Delivering services					4.3
Maintaining continuity					4.3

Recommendations

Acute Care Medicine — Criterion 4.3 — Descriptor: *Effectiveness*

Recommendation

It is recommended that the team work with leadership in the organization to increase its efforts in prevention and early detection.

Organization Rating	Survey Rating	Risk Rating					
3	**3**	Likelihood	**L**	Severity	**L**	Urgency	**L**

Potential Adverse Event

The growing burden of illness and disease may lead to capacity issues for acute care and community care.

Reason for Urgency

The team is engaged in some prevention and monitoring activities. Having stronger involvement in early detection strategies, as well as stronger awareness and linkages to the region's prevention strategies will assist the acute care medicine programs in continuing to reduce readmissions, length of stay and other key indicators.

Recommendation

It is recommended that the organization finalize and disseminate the informed consent policy throughout IHA.

Organization Rating	Survey Rating	Risk Rating					
5	3	Likelihood	M	Severity	H	Urgency	H

Potential Adverse Event

A patient may receive an unwanted medical intervention. There may be risk to IHA for legal action and loss of public credibility and trust.

Reason for Urgency

The organization needs to protect the patients' rights and reduce its financial risk.

Key Findings

Being a learning organization and achieving positive outcomes	Criteria	Organization Rating	Survey Rating
1.0 The team continually plans and designs its services to meet the current and future needs of the populations it serves, and to achieve the best possible outcomes.	1.1	4	5
	1.2	5	4
	1.3	4	4
2.0 The team uses research, evidence, and best practice information to develop and improve its services.	2.1	5	5
	2.2	5	5
	2.3	4	4
	2.4	4	4
	2.5	5	5
3.0 The team monitors and improves the quality of its services to achieve the best possible outcomes.	3.1	4	4
	3.2	4	4
	3.3	4	4
	3.4	4	4
	3.5	4	4

Key Findings (Continued)

Strengths:

The specific health service area frontline staff had an opportunity to self-rate and to participate using the mock net, evidence binder, and local discussions. It was a good experience and useful in becoming integrated as one regional system. The accreditation team is doing very important work and will continue.

This learning organization is achieving positive outcomes. It has a sound, detailed action plan for future QI work. It is especially engaged in the respiratory service area on a region-wide basis.

The team has participated in the Safer Healthcare Now initiative since 2005.

There is very strong physician leadership within the team and good community partners in pastoral care.

The team is working on a framework for long term planning, which is a pilot program for the province.

Cranbrook has analyzed medication errors. Work is underway to deal with errors of omission and commission.

The staff are very active and use the pharmacist to enter all 2006 errors into the database. Other centres are looking at errors and changing orders to standardize processes and prevent errors.

The rural centres now have access to itinerant pharmacy.

The team is using population health data in smoking rates to start smoking cessation programs for clients and staff.

Respiratory services are involved in strategic planning.

There is an awareness of the importance of spiritual care.

While the team is not directly involved in strategic planning, it is a newcomer to the process as a community partner. It is learning the ways to have input.

The team seeks out best practices in a variety of ways and updates are available to all physicians in the province via the new library services. The librarians come to the rural sites.

Knowledge and experience are transferred to the frontline staff with the tracking of medical errors, as well as the use of Meditech email.

There is a culture for reporting near misses. It needs work still but the team hopes it will improve.

There is good progress on safety as it is on the agenda for all staff in Cranbrook.

The number of reported incidents is increasing as there is less fear of repercussions. Both doctors and nurses feel more comfortable reporting than in the past.

There is a policy for least restraints with procedures to follow to protect clients. One incident with restraints resulted in a change in practice.

Key Findings (Continued)

Areas for Improvement:

Continue to work with population health data and seek opportunities to have the population health department provide data and expertise to inform program planning in collaboration with the medicine stakeholders.

Consider having physicians educate patient groups in public forums.

Take a more proactive approach to seeking opportunities for input into the strategic planning process.

Increase the awareness of the regional ethics board. Staff are not aware of this committee but are aware of the research ethics process. The ethics committee is not well known and needs more visibility. It is in the early stages of development.

Include the cardiac lab in the strategic planning process and other initiatives.

Key Findings (Continued)

Achieving wellness	Criteria	Organization Rating	Survey Rating
4.0 The team, working with the community, promotes health, prevents or detects health problems early, and maximizes the well-being of those it serves.	4.1 4.2 4.3	4 4 3	4 4 3

Strengths:

The team is in the early stages of linking across continuum from prevention to treatment.

There is a basic understanding of vulnerable population groups.

Areas for Improvement:

Ensure that written, easy to understand patient educational materials are available in all areas.

Develop a process to evaluate the efforts in promotion, protection, and early intervention.

Key Findings (Continued)

Being responsive	Criteria	Organization Rating	Survey Rating
5.0 The team's services are integrated and coordinated to ensure continuity of service for the populations it serves.	5.1	5	5
	5.2	4	4
	5.3	4	4
6.0 The clients' first contacts with the team lead to the best decision about services.	6.1	5	5
	6.2	4	4
	6.3	4	4
	6.4	5	5
	6.5	4	4
	6.6	4	4

Strengths:

There are many examples of integrated and coordinated services with a multidisciplinary team including links to pharmacy.

There is good follow up on discharge and good working relationships with family physicians in the community.

The connections to community and family doctors by the cardiac lab are strong.

Family physicians involved and are often the MRP. There are weekly planning meetings.

There are clear policies for reporting between nurses and physicians region wide at shift change and on discharge.

The team reviews the wait lists and coordinates access. The cardiac meeting goes through every week and sometimes can acquire one-time funding to decrease the wait list. The team has input on wait list management issues to resolve problems where possible.

There is a classification wait list in place so patients can be moved up according to their clinical status.

Central wait lists are coordinated across the HSA, the region, and the province.

Respiratory has set up a rapid response system.

The staff know how to handle and refer client complaints.

IHA-wide approaches include Meditech, bed management, wound care, library services, and video and teleconference communication.

There are regional aboriginal health committee meetings in the TCS area. In EKHSA, there is a regional aboriginal committee representative.

Key Findings (Continued)

Areas for Improvement:

Continue to develop integrated and coordinated services.

Continue to explore how non-traditional wait lists could improve care.

Address the insufficient numbers of family doctors in the community due to the increased higher needs population, such as the older adult.

Key Findings (Continued)

Addressing needs	Criteria	Organization Rating	Survey Rating
7.0 The team accurately and appropriately assesses its clients.	7.1	3	4
	7.2	5	5
	7.3	4	4
	7.4	3	4
	7.5	N/A	4
8.0 The team has access to diagnostic services that are safe, efficient, and accurate.	8.1	4	5
	8.2	4	4
	8.3	4	4
	8.4	4	4
	8.5	4	4

Strengths:

Telewound Pixalere is an outstanding innovation. The team can see the opportunities in videoconferencing and telemedicine to enhance services and it is starting to use this technology in respiratory and oncology. This is a creative use of technology resources for this geographically expansive area. Clients are seen in a timely way and there is high satisfaction with both clinicians and patients.

Diagnostics are generally available. Equipment is safe and in good operating order.

The team participates in the Safer Healthcare Now processes for medication reconciliation.

Areas for Improvement:

Address the billing code issue identified that may be a barrier to expansion into the Telehealth area.

Enhance the pharmacist services in the rural area using telemedicine.

Enhance communication about changes in some services.

Address the gap in clinical education for staff.

Address the isolated equipment problems. Recruit more biomedical staff and enhance the focus on QI.

Improve access to pain management across IHA.

Address the material management issues raised such as redundancy, reordered and re billed for supplies lost in inventory, difficulty finding supplies, inability to return items, disjointed services, unclear contact processes, and the responsibility/accountability structure.

Key Findings (Continued)

Empowering clients	Criteria	Organization Rating	Survey Rating
9.0 The team works with clients and families to help them actively participate in service delivery and carry out their responsibilities.	9.1	4	4
	9.2	4	4
	9.3	4	4
	9.4	5	5
	9.5	3	4
10.0 The team obtains informed consent before starting any service or intervention.	10.1	5	3
	10.2	5	4
	10.3	4	4
	10.4	4	4
11.0 The team protects and promotes the rights of its clients and families.	11.1	5	4
	11.2	4	4
	11.3	4	4
	11.4	3	4
	11.5	5	5
	11.6	5	4

Strengths:

There is more central planning within IHA.

Clients and families are aware of their rights and the complaint process as physicians explain the right-of-refusal and pamphlets are available at many locations at the facilities.

The team supports being transparent and believes that disclosure is important.

Respiratory services has started education on informed consent recognizing that the policy statements are to be finalized soon.

Areas for Improvement:

Finalize and implement the informed consent process with an educational plan.

Improve the patient information on rights and responsibilities including access to the client representative. They did not know how to access this person.

Key Findings (Continued)

Setting goals and monitoring achievements	Criteria	Organization Rating	Survey Rating
12.0 The team has an appropriate and integrated service plan for each client.	12.1	3	4
	12.2	4	4
	12.3	5	4
	12.4	3	5

Strengths:

Goal setting from interdisciplinary perspectives is done at a basic level.

The team is actively searching out best practices.

There is an excellent pilot with the computerization of medications, medical charts, and inventory management.

Care plans exist for some areas.

Areas for Improvement:

Formalize the process for interdisciplinary care plans and adapt it for IHA-wide services in high priority areas.

Continue with the pilot in Oliver to gain further efficiencies with staff time, monitor patient safety outcomes, and shape the software further for the Canadian health care environment.

Key Findings (Continued)

Delivering services	Criteria	Organization Rating	Survey Rating
13.0 The team delivers safe, efficient, and effective services.	13.1	4	4
	13.2	4	4
	13.3	4	4
	13.4	4	4
	13.5	4	4
	13.6	4	5
	13.7	5	5
14.0 The use of medications and other therapeutic technologies is safe, efficient, effective, and promotes the best possible quality of life.	14.1	3	4
	14.2	3	4
	14.3	4	4
	14.4	5	5
	14.5	4	4

Strengths:

The team has made changes to air and oxygen hook ups as a result of an adverse event.

It is increasing education to staff.

The team has participated in the Safer Healthcare Now initiative since 2005.

There is an Oliver pilot with the bar coding technology.

The team was involved in three adverse events and the support for staff was good, but could have been better for physicians. The physicians and chief of staff supported each other.

