ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:

Interior Health Authority

Kelowna, BC

On-site Survey Dates:

September 20, 2009 - September 25, 2009

March 11, 2010

ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

Accreditation Report

About this Report

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

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

Confidentiality

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

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

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About the Accreditation Report

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

Legend

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

Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.

Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.

Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.

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

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Interior Health Authority

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

On-site survey dates	September 20 to 25, 2009
Report Issue Date:	March 11, 2010

Accreditation Decision	Accreditation with Condition (Report)

Locations

The following locations were visited during this survey visit:

1 100 Mile House District Hospital, 100 Mile House
2 1212 2nd Street N, (EK HQ), Cranbrook
3 Boundary Hospital & Community Care Centre, Grand Forks
4 Brookhaven Care Centre, Westbank
5 Cariboo Memorial Hospital, Williams Lake
6 Creston Valley Hospital & Health Centre, Creston
7 Dr Helmcken Memorial Hospital, Clearwater
8 Durand Manor, Golden
9 East Kootenay Regional Hospital, Cranbrook
10 Elk Valley Hospital, Fernie
11 Gillis House, Merritt
12 Golden & District Regional Hospital, Golden
13 Hillside Psychiatric Centre, Kamloops
14 Kelowna General Hospital, Kelowna
15 Kirschner Road, (IH HQ) Kelowna
16 Kootenay Boundary Regional Hospital, Trail
17 Kootenay Lake Hospital, Nelson
18 Logan Lake Health Care Centre, Logan Lake
19 May Bennett Wellness Centre, Kelowna
20 Nicola Valley Health Care Centre, Merritt
21 Overlander Residential Care, Kamloops
22 Penticton Integrated Health Centre, Penticton
23 Penticton Regional Hospital, Penticton
24 Polson Place, Vernon

25 Ponderosa Lodge, Kamloops
26 Queen Victoria Hospital, Revelstoke
27 Royal Inland Hospital, Kamloops
28 Shuswap Lake Hospital, Salmon Arm
29 South Hills Centre, Kamloops
30 Summerland Health Centre, Summerland
31 Vernon Health Unit, 14th Ave, Vernon
32 Vernon Jubilee Hospital, Vernon
33 Westview Place, Penticton

Service areas

The following service areas were visited during this survey visit:

1 Ambulatory Care
2 Cancer Care
3 Emergency Department
4 Home Care
5 Intensive Care Unit/Critical Care
6 Long Term Care
7 Managing Medications
8 Maternal/Perinatal
9 Medicine
10 Mental Health
11 Operating