There was a case of the birth of baby on the way to the hospital and the support was good for staff and the organization.

Regular information forums are held.

There is clarity about the staff role in client safety among this team. The team created an admission sheet to include questions on items that might be easily missed. They use special endo-tracheal tubes with an adapter. Nurses work with frontline staff to improve safety and look at accuracy via safety rounds.

Staff training sessions on client safety are excellent in respiratory, the catheterization lab, and ICU.

There is a focus on hand washing stations, posters, education, and training.

The team is training team members on new equipment and infusion pumps. It is well done for regular staff. The team is using a safer infusion pump and nurse educators to train staff.

The team uses the Analyze database across the IHA for adverse events.

Key Findings (Continued)

Areas for Improvement:

Enhance the medical and staff support in Trail.

Offer consistent high quality staff training sessions on client safety.

Educate the physicians about hand washing and monitor compliance. With the exception of surgeons, hand washing for physicians needs to be addressed. Staff and clients indicated they do remind physicians to do this.

Key Findings (Continued)

Maintaining continuity	Criteria	Organization Rating	Survey Rating
15.0 After transition or the end of service, the clients' ongoing needs are met and continuity of service is maintained.	15.1	4	4
	15.2	4	5
	15.3	3	4

Strengths:

There are a number of examples of integrated and coordinated services with a multidisciplinary team.

There is good follow up on discharge and the team has a good working relationship with family physicians in the community.

The cardiac catheterization lab has strong connections to the community and family physicians.

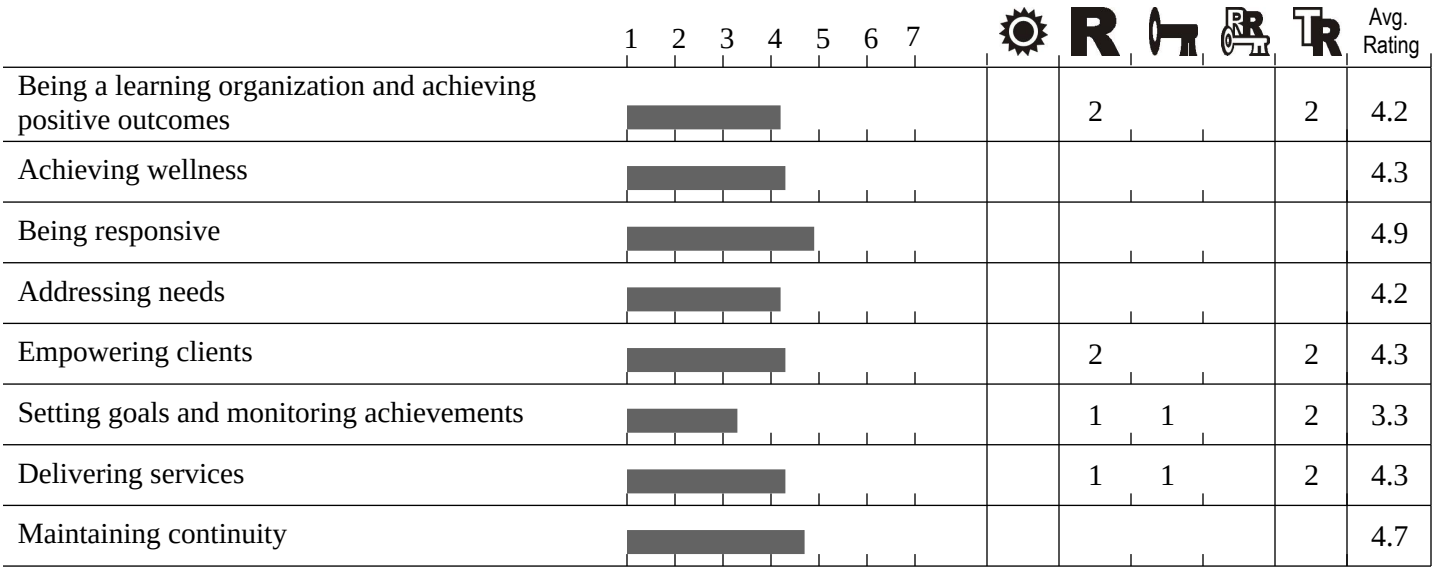
The family physicians are involved and are often the MRP.

Areas for Improvement:

Continue to develop integrated and coordinated services with a multidisciplinary team including admission, inpatient care, and the community.

Ambulatory Care Renal

Rating at the Sub-section Level



	1 2 3 4 5 6 7		R		RR	TR	Avg. Rating
Being a learning organization and achieving positive outcomes			2			2	4.2
Achieving wellness							4.3
Being responsive							4.9
Addressing needs							4.2
Empowering clients			2			2	4.3
Setting goals and monitoring achievements			1	1		2	3.3
Delivering services			1	1		2	4.3
Maintaining continuity							4.7

Recommendations

Ambulatory Care Renal — Criterion 3.1 — Descriptor: *Effectiveness*

Recommendation

It is recommended that the team conduct formal patient satisfaction surveys.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

The team may lack knowledge of patient dissatisfaction and ways to improve care.

Reason for Urgency

The team needs to identify and address areas for improvement to improve the patient experience.

Ambulatory Care Renal — Criterion 3.3 — Descriptor: *Effectiveness*

Recommendation

It is recommended that the team develop a process to determine the relationship between infections, septicemias and the access type.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

Staff may be unable to discover ongoing or episodic problems.

Reason for Urgency

The team needs to be able to monitor these key indicators, protect patient safety and identify areas for improvement.

Ambulatory Care Renal — Criterion 10.4 — Descriptor: *Participation and Partnership*

Recommendation

It is recommended that the team ensure that the consents include all advance directives.

Organization Rating	Survey Rating	Risk Rating					
4	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

Events or treatments may occur without patient or family input. Patients' wishes may be missed causing unwanted or harmful care.

Reason for Urgency

A standardized process will assist all in ensuring that all aspects of care are discussed with the patient, and that the patient's wishes are both documented and respected.

Ambulatory Care Renal — Criterion 11.6 — Descriptor: *Participation and Partnership*

Recommendation

It is recommended that the team ensure that patients are made aware of the complaint process and assured that the process will be confidential.

Organization Rating	Survey Rating	Risk Rating					
4	3	Likelihood	M	Severity	H	Urgency	M

Potential Adverse Event

Patients may not bring ideas or problems forward, and may not know how to have their concerns addressed in an efficient and timely manner.

Reason for Urgency

Once patients bring their complaints forward, the team and the organization will be able to watch for trends much more effectively.

Ambulatory Care Renal — Criterion 12.2 — Descriptor: *Appropriateness*

Recommendation

It is recommended that the nephrologist be present in the dialysis units at reasonable intervals. Telemedicine could be used in distant units for bimonthly or monthly sessions with the patients and the multidisciplinary teams.

Organization Rating	Survey Rating	Risk Rating
5	1	Likelihood M Severity H Urgency H

Potential Adverse Event

A patient could develop a problem and there could be poor understanding by the staff.

Reason for Urgency

The patients need nephrology involvement, visits and plans.

Ambulatory Care Renal — Criterion 12.3 — Descriptor: *Timeliness*

Recommendation

It is recommended that the team involve the entire team, including the nephrologist, in family conferences, and that this be standardized across the region.

Organization Rating	Survey Rating	Risk Rating
5	4	Likelihood M Severity M Urgency M

Potential Adverse Event

Without input from all relevant providers, patients and family members may not understand the problems or goals fully to make informed decisions about their care. Health care providers may not have all the information to base to build an appropriate care plan.

Reason for Urgency

All members of the team need to be present to set and communicate a truly integrated care plan.

Ambulatory Care Renal — Criterion 13.1 — Descriptor: *Appropriateness*

Recommendation

It is recommended that the team increase the frequency with which long distance patients are seen by the physician to at least every two months. This could be done by telemedicine.

Organization Rating	Survey Rating	Risk Rating
6	3	Likelihood M Severity H Urgency H

Potential Adverse Event

Without regular and timely contact with the physician, patient and care problems may be missed and the patients may be dissatisfied with the lack of nephrology care.

Reason for Urgency

The organization needs to ensure that appropriate and adequate nephrology care is provided. Patients have expressed concern with the frequency of visits by some nephrologists.

Ambulatory Care Renal

Criterion 14.1

Descriptor: *Safety*

Recommendation

It is recommended that the team access a pharmacist, possibly by telemedicine.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

Staff may lack understanding of side effects, which could interfere with care or lead to other more serious health complications.

Reason for Urgency

A pharmacist is needed to support safe medication practices. The team is fully aware of the need for a pharmacist on the team and of the human resource challenge they are facing.

Key Findings

Being a learning organization and achieving positive outcomes	Criteria	Organization Rating	Survey Rating
1.0 The team continually plans and designs its services to meet the current and future needs of the populations it serves, and to achieve the best possible outcomes.	1.1	5	5
	1.2	4	4
	1.3	5	4
2.0 The team uses research, evidence, and best practice information to develop and improve its services.	2.1	6	5
	2.2	6	6
	2.3	5	4
	2.4	4	4
	2.5	5	5
3.0 The team monitors and improves the quality of its services to achieve the best possible outcomes.	3.1	3	3
	3.2	3	4
	3.3	3	3
	3.4	4	4
	3.5	3	4

Strengths:

A nephrologist and a registered nurse see new patients in the renal insufficiency clinic. A social worker and dietitian see them later.

Some areas have very few First Nations patients while others have more. Language is not usually an issue. They work with the patient individually. First Nations people have a smaller number of transplants proportionally than expected. East Indian patients have translation services.

The organization recognizes that it needs an outreach strategy for First Nations patients and has already met with an aboriginal liaison worker. Trust has been identified as an important place to start given the First Nations history. The First Nations do not seek services as it is a six hour drive. Outreach could expand with telehealth.

There has been excellent experiences in supporting clients via telehealth and this could apply to renal. The program is only seven months old in the region.

The distances are vast and some patients travel far for dialysis and the clinics.

There is an excellent program in place by the BC renal agency called Promis. All patients in renal failure clinics and on dialysis have their data online such as demographic, lab, x-ray, and medication. There is up-to-date data on all patients. The dialysis prescription is online. The lab data is automatically downloaded from the Meditech program. The medication has to be entered by hand and the charts cannot be signed off until a nurse or clerk has entered the new order. At this time, there is no connection to the BC drug store plan where all prescriptions are kept. An order from a family doctor may not be transcribed. Transplanted patients have their own database not connected to Promis.

Key Findings (Continued)

Areas for Improvement:

Ensure that patients have regular access to the nephrologist. Telehealth could be very beneficial.

Connect Promis to the BC pharmacy database so that prescriptions written by family doctors are picked up automatically. Continue to develop the Promis system so that it can connect the electronic chart with multidisciplinary progress notes including doctors notes'.

Continue to implement telehealth across the region at small centres so that the physician and teams such as nurses, dietitians, social workers, and pharmacists can have video links and answer questions easily.

Track data such as infections in Promis.

Conduct a patient satisfaction survey regularly.

Track the client GFR across the clinics.

Key Findings (Continued)

Achieving wellness	Criteria	Organization Rating	Survey Rating
4.0 The team, working with the community, promotes health, prevents or detects health problems early, and maximizes the well-being of those it serves.	4.1 4.2 4.3	5 6 4	4 5 4

Strengths:

The team works with the community dietitian and social workers. There is very little contact with family doctors in the community.

Patients are referred from the family doctors. The team includes a dietitian, social worker, and a pharmacist.

The nurse and the dietitian review the lab data on a monthly basis. The nephrologists are involved in different ways.

The team is enhancing its work with the aboriginal community.

A chronic renal failure clinic is in development.

Areas for Improvement:

Ensure that all unit patients are seen regularly by a nephrologist.

Enhance the liaison between the family doctors and the renal units.

Increase education to the family doctors about patient care and drug doses.

Key Findings (Continued)

Being responsive	Criteria	Organization Rating	Survey Rating
5.0 The team's services are integrated and coordinated to ensure continuity of service for the populations it serves.	5.1	6	6
	5.2	6	5
	5.3	5	5
6.0 The clients' first contacts with the team lead to the best decision about services.	6.1	5	5
	6.2	5	4
	6.3	6	5
	6.4	6	4
	6.5	5	5
	6.6	6	5

Strengths:

Multidisciplinary teams meet on a monthly basis.

They are developing a system of charts that are available to all so that when a patient is admitted anywhere the data is available related to lab, radiology, dialysis, and medications.

The chronic renal failure clinics educate family members and the patient.

The nephrologist is on call across the region and transfers are handled well.

Areas for Improvement:

Address the delay in some units in referring for patients for transplant. Part of the problem in two units is the rare physician visits.

Develop a mechanism to ensure rapid and easy referrals and workup for transplantation.

Increase the physician visits to the small, distant units, as they should be monthly or at most bimonthly. This could be achieved by telemedicine.

Provide more education and improve collaboration with the family physicians.

Consider hiring a vascular access coordinator for the entire region to set up a central vascular access clinic with standard care and follow up across the region.

Consider increasing access to the distant chronic renal failure clinics through the use of telemedicine.

Key Findings (Continued)

Addressing needs	Criteria	Organization Rating	Survey Rating
7.0 The team accurately and appropriately assesses its clients.	7.1	6	4
	7.2	5	4
	7.3	6	4
	7.4	4	4
	7.5	N/A	N/A
8.0 The team has access to diagnostic services that are safe, efficient, and accurate.	8.1	5	5
	8.2	4	4
	8.3	5	4
	8.4	5	4
	8.5	5	5

Strengths:

Clients are assessed by the team in preparation for long term treatment.

There is a PACS system in place. X-ray results are available from the computer and the lab is on Meditech.

Lab equipment is checked and there is a good process for maintenance.

Areas for Improvement:

Ensure that there are more complete progress notes, particularly by physicians.

Develop a standardized peritonitis protocol across the region that is available in all emergency departments.

Track and trend infections.

Key Findings (Continued)

Empowering clients	Criteria	Organization Rating	Survey Rating
9.0 The team works with clients and families to help them actively participate in service delivery and carry out their responsibilities.	9.1	5	4
	9.2	5	4
	9.3	4	4
	9.4	5	5
	9.5	3	4
10.0 The team obtains informed consent before starting any service or intervention.	10.1	6	5
	10.2	5	5
	10.3	5	5
	10.4	4	3
11.0 The team protects and promotes the rights of its clients and families.	11.1	6	4
	11.2	5	5
	11.3	5	5
	11.4	4	4
	11.5	6	5
	11.6	4	3

Strengths:

Patients are well taught about the various options of therapy available to them. They are reassured that they can change therapies if needed.

End of life services are being developed for the province.

The dietitian works before and during dialysis to prepare the client and family for self sufficiency.

Staff review the lab results.

The consents meet provincial standards.

Patient complaints go to the nursing manager at Kelowna. Patients may see the client representative if the issue cannot be resolved.

Areas for Improvement:

Develop and implement a process for advance directives. The process for collecting and documenting advance directives is currently inconsistent.

Educate patients and families about how to lodge a complaint.

Key Findings (Continued)

Setting goals and monitoring achievements	Criteria	Organization Rating	Survey Rating
12.0 The team has an appropriate and integrated service plan for each client.	12.1	5	4
	12.2	5	1
	12.3	5	4
	12.4	5	4

Strengths:

In many units, the patients are very well handled and the teams work closely together.

Areas for Improvement:

Address the need for a nurse manager. The dialysis unit has no nurse manager and has been without one since October 2005. There was a temporary person but no one has been found on a more permanent basis.

Ensure the nephrologist's regular presence and support at all sites. Five community dialysis units in the East Kootenay region are operated as satellites of Trail. The nephrologist is the medical director of these units and is the only nephrologist responsible for the patients. He visits every six months but the last progress note in Cranbrook was nine months ago. He is on call constantly and is available by phone. The program is strongly encouraged to use telemedicine. In Vernon, patients complained that they have not seen a physician in two years.

Key Findings (Continued)

Delivering services	Criteria	Organization Rating	Survey Rating
13.0 The team delivers safe, efficient, and effective services.	13.1	6	3
	13.2	5	4
	13.3	5	4
	13.4	6	4
	13.5	5	5
	13.6	6	6
14.0 The use of medications and other therapeutic technologies is safe, efficient, effective, and promotes the best possible quality of life.	14.1	3	3
	14.2	3	4
	14.3	5	4
	14.4	6	6
	14.5	4	4

Strengths:

Chronic renal failure clinics are used across the area. Family doctors who have been educated and are using the estimated GFR to determine the severity of renal disease refer patients in.

Dialysis treatments are monitored in a standard way across the district. Patients can easily be transferred to another unit and their data is available.

Interdisciplinary rounds are held regularly.

Infection control guidelines are followed.

Areas for Improvement:

Ensure that pharmacy services are uniform throughout the region. There are not enough pharmacists, but telemedicine could be used for pharmacy. Drugs prescribed by the family doctor are not put on the system and can be easily missed.

Look at ways to standardize pain management across the region.

Key Findings (Continued)

Maintaining continuity	Criteria	Organization Rating	Survey Rating
15.0 After transition or the end of service, the clients' ongoing needs are met and continuity of service is maintained.	15.1	6	5
	15.2	6	5
	15.3	4	4

Strengths:

No particular strengths were identified.

Areas for Improvement:

Ensure that all teams on the units have adequate nephrology input.

Critical Care

Rating at the Sub-section Level

	1 2 3 4 5 6 7		R			Avg. Rating
Being a learning organization and achieving positive outcomes			1		1	4.2
Achieving wellness						5.0
Being responsive						4.7
Addressing needs			1		1	4.7
Empowering clients			1		1	4.5
Setting goals and monitoring achievements						5.0
Delivering services						4.7
Maintaining continuity			1		1	4.3

Recommendations

R **Critical Care** Criterion 1.1 Descriptor: *Availability*

Recommendation

It is recommended that the team work with the information available at the regional, provincial, and national level and use population health data to determine future needs and guide planning.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

The ICU team and the region may not be aware of the ongoing needs and demands for services and the resource allocation necessary to meet the needs.

Reason for Urgency

This recommendation should be addressed in a planning and budgeting cycle as part of the strategic directions for the ICU team.

Critical Care — Criterion 7.1 — Descriptor: *Appropriateness*

Recommendation

It is recommended that the team work with management to develop a workload measurement tool to assess the level of staffing needed in the ICU environment.

Organization Rating	Survey Rating	Risk Rating
6	3	Likelihood **M** Severity **M** Urgency **M**

Potential Adverse Event

Staffing levels may be inappropriate resulting in over or understaffing in the ICU areas.

Reason for Urgency

The nurse to patient ratio for ventilated patients should be one-on-one and this is not always the case throughout the region.

Critical Care — Criterion 11.6 — Descriptor: *Participation and Partnership*

Recommendation

It is recommended that the team inform patients and their families about the availability of the complaint process and how they can express concerns about their care.

Organization Rating	Survey Rating	Risk Rating
5	3	Likelihood **M** Severity **H** Urgency **M**

Potential Adverse Event

Patients and families with concerns about their care may not be aware of the mechanisms that are in place. Patient and family concerns are not being addressed.

Reason for Urgency

Increased patient awareness of the complaints process will ensure that complaints are addressed in an efficient and timely manner.

Critical Care — Criterion 15.3 — Descriptor: *Effectiveness*

Recommendation

It is recommended that the team monitor patients following discharge to determine the outcomes including mortality, morbidity, adverse events, average length of stay, and readmission rates.

Organization Rating	Survey Rating	Risk Rating
4	3	Likelihood **M** Severity **M** Urgency **M**

Potential Adverse Event

The team is uncertain outcome data for the ICU population in the region and this may result in misallocation of resources.

Reason for Urgency

Better awareness of outcomes will assist this team in better overall operational and strategic planning.

Key Findings

Being a learning organization and achieving positive outcomes	Criteria	Organization Rating	Survey Rating
1.0 The team continually plans and designs its services to meet the current and future needs of the populations it serves, and to achieve the best possible outcomes.	1.1	3	3
	1.2	4	4
	1.3	3	4
2.0 The team uses research, evidence, and best practice information to develop and improve its services.	2.1	6	5
	2.2	6	5
	2.3	4	4
	2.4	4	4
	2.5	6	5
3.0 The team monitors and improves the quality of its services to achieve the best possible outcomes.	3.1	4	4
	3.2	4	4
	3.3	3	4
	3.4	5	5
	3.5	6	4

Strengths:

This team met to complete the self-assessment and it was a very helpful process. There was representation and input from frontline staff, management, and physicians. The team has created bonds out of this process and a sense of shared goals. Patient input was primarily from provider experience.

This process has helped with a sense of regionalization by meeting with others. Progress is now being made in sharing more information via e-mails and consultation. A subcommittee has been formed including physicians to share protocols. The senior management team supports this committee including physician reimbursement.

There are regular meetings with the multidisciplinary team to plan bed utilization at most sites. The trauma 97 policy allows ambulances to bypass local hospitals if tertiary care is required.

Integrated care coordinators are present at some sites.

Critical care is tracking several indicators such as infection control, occupancy, ventilated client days, falls, and medication errors.

A system is in place throughout the region to determine the bed availability on a daily basis.

Despite the challenges of a large geographical area with sparse population and difficult topography, the team has developed measures to safely transfer critically ill patients to an appropriate critical care facility. The region has a no refusal policy for critically ill patients.

The role of the integrated care coordinator has been developed to provide linkages to other levels of care and facilitate a return to the community.

The ICU team and the organization have developed excellent criteria for student placement and mentoring. The numbers and types of students are increasing annually.

Key Findings (Continued)

Indicators are selected based on high risk, high cost, and high volume methods. The team is monitoring the myocardial infarction pathway, stroke pathway, VAP rates, and central line sepsis.

The family conference form is an excellent tool for capturing the areas of discussion when conferences are held and for ensuring that all team members are informed.

Areas for Improvement:

Standardize data collection.

Review the need for alternate beds for chronic dependent ventilator patients. They use ICU beds because other units cannot manage them.

Develop IHA-wide goals and objectives for critical care and a strategic plan.

Ensure that incident reporting is done in the Schuswap ICU. While most sites are reporting incidents in a very supportive environment, Schuswap ICU in Salmon Arm report that it has not had any incidents related to patient safety since 1988. This is highly unlikely and may reflect a problem with the culture of reporting at this site.

Ensure that all events are formally reported and reviewed using the processes and policies of the organization.

Conduct a prospective analysis of incidents, such as FEMA.

Use population health criteria to plan for future service needs. Engage in more proactive strategic planning based on population health data and principles.

Ensure that all ICU sites participate in the Canadian ICU collaborative. One site has lowered VAP rates by 50% as a result of using best practice guidelines from the collaborative.

Strengthen internal communications to enhance uniform practice relating to research and best practices.

Follow up on the plan for a good catch program with the support of the quality improvement department.

Develop best practice guidelines and roll them out across the region. Care maps exist for some areas and the Safer Healthcare Now initiative has focused on cardiac care. This process has really just started. The PDSA model is an excellent starting point for the development and implementation of best practices at all sites.

Key Findings (Continued)

Achieving wellness	Criteria	Organization Rating	Survey Rating
4.0 The team, working with the community, promotes health, prevents or detects health problems early, and maximizes the well-being of those it serves.	4.1	5	5
	4.2	5	5
	4.3	5	5

Strengths:

The trauma committee does educational sessions on prevention.

Pre-surgical assessments are done in ICU.

The hand washing campaign and staff immunization are encouraged.

Team members have participated in many different educational sessions including fractured hip and falls prevention, trauma activation for EMS, smoking cessation education, and head and spinal injury.

The team has initiated the VAP protocol of the Canadian ICU collaborative resulting in a reduction of VAP.

Areas for Improvement:

Increase the emphasis on promoting wellness across the team and evaluate the effectiveness of these initiatives. The community prevention programs could include trauma prevention strategies, smoking cessation, and primary prevention of heart disease.

Work with the partners to finish the development of the chronic disease template model for chronic obstructive pulmonary disease (COPD).

Provide more clinical education.

Key Findings (Continued)

Being responsive	Criteria	Organization Rating	Survey Rating
5.0 The team's services are integrated and coordinated to ensure continuity of service for the populations it serves.	5.1	6	6
	5.2	6	5
	5.3	5	5
6.0 The clients' first contacts with the team lead to the best decision about services.	6.1	3	4
	6.2	4	5
	6.3	3	4
	6.4	4	4
	6.5	4	4
	6.6	5	5

Strengths:

There are daily client bedside rounds on some sites by the multidisciplinary team.

Pharmacists are more involved as team members.

There are regular reviews of clients waiting for ICU beds. This is done at a site level.

An interdisciplinary approach to patient care and documentation through interdisciplinary notes is in place at all sites.

The response time in tertiary sites is 10 minutes for telephone contact and 45 minutes for direct patient management.

The newly formed critical care transport team facilitates transfer from a lower to a higher level of care.

Penticton has initiated Friday rounds as a way of preparing for the weekend.

Kelowna has interdisciplinary rounds daily and includes the physician-to-physician hand over. The bedside nurses would like to be included in these. The team is going to make an effort to include them in the future.

There is a no refusal policy in place. Some sites such as Kelowna, have developed admission and discharge criteria; however, the unit does accommodate no refusal patients because this team works well across the region.

Larger units provide consultation and advice to smaller units to try to keep patients in their home community when appropriate.

Some areas use telehealth very effectively for thoracic surgery and wounds.

Key Findings (Continued)

Areas for Improvement:

Continue to strengthen linkages between larger and smaller sites to increase access to aspects of the multidisciplinary team.

Continue developing strategies to deal with the critical care nursing shortage.

Provide more staff education related to end of life decisions.

Increase the utilization of the ethics committee. This resource might be more optimally utilized.

Ensure that all patients and families know who is the most responsible physician. Patients and families are sometimes unaware of the MRP.

Develop admission criteria and ICU outreach teams at all sites.

Look at some other models that rural, non-academic centres have adopted to address physician hand over. Smaller sites have challenges around physician hand over because the units are more open. Salmon Arm has closed the unit.

Share the admission and discharge criteria with other sites.

Key Findings (Continued)

Addressing needs	Criteria	Organization Rating	Survey Rating
7.0 The team accurately and appropriately assesses its clients.	7.1	6	3
	7.2	6	5
	7.3	5	5
	7.4	5	5
8.0 The team has access to diagnostic services that are safe, efficient, and accurate.	8.1	5	5
	8.2	6	5
	8.3	4	4
	8.4	6	5
	8.5	5	5

Strengths:

The Meditech information system and PACS is making a noticeable difference in the rural areas related to the timely access to information. The PACS system is functioning extremely well across the IHA and has resulted in an improvement of radiology services. The implementation of Meditech permits instant access to lab results and easy trending of results in the complex ICU environment.

All diagnostic services meet the standard of the diagnostic accreditation program of BC.

Service contracts are in place for all equipment not serviced by IHA staff. The service response is excellent.

A standardized head to toe assessment is carried out in all ICUs in the region.

Areas for Improvement:

Identify creative strategies such as hiring permanently into the casual line in East Kootenay to avoid significant service disruption. There is difficulty recruiting into many positions. Ultrasound wait lists grew recently when the organization was unable to find staff for positions vacated due to illness. This will continue to be a challenge for IHA.

Standardize the pain assessment tool and the approach to pain management across the IHA.

Conduct utilization reviews of laboratory tests and diagnostic imaging tests to ensure that resources are utilized appropriately.

Develop a workload measurement tool to determine the level of staffing needed to effectively manage ICU patients.

Continue to develop quality indicators for lab services.

Key Findings (Continued)

Empowering clients	Criteria	Organization Rating	Survey Rating
9.0 The team works with clients and families to help them actively participate in service delivery and carry out their responsibilities.	9.1	6	5
	9.2	6	5
	9.3	6	4
	9.4	6	5
	9.5	4	4
10.0 The team obtains informed consent before starting any service or intervention.	10.1	6	5
	10.2	6	5
	10.3	5	5
	10.4	4	4
11.0 The team protects and promotes the rights of its clients and families.	11.1	6	4
	11.2	5	5
	11.3	5	4
	11.4	3	4
	11.5	6	5
	11.6	5	3

Strengths:

Pharmacists, dietitians, nurses, and physicians do patient and family teaching.

Interpreters are available.

Referrals are made to the community for addictions counselling.

There is awareness of the regional ethics committee and the HSAs have access to ethics consultations. It is hoped that utilization of these resources will increase as more staff and physicians experience the benefit.

Sites have access to a patient representative, though the service is underutilized. Some patients report the responses to complaints are to merely smooth things over.

The new consent process, policies, and forms have been developed and education sessions are scheduled to start in the fall of 2006.

Some areas are very diligent about reviewing advance directives. Advance directives are obtained whenever possible and are readily available on the chart.

The team has developed a practice of informing patients about all aspects of care. The most appropriate member of the team will inform the patient about their status. The physician describes the procedure and provides an overall summary of the medical condition as part of the consent process. The dietitian instructs patients about diet.

Patient education is well done when patients are in the unit for a reasonable period of time and it is reinforced throughout the ICU stay. It is recorded on the patient record in the interdisciplinary notes.

Key Findings (Continued)

Social workers are available to assist families and in some cases to advocate on behalf of the patients. The team encourages patient and family participation in the care plan.

This team has recently reaffirmed its commitment to patient centred care.

Areas for Improvement:

Ensure that the patients and their families are aware of the patient representatives and understand their role and how to contact them.

Implement the new consent process across the organization. Examine the deficiencies that exist and work with the ethics committee to improve the consent process for this very challenging group of patients. Consent is not always obtained. The region has developed a consent policy that complies with the provincial directive and this policy is to be implemented in response to previous recommendations.

Establish a consistent approach to the review of advance directives.

Consider the role of the patient in safety and develop education and a practice plan so that this aspect of safety is communicated.

Evaluate the effectiveness of patient teaching.

Inform patients about the complaint process. The team acknowledges that complaint processes are rarely discussed explicitly with patients and families, but agrees that it will be addressed at future meetings. Many patients were unaware that there was a complaint process available to them.

Key Findings (Continued)

Setting goals and monitoring achievements	Criteria	Organization Rating	Survey Rating
12.0 The team has an appropriate and integrated service plan for each client.	12.1	5	5
	12.2	5	5
	12.3	6	5
	12.4	6	5

Strengths:

The interdisciplinary team works well together to develop care plans for ICU patients on some sites.

Multidisciplinary bedside rounds are used on a daily basis to develop the integrated service plan for each patient on the unit. This is recorded on the interdisciplinary progress note.

Areas for Improvement:

Develop care pathways in all areas.

Develop and implement care maps for the most common diagnoses.

Key Findings (Continued)

Delivering services	Criteria	Organization Rating	Survey Rating
13.0 The team delivers safe, efficient, and effective services.	13.1	5	5
	13.2	5	5
	13.3	6	5
	13.4	5	5
	13.5	4	4
	13.6	4	4
	13.7	6	6
14.0 The use of medications and other therapeutic technologies is safe, efficient, effective, and promotes the best possible quality of life.	14.1	4	4
	14.2	5	5
	14.3	4	4
	14.4	5	5
	14.5	4	4

Strengths:

Nurses are mentored and receive training to move into critical care roles.

There are regular discussions about the patient's progress in the ICU. The team reports excellent pharmaceutical support and expertise.

The IHA infection control policy is used at all sites. The screening tools for antibiotic resistant organisms is posted on the units and is followed for each patient. Staff are aware of infection rates. The Canadian collaborative for ventilator-acquired pneumonia (VAP)was implemented and resulted in a significant reduction in the rate of VAP in the ICU.

This team has been exploring data at the Kelowna site around case mix, ventilated patients, resources used, and VAPs. This data has been presented at the ICU advisory committee. East Kootenay has been collecting data to support strategic planning.

Medication reconciliation is done on admission by talking to the to patient and family, Pharmanet check, and consulting with a pharmacist. The team reports excellent coverage and expertise from pharmacy. East Kootenay is using Telehealth pharmacy support in the rural areas.

Pixus is expanding across IHA and the reports are very positive.

One incident was described and the error was fully disclosed to the patient and family. The intensivist reports full disclosure of errors in her practice and the error would be discussed with the chief of staff depending on the incident and the need for critical incident review. The IHA disclosure policy is being followed in the ICUs.

Key Findings (Continued)

Areas for Improvement:

Develop a region-wide restraint policy and process for monitoring use.

Initiate at least one prospective analysis in the coming year.

Obtain workload measurement data to effectively plan resources for these units.

Provide support to the smaller ICUs to engage in data collection. Regional data collection and analysis would enable the region to benchmark against other regions. Dedicated resources will be needed to accomplish this.

Ensure that data collected in the region is routinely compiled, analyzed, and communicated to the managers.

Continue to address the challenge of maintaining and recruiting well trained critical care staff.

Key Findings (Continued)

Maintaining continuity	Criteria	Organization Rating	Survey Rating
15.0 After transition or the end of service, the clients' ongoing needs are met and continuity of service is maintained.	15.1	6	5
	15.2	5	5
	15.3	4	3

Strengths:

Patients are prepared for transfer to other regions for services not provided in IHA such as Vancouver and Calgary. Families report clear explanations of the rationale and process.

Discharge planning begins at the time of admission. The interdisciplinary team assesses the patient and discharge is considered. The discharge planning process includes patient and family education.

Medication reconciliation is verified by the clinical pharmacy prior to discharge.

The critical care transport team has been developed to safely move critically ill patients from one centre to another.

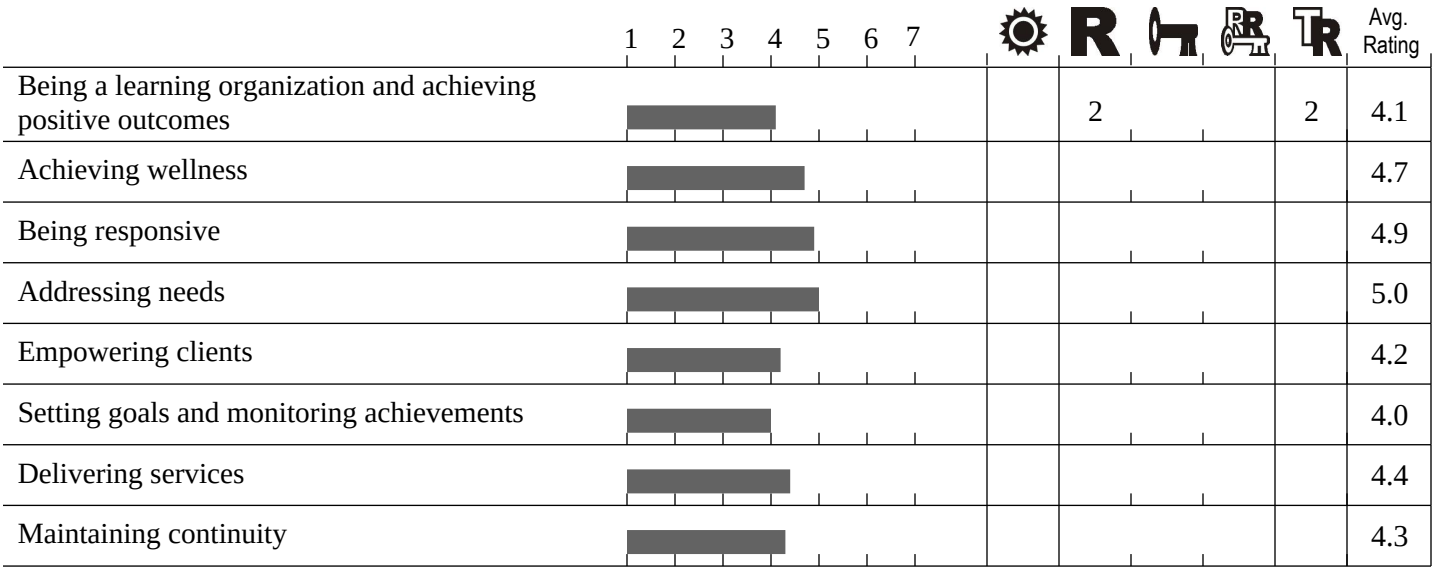
Areas for Improvement:

Conduct earlier discussions about discharge plans with the patients and families related to the community supports that are available to ease transition. While the ICU is preoccupied with the urgent care required by these patients, a brief conversation with families about life after ICU can provide them with reassurance that care will move beyond the walls of the hospital.

Follow up patients following discharge to determine the outcomes including mortality, morbidity, adverse events, average length of stay, and readmission rates. Readmission to ICU is an accurate predictor of mortality and increased length of stay and typically runs at five to seven percent in the critical care setting. This could be accompanied by formal morbidity and mortality rounds to identify potential changes to practice when relevant.

Rehabilitation

Rating at the Sub-section Level



	1 2 3 4 5 6 7		R			Avg. Rating
Being a learning organization and achieving positive outcomes			2		2	4.1
Achieving wellness						4.7
Being responsive						4.9
Addressing needs						5.0
Empowering clients						4.2
Setting goals and monitoring achievements						4.0
Delivering services						4.4
Maintaining continuity						4.3

Recommendations

Rehabilitation Criterion 1.1 Descriptor: *Availability*

Recommendation

It is recommended that rehabilitation services develop and implement a strategic plan.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

Inappropriate use of resources and ongoing fragmentation of services may result.

Reason for Urgency

This has been an ongoing issue and it is essential to high quality service delivery. The team has very ambitious plans and objectives. It needs to exercise caution, prioritize efforts, and collectively develop a series of reasonable steps.

Recommendation

It is recommended that the team implement appropriate administrative structures for rehabilitation services at both the HSA and IHA levels.

Organization Rating	Survey Rating	Risk Rating					
3	**3**	Likelihood	**M**	Severity	**M**	Urgency	**M**

Potential Adverse Event

The group may be voiceless and the rehabilitation services team may not be able to come together.

Reason for Urgency

Studies and documents were produced at the HSA level in the past few years that have dealt with this issue, but no action has yet been taken.

Key Findings

Being a learning organization and achieving positive outcomes	Criteria	Organization Rating	Survey Rating
1.0 The team continually plans and designs its services to meet the current and future needs of the populations it serves, and to achieve the best possible outcomes.	1.1	3	3
	1.2	3	3
	1.3	3	4
2.0 The team uses research, evidence, and best practice information to develop and improve its services.	2.1	5	5
	2.2	3	4
	2.3	3	4
	2.4	3	4
	2.5	5	5
3.0 The team monitors and improves the quality of its services to achieve the best possible outcomes.	3.1	3	4
	3.2	4	4
	3.3	3	4
	3.4	5	5
	3.5	3	4

Strengths:

The team brought together a rehabilitation quality service team about a year ago from across the region to raise awareness of the rehabilitation agenda. The team met for four full days to go through the document. Every region is different but they have many similarities. The team is committed to moving forward with the action plan. They appreciated the accreditation process and found it very useful.

There is good information available on population demographics and the major patient groups are geriatrics, orthopedics, stroke, and acquired brain injuries. CIHI data is used for services review.

There is a well conceived and thoughtful plan written for rehabilitation design in the Okanagan health service area. A series of excellent recommendations in the report can serve as a model for the IHA. It should review and use this for planning.

Strong interdisciplinary work is evident. There is a lot of support for staff education in some areas.

The librarians are working successfully to bring updated literature and make evidence and literature accessible to staff. There are new programs being adopted and training is implemented through multiple means.

The teams participate in a number of collaborative and provincial programs.

The first step in planning programs may be an inventory of activities. There is an excellent inventory of falls prevention programs. It outlines activities and the focus of the programs. There are some excellent evaluations of the effects of these programs that could serve as a model for other areas.

Staff on the floors understand how to use the incident report. The team shows great capacity as a learning organization.

Staff use many strategies to improve communication. Electronic linkages have facilitated communication and partnerships.

Key Findings (Continued)

Teleconferencing for staff in residential care has been started and should be encouraged. EK has started planning an annual conference to facilitate networking and informed practice.

A proposal was made to the ministry for money to do an IHA-wide annual conference and quarterly teleconferences.

The team is coming together in collegial way. It is working on a common mission, vision, and guiding principles to inform a strategic plan for rehabilitation services. The clinicians are networking regularly.

The team shows good capacity to use data to change practice. Okanagan found the length of stay (LOS) was above average for amputees, so a CQI project was done, and it reduced the LOS by five days. An interdisciplinary quality team mapped total hips and total knees to decrease LOS from seven to five days. They found that anesthesia created a barrier to the first-day standing, which is the provincial standard. It is now being addressed in collaboration with the surgeons. Another project was related to bladder control.

Areas for Improvement:

Review the excellent information available about the health status of the population with appropriate stakeholders to identify demographics as a basis for an overall rehabilitation strategy for IHA.

Develop a methodology to define best practices to be used across the IHA.

Share the many excellent local initiatives across the IHA.

Focus on some key processes, select indicators, and measure and evaluate them using a defined process.

Involve clients, families, and other organizations in the evaluation processes.

Key Findings (Continued)

Achieving wellness	Criteria	Organization Rating	Survey Rating
4.0 The team, working with the community, promotes health, prevents or detects health problems early, and maximizes the well-being of those it serves.	4.1 4.2 4.3	3 5 4	5 5 4

Strengths:

There is a very extensive list of activities in the community directed at health prevention and promotion.

The team has an attractive pamphlet for seniors on falls prevention. Falls prevention is available in many areas. An inventory has been created with target populations.

Areas for Improvement:

Prioritize population needs, develop an inventory of existing activities, and evaluate best practices and outcomes. The team needs a regional plan for moving forward with key prevention targets and strategies.

Work with the chronic disease management group and research group to get more statistics about morbidity.

Use specialists to educate staff in continuing care and in the community to assist in program development.

Key Findings (Continued)

Being responsive	Criteria	Organization Rating	Survey Rating
5.0 The team's services are integrated and coordinated to ensure continuity of service for the populations it serves.	5.1	6	5
	5.2	5	5
	5.3	5	4
6.0 The clients' first contacts with the team lead to the best decision about services.	6.1	5	5
	6.2	5	5
	6.3	5	5
	6.4	5	5
	6.5	5	5
	6.6	5	5

Strengths:

There are multiple specialty teams to deal with distinct patient populations. There is strong interdisciplinary participation in team meetings.

The electronic health record is contributing to the continuity of care.

There is good documentation available related to community resource lists and programs such as industrial rehabilitation and tuberculosis.

Areas for Improvement:

Assess the possibility of using a regional waiting list. The team needs a consistent approach to waiting lists. This should include eligibility criteria and information for patients.

Develop a process to inform patients about how long their wait will be.

Address the acute absence of resources in some rural areas.

Review and standardize the level of care. It changes markedly as patients move from inpatient to outpatient services.

Standardize the professional leadership reporting structures. The variations cause fragmentation in some areas, while others have a more strongly networked set of services across health service areas.

Strengthen and smooth the transition between facilities or between health service areas. Sometimes plans and policies differ between health service areas, such as staple removal. Enhance communication and coordination with other sites and communities.

Address the inequities in service availability.

Address the areas of service fragmentation. Integrated care coordinators help coordinate processes.

Key Findings (Continued)

Addressing needs	Criteria	Organization Rating	Survey Rating
7.0 The team accurately and appropriately assesses its clients.	7.1	6	5
	7.2	6	5
	7.3	6	5
	7.4	5	5
8.0 The team has access to diagnostic services that are safe, efficient, and accurate.	8.1	5	5
	8.2	5	5
	8.3	2	4
	8.4	6	6
	8.5	5	5

Strengths:

Patients are assessed on regular basis and pain scales are used regularly.

Patient goals are updated regularly.

The dietitians review patient preferences and adjust diet accordingly.

Many objective assessment tools are used.

Areas for Improvement:

Improve the interdisciplinary assessment and reduce duplication.

Use standardized assessment forms.

Establish a system for biomedical staff to calibrate the electrotherapy equipment on a regular basis. There is concern that physiotherapy departments would not meet licensing body requirements for annual checks of physiotherapy's electrotherapy equipment. Calibration is an issue. IHA has hired an additional four biomedical technicians.

Key Findings (Continued)

Empowering clients	Criteria	Organization Rating	Survey Rating
9.0 The team works with clients and families to help them actively participate in service delivery and carry out their responsibilities.	9.1	4	5
	9.2	4	4
	9.3	4	5
	9.4	3	4
10.0 The team obtains informed consent before starting any service or intervention.	10.1	4	4
	10.2	4	4
	10.3	4	4
	10.4	4	4
11.0 The team protects and promotes the rights of its clients and families.	11.1	5	5
	11.2	3	4
	11.3	4	4
	11.4	4	4
	11.5	5	4

Strengths:

There is good documentation available for patients and families including welcome to rehabilitation, the convalescent care program, and the client and family information sheet.

Clinical pathways are being implemented such as stroke and joint replacement.

Quite a bit of attention has been directed to emergency measures and fire readiness. There is a new focus on emergency preparedness education and mock disasters.

Areas for Improvement:

Ensure that advance directives are clearly indicated on the files and are portable from one area to another.

Provide more information on the ethics committee and how to access it.

Increase the ongoing attention and focus on client and family needs.

Provide standardized and adaptable information packages for patients.

Key Findings (Continued)

Setting goals and monitoring achievements	Criteria	Organization Rating	Survey Rating
12.0 The team has an appropriate and integrated service plan for each client.	12.1	3	4
	12.2	3	4
	12.3	3	4
	12.4	3	4

Strengths:

The MSK injury prevention program is working well in all areas with champions in every region.

Integrated comprehensive programming seems to work best in specialty areas and there is a strong integrated acquired brain injury (ABI) program.

A discharge planning meeting is held regularly.

There is a team approach and family and client input is regularly solicited.

Areas for Improvement:

Strengthen documentation processes. The plans are often discussed verbally but they are not clearly documented.

Ensure that the clients receive written copies of their goals.

Collect quantitative results and conduct systematic monitoring to provide input and guidance in individual and population progress.

Improve communication between the rehabilitation team and the family physicians.

Key Findings (Continued)

Delivering services	Criteria	Organization Rating	Survey Rating
13.0 The team delivers safe, efficient, and effective services.	13.1	4	5
	13.2	4	4
	13.3	3	4
	13.4	6	5
	13.5	3	4
	13.6	3	4
	13.7	3	4
14.0 The use of medications is safe, efficient, effective, and promotes the best possible quality of life.	14.1	5	5
	14.2	5	5
	14.3	4	4
	14.4	N/A	N/A
	14.5	N/A	N/A

Strengths:

Falls prevention programs are in place. The restraint policy is used and it includes a flow sheet.

The staff use good sterilization precautions in the physiotherapy department. The whirlpool attendant discussed good sterilization techniques after use for a wound. Infection control tests about every two months.

Meditech is providing better safety and better access to patient information.

The HARP protocol is used in home. There is an excellent program for lifts and transfers particularly related to ceiling lifts.

Team members have input into treatment and decisions about medications. It is involved in medications in residential care related to falls, cognition, and aggression.

Informed consent policies will be rolled out. A coordinated strategy for inservicing and staff education is planned. The professional practice office ensures compliance with the colleges.

There are strong outreach and community-based programs in many areas.

Areas for Improvement:

Review the data to ensure that the team is achieving the expected results. The falls prevention program is an example of a program where staff intuitively feel that it has made a difference; however, data was not easily available.

Enhance staff education in emergency training such as CPR, emergency planning, crisis management, and nonviolent interventions, especially in isolated regions and community rehabilitation.

Key Findings (Continued)

Maintaining continuity	Criteria	Organization Rating	Survey Rating
15.0 After transition or the end of service, the clients' ongoing needs are met and continuity of service is maintained.	15.1	5	5
	15.2	4	4
	15.3	2	4

Strengths:

Patients and families are involved early in the process of discharge planning. Community staff are involved in discharge planning to facilitate transitions.

Areas for Improvement:

Ensure that there are formal and consistent follow ups. They vary from area to area and the information cannot be used for planning purposes.

Use the client satisfaction questionnaires on a regular basis with a standardized approach. They can target specific populations

Develop a web-based list of rehabilitation services. A rehabilitation services website is developed for one HSA that contains the templates, forms, communications, and announcements; however is not available across the region.

FUTURE DIRECTION

A template to help focus your quality improvement progress

CCHSA has created a follow-up template to help support ongoing improvement activities following the accreditation survey, to act as a record of progress throughout the three-year accreditation cycle, and to assist in the completion of the follow-up action required as a condition of the accreditation status.

This template is now available online through CCHSA's website. Instructions on how to access and use the template are attached to your award letter and are also available through our website.

Is it necessary for our organization to use the online template?

For an organization that receives Accreditation with Report or Focused Visit, completion of this online template is mandatory. For an organization that receives full Accreditation, completion of this online template is not a requirement of your accreditation status. However, the organization is encouraged to use the template to support your ongoing improvement activities.

Organizations are asked to respond to the recommendations using this online tool to further automate the accreditation process.

How does the online template work?

The organization is required to use the template for all recommendations, including required organizational practices recommendations, that require further action as a condition of accreditation (i.e. Report or Focused Visit) and provide supporting evidence that the recommendation requirements have been met. The completed template must identify a summary of how the recommendation has been fully addressed and should include attached documents that provide supporting evidence. The organization also has the opportunity to document its plan of action to address each recommendation, target dates, responsibilities and the status of these plans. Full instructions on how to complete the template are included in the Guidelines for Preparing a Report or Focused Visit as a Condition of Accreditation.

Next steps for your organization

Your organization has received Accreditation with Condition: Report and Focused Visit. Please use the template to support your accreditation status and continuous quality improvement progress.

FOLLOW-UP TEMPLATE

Recommendations by Required Organizational Practices

	RATINGS	Date Required	Plan of Action	Target Dates	Responsibility	Status
Culture						
Quarterly Reports It is recommended that the organization implement a full safety reporting system to the board including the implemented changes and improvements following the investigation of serious incidents.	**D**					
Reporting Adverse Events It is recommended that the IHA move forward with its plan to consolidate the HSAs' multiple reporting systems and begin to implement training to address adequate reporting.	**D**					
Disclosure It is recommended that IHA develop and implement its own regional disclosure policy. The region has been waiting for provincial work on a disclosure policy.	**D**					
Prospective Analysis It is recommended that the organization implement a process to define and implement a patient safety prospective analytical process every year.	**N**					

Recommendations by Required Organizational Practices

	RATINGS	Date Required	Plan of Action	Target Dates	Responsibility	Status
Communication						
Verification Processes It is recommended that the organization educate staff and reinforce the routine use of verification methodologies including consistent verification of patient identification using armbands, and verification of patient medications at each medication transaction. The organization participated in a pilot project aimed at improved patient quality and safety at the South Okanagan Health Centre. It is recommended that the IHA expand this pilot strategy to other areas.	**D**					
Worklife/Workforce						
Patient Safety Training It is recommended that the organization provide education on patient safety to all staff this fiscal year and develop a mechanism for tracking.	**D**					
Patient Safety Plan It is recommended that the organization assess the region's safety issues to guide the development of a detailed action plan for implementation this fiscal year. Start implementation with targets and methods to monitor. Report the plan to senior leadership and the board.	**D**					

Recommendations by Required Organizational Practices

	RATINGS	Date Required	Plan of Action	Target Dates	Responsibility	Status
Worklife/Workforce						
Roles & Responsibilities It is recommended that the organization implement its plan to use the high-level delineation document to help support all staff to have an awareness of and be able to consistently articulate their roles and responsibilities in safety.	**D**					
Infection Control						
Hand Washing/Hygiene It is recommended that the organization educate the physicians about hand washing and monitor compliance. Hand washing in physicians needs some attention as staff and clients have to remind them. This does not apply to surgeons.	**D**					

Recommendations by Quality Dimensions

	RATINGS		Potential	URGENCY			Reason for	Date	Plan of Action	Target	Respon-	Status
	Org	Survey	Adverse Event	L	M	H	Urgency Rating	Required		Dates	sibility	
Responsiveness												
Ambulatory Care Renal 12.3 It is recommended that the team involve the entire team, including the nephrologist, in family conferences, and that this be standardized across the region.	**5**	**4**	Without input from all relevant providers, patients and family members may not understand the problems or goals fully to make informed decisions about their care. Health care providers may not have all the information to base to build an appropriate care plan.	☐	☑	☐	All members of the team need to be present to set and communicate a truly integrated care plan.					
Critical Care 1.1 It is recommended that the team work with the information available at the regional, provincial, and national level and use population health data to determine future needs and guide planning.	**3**	**3**	The ICU team and the region may not be aware of the ongoing needs and demands for services and the resource allocation necessary to meet the needs.	☐	☑	☐	This recommendation should be addressed in a planning and budgeting cycle as part of the strategic directions for the ICU team.					
Rehabilitation 1.1 It is recommended that rehabilitation services develop and implement a strategic plan.	**3**	**3**	Inappropriate use of resources and ongoing fragmentation of services may result.	☐	☑	☐	This has been an ongoing issue and it is essential to high quality service delivery. The team has very ambitious plans and objectives. It needs to exercise caution, prioritize efforts, and collectively develop a series of reasonable steps.					
Rehabilitation 1.2 It is recommended that the team implement appropriate administrative structures for rehabilitation services at both the HSA and IHA levels.	**3**	**3**	The group may be voiceless and the rehabilitation services team may not be able to come together.	☐	☑	☐	Studies and documents were produced at the HSA level in the past few years that have dealt with this issue, but no action has yet been taken.					

Recommendations by Quality Dimensions

	RATINGS		Potential	URGENCY			Reason for	Date		Target	Respon-	
	Org	Survey	Adverse Event	L	M	H	Urgency Rating	Required	Plan of Action	Dates	sibility	Status
System Competency												
Acute Care Medicine 4.3 It is recommended that the team work with leadership in the organization to increase its efforts in prevention and early detection.	**3**	**3**	The growing burden of illness and disease may lead to capacity issues for acute care and community care.	☑	☐	☐	The team is engaged in some prevention and monitoring activities. Having stronger involvement in early detection strategies, as well as stronger awareness and linkages to the region's prevention strategies will assist the acute care medicine programs in continuing to reduce readmissions, length of stay and other key indicators.					
Acute Care Medicine 10.1 It is recommended that the organization finalize and disseminate the informed consent policy throughout IHA.	**5**	**3**	A patient may receive an unwanted medical intervention. There may be risk to IHA for legal action and loss of public credibility and trust.	☐	☐	☑	The organization needs to protect the patients' rights and reduce its financial risk.					
Ambulatory Care Renal 3.1 It is recommended that the team conduct formal patient satisfaction surveys.	**3**	**3**	The team may lack knowledge of patient dissatisfaction and ways to improve care.	☐	☑	☐	The team needs to identify and address areas for improvement to improve the patient experience.					
Ambulatory Care Renal 3.3 It is recommended that the team develop a process to determine the relationship between infections, septicemias and the access type.	**3**	**3**	Staff may be unable to discover ongoing or episodic problems.	☐	☑	☐	The team needs to be able to monitor these key indicators, protect patient safety and identify areas for improvement.					

Recommendations by Quality Dimensions

	RATINGS		Potential	URGENCY			Reason for	Date		Target	Respon-	
	Org	Survey	Adverse Event	L	M	H	Urgency Rating	Required	Plan of Action	Dates	sibility	Status
System Competency												
Ambulatory Care Renal 12.2 It is recommended that the nephrologist be present in the dialysis units at reasonable intervals. Telemedicine could be used in distant units for bimonthly or monthly sessions with the patients and the multidisciplinary teams.	**5**	**1**	A patient could develop a problem and there could be poor understanding by the staff.	☐	☐	☑	The patients need nephrology involvement, visits and plans.					
Ambulatory Care Renal 13.1 It is recommended that the team increase the frequency with which long distance patients are seen by the physician to at least every two months. This could be done by telemedicine.	**6**	**3**	Without regular and timely contact with the physician, patient and care problems may be missed and the patients may be dissatisfied with the lack of nephrology care.	☐	☐	☑	The organization needs to ensure that appropriate and adequate nephrology care is provided. Patients have expressed concern with the frequency of visits by some nephrologists.					
Ambulatory Care Renal 14.1 It is recommended that the team access a pharmacist, possibly by telemedicine.	**3**	**3**	Staff may lack understanding of side effects, which could interfere with care or lead to other more serious health complications.	☐	☑	☐	A pharmacist is needed to support safe medication practices. The team is fully aware of the need for a pharmacist on the team and of the human resource challenge they are facing.					
Critical Care 7.1 It is recommended that the team work with management to develop a workload measurement tool to assess the level of staffing needed in the ICU environment.	**6**	**3**	Staffing levels may be inappropriate resulting in over or understaffing in the ICU areas.	☐	☑	☐	The nurse to patient ratio for ventilated patients should be one-on-one and this is not always the case throughout the region.					

Recommendations by Quality Dimensions

	RATINGS		Potential	URGENCY			Reason for	Date		Target	Respon-	
	Org	Survey	Adverse Event	L	M	H	Urgency Rating	Required	Plan of Action	Dates	sibility	Status
System Competency												
Critical Care 15.3 It is recommended that the team monitor patients following discharge to determine the outcomes including mortality, morbidity, adverse events, average length of stay, and readmission rates.	**4**	**3**	The team is uncertain outcome data for the ICU population in the region and this may result in misallocation of resources.	☐	☑	☐	Better awareness of outcomes will assist this team in better overall operational and strategic planning.					
Client/Community Focus												
Ambulatory Care Renal 10.4 It is recommended that the team ensure that the consents include all advance directives.	**4**	**3**	Events or treatments may occur without patient or family input. Patients' wishes may be missed causing unwanted or harmful care.	☐	☑	☐	A standardized process will assist all in ensuring that all aspects of care are discussed with the patient, and that the patient's wishes are both documented and respected.					
Ambulatory Care Renal 11.6 It is recommended that the team ensure that patients are made aware of the complaint process and assured that the process will be confidential.	**4**	**3**	Patients may not bring ideas or problems forward, and may not know how to have their concerns addressed in an efficient and timely manner.	☐	☑	☐	Once patients bring their complaints forward, the team and the organization will be able to watch for trends much more effectively.					
Critical Care 11.6 It is recommended that the team inform patients and their families about the availability of the complaint process and how they can express concerns about their care.	**5**	**3**	Patients and families with concerns about their care may not be aware of the mechanisms that are in place. Patient and family concerns are not being addressed.	☐	☑	☐	Increased patient awareness of the complaints process will ensure that complaints are addressed in an efficient and timely manner.					

APPENDIX A

Quality Dimensions and Descriptors

The CCHSA program is designed to evaluate the quality of health care and services. But what is quality? Even a small amount of research will reveal that there are a number of definitions for the concept of quality. In order to make sure that all organizations and teams involved in accreditation are using the same reference, CCHSA defines quality as:

The degree of excellence; the extent to which an organization meets clients' needs and exceeds their expectations.

To help organizations measure the quality of their services to determine what can be improved, CCHSA has identified four dimensions of quality that define what is meant by quality. These dimensions are: Responsiveness, System Competency, Client/Community Focus and Worklife. Each dimension in turn has a number of descriptors that explain what is meant by that dimension. For example, there are five descriptors related to Responsiveness, which include Availability, Accessibility, Timeliness, Continuity and Equity. There are a total of 22 descriptors tied to the four dimensions.

The four quality dimensions and their corresponding descriptors play an important role in the program by offering organizations a framework for measuring quality. These dimensions and descriptors were used to develop the standards and criteria and similarly, the standards and criteria were written to reflect the appropriate dimension and descriptor.

As an organization's teams complete their self-assessments, teams are encouraged to use the dimensions and descriptors as a focusing tool to help guide both the teams' discussions regarding the criteria and the resulting comments in the self-assessments. The dimensions and descriptors are also used in the survey report to assist organizations in identifying general areas of strength and those areas where improvements are required.

The four dimensions and their descriptors are defined in detail on the following pages.

R **Responsiveness** The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment.	**Availability** • Service(s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s). **Accessibility** • The client and/or community easily obtains required or available services in the most appropriate setting. **Timeliness** • Services are provided and/or activities are conducted to meet client and/or community needs at the most beneficial or appropriate time. **Continuity** • Coordinated services are provided across the continuum, over time. **Equity** • Decisions are made and services are delivered in a fair and just way.

System Competency

The organization consistently provides service(s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources.

Appropriateness

- Services meet the needs of the client and/or community population(s), achieve the organization's goals, are proven (evidence-based) to produce benefits, and are based on established standards.

Competence

- An individual's knowledge, skills, and attitudes are appropriate to the service provided.

Effectiveness

- Services, interventions, or actions achieve optimal results.

Safety

- Potential risks and/or unintended results are avoided or minimized.

Legitimacy

- Services and/or activities conform to ethical principles, values, conventions, laws, and regulations.

Efficiency

- Resources (inputs) are brought together to achieve optimal results (outputs) with minimal waste, re-work, and effort.

System Alignment

- The mission, vision, goals and objectives are clear, well-integrated, coordinated and understood both internally and externally. These are reflected in organization plans, delegations of authority, and decision-making processes.

Quality Dimensions and Descriptors

Client/Community Focus

The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities.

Communication

- All relevant information is exchanged with the client, family and/or community in a manner that is ongoing, consistent, understandable and useful.

Confidentiality

- Information to be kept private is safeguarded.

Participation and Partnership

- The client and/or community actively participates as a partner in decision-making, and in service planning, delivery, and evaluation.

Respect & Caring

- Politeness, consideration, sensitivity and respect are incorporated into all interactions with the client and/or community.

Organization Responsibility and Involvement in the Community

- The organization supports and strengthens the community and its development, and contributes to its overall health.

Worklife

The organization provides a work atmosphere conducive to performance excellence, full participation, personal/ professional and organizational growth, health, well-being, and satisfaction.

Open Communication

- The organization fosters a climate of openness, free expression of ideas, and information sharing.

Role Clarity

- Staff have clearly defined job scope and objectives, and these are aligned with team and organization goals.

Participation in Decision-making

- Staff input is encouraged and used in decision-making.

Learning Environment

- Staff creativity, innovation, and initiative is encouraged. The necessary training and development, to attain organizational goals and personal/professional development objectives, is provided.

Well-being

- The organization provides a safe, healthy, and supportive environment, recognizes staff contribution, and links staff feedback to improvement opportunities.

APPENDIX B

Patient Safety Criteria across Themes

Patient Safety Criteria across Themes

Risk Theme	Standard	Abbreviated Content
Managing Risks This involves the management of possible dangers, losses or injuries so as to ensure the efficient and effective achievement of the organization's objectives. Organizational activities should be designed to identify and analyze risk and support the reduction of incidents.	L&P	Processes for identifying, reporting, assessing, and managing sentinel events
	L&P	Sentinel event investigation
	L&P	Risk reduction strategies for sentinel events
	L&P	Processes for identifying, reporting, assessing, and managing near-misses
	L&P	Process to identify, report, assess, and manage risk
	L&P	Supporting risk management practices
	L&P	External reviewer or body reviews all formal research projects
	L&P	Human subject research protects clients and respects their rights
	Environment	Organization's physical space
	Environment	Manage utilities to minimize risk and failures
	Environment	Processes to minimize hazards and risks
	Environment	Investigates incidents related to hazards and risks; prevention
	HR	There is a process in place to address health and safety hazards
	HR	Creating a safe, healthy and positive work environment
	HR	Staff, independent practitioners and volunteers are actively consulted about workplace issues
	Service Delivery	Maintaining continuity between service components
	Service Delivery	Preventing accidents, injuries, and infections
	Service Delivery	Managing aggressive or violent behaviour
	Service Delivery	Identifying, reporting and recording incidents
	Service Delivery	Waiting lists

Patient Safety Criteria across Themes

Risk Theme	Standard	Abbreviated Content
Equipment Use Equipment and medical devices are an integral part of the health service team but using them has risks as well as benefits. Risk may stem from design, manufacture, maintenance, storage, housekeeping, or lack of user competence. The criteria associated with equipment usage promote its safe use and operation as well as reporting systems that encourage the reporting of latent defects and adverse events.	Environment	Policies and process for managing equipment
	Environment	Processes for the safe use of equipment, supplies and medical devices
	Environment	Educate and train staff on safe use and maintenance of equipment
	Service Delivery	Seclusion and restraint control; modification of problem behaviour
	Service Delivery	Preventive maintenance of equipment
Disaster/Emergency Preparedness Disaster and emergency preparedness is vital when an unexpected crisis hits an organization or the surrounding community. The organization and staff must be prepared for various potential disasters and/or emergencies. Preparation includes the development and testing of plans and training of staff.	Environment	Processes for preparation of emergency or crisis situations
	Environment	Review of disaster and emergency plans
	Environment	Access to first aid equipment and supplies
	Environment	Processes to reduce the risk of fire
	Environment	Similar/same processes for disaster risk reduction at all sites
	Service Delivery	Dealing with complications, crisis, emergency
Medication Use & Diagnostic Tests It is essential that medications and diagnostic tests be used in a safe, timely and appropriate manner. Safe medication and diagnostic services take into account not only a patient's safety while receiving services but also reduced hospital costs for treating complications resulting from errors. The standard includes reviewing prescriptions, monitoring and promptly reporting any adverse drug effects, as well as the training of staff.	Service Delivery	Use of medications
	Service Delivery	The client receives written and verbal information about the medications
	Service Delivery	There is access to current information and education on using medications
	Service Delivery	Use of medications meeting legal requirements/standards of practice
	Service Delivery	Monitoring the quality of pharmacy services and other therapeutic technologies
	Service Delivery	Timeliness of diagnostic services, results, consultation or advice
	Service Delivery	Safe diagnostics tests and handling of specimens
	Service Delivery	Accurate and reliable diagnostic test results and interpretation

Patient Safety Criteria across Themes

Risk Theme	Standard	Abbreviated Content
Infection Control An important issue in today's health service environment is control of the spread of infectious diseases. When appropriate infection control precautions are used, the risk of occupational transmission to staff and patients is reduced. The organization and staff should be prepared to prevent and control infections. Preparation includes the detection, investigation, and management of infections as well as training of staff.	Environment	Resources and support systems to prevent and control infections
	Environment	Infection prevention processes
	Environment	Processes for handling food, soiled laundry or linen
	Environment	Infection response processes
	Environment	Staff members receives ongoing education about risks of infections
	Environment	Processes for preventing and controlling infections are based on current accepted practice
	Environment	Processes for preventing and controlling infections are coordinated
Staff Competence The organization and staff must be prepared and competent to deliver services safely and minimize risks. Preparation includes necessary knowledge, skills, certification and training of staff.	HR	There are clearly defined roles and responsibilities for independent practitioners
	HR	Staff development and training is encouraged and supported
	HR	Roles and responsibilities are clearly defined in position descriptions
	HR	Staff understand their role in achieving the organization's goals and objectives
	Service Delivery	Meeting unique needs of dying clients
Documentation Healthcare documentation and records are a valuable resource because of the information they contain. The information is only usable if it is correctly recorded, regularly up-dated, and is easily accessible when needed. Information is essential to the delivery of high quality evidence-based health care on a day-to-day basis and effective records management ensures that such information is properly managed and is available.	Info Mgt	Processes to support collection, access and exchange of information
	Info Mgt	Appropriate staff have timely access to the information contained in the clients' files
	Info Mgt	Policies and guidelines for managing client files
	Info Mgt	Complete client file that meets legal requirements
	Service Delivery	Informed consent

APPENDIX C

Patient Safety Goals and Required Organizational Practices

Patient Safety Goals and Required Organizational Practices (ROPs)	
Patient Safety Goal	Required Organizational Practices
Goal Area # 1: Culture Create a culture of safety within the organization	**Strategic Priority** • Adopt patient safety as a written, strategic priority/goal. **Quarterly Reports** • Provide quarterly reports to Board on patient/client safety, including changes /improvements following incident investigation and follow-up. **Reporting Adverse Events** • Establish a reporting system for actual and potential adverse events, including appropriate follow-up. This should be in compliance with any applicable legislation; and within any protection afforded by legislation. **Disclosure** • Implement a formal (transparent) policy and process of disclosure of adverse events to patients/families, including support mechanisms for patients, family, and care/service providers. **Prospective Analysis** • Carry out one patient safety-related prospective, analytical process per year (e.g. Failure Modes and Effects Analysis), and implement appropriate improvements/changes.

Patient Safety Goals and Required Organizational Practices (ROPs)

Patient Safety Goal	Required Organizational Practices
Goal Area # 2: Communication Improve the effectiveness and coordination among care/service providers and with the recipients of care/service across the continuum	**Client Role** • Inform and educate patients/clients and/or family about their role in patient safety, using both written and verbal communication. **Transfer of Information** • Employ effective mechanisms for transfer of information at interface points, including shift changes; discharge; and, patient/client movement between health care services and sectors, and implement improvements. **Verification Processes** • Implement verification processes and other checking systems for high risk care/service activities, including ordering and receiving results of critical tests; administering surgical or other invasive procedures; diagnostic testing; medication use, and implement improvements. **Medication Rec - admission** • Reconcile the patient's/client's medications upon admission to the organization, and with the involvement of the patient/client. **Medication Rec - transfer** • Reconcile medications with the patient/client at referral or transfer, and communicate the patient's/client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Goal Area # 3: Medication Use Ensure the safe use of high risk medications Ensure the safe administration of parenteral medications	**Concentrated Electrolytes** • Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient/client care units. **Drug Concentrations** • Standardize and limit the number of drug concentrations available in the organization. **Training on Infusion Pumps** • Provide ongoing, effective training for service providers on all infusion pumps.

Patient Safety Goals and Required Organizational Practices (ROPs)

Patient Safety Goal	Required Organizational Practices
Goal Area # 4: Worklife/Workforce Create a worklife and physical environment that supports the safe delivery of care/service	**Patient Safety Training** • Deliver at least annual education/training on patient safety to all staff, including targeted patient safety focus areas within the organization. **Patient Safety Plan** • Develop and implement a plan and process to assess patient safety issues within the organization, and to carry out improvement activities. **Roles & Responsibilities** • Delineate clearly the roles, responsibilities, and accountabilities of staff and other providers for patient/client care and safety. **Preventive Maintenance** • Implement an effective preventive maintenance program for all medical devices, equipment, and technology.
Goal Area # 5: Infection Control Reduce the risk of health service organization-acquired infections, and their impact across the continuum of care/service	**Guidelines** • Adhere to federal and/or provincially-developed infection control guidelines such as Health Canada's Infection Control Guidelines: Hand Washing, Cleaning, Disinfection and Sterilization in Health Care. **Hand Washing/Hygiene** • Deliver education and training for staff, other providers and volunteers on hand washing/hygiene. **Infection Rates** • Monitor infection rates and share this information throughout the organization. **Sterilization Process** • Examine, and where indicated, improve processes for sterilization of equipment and facilities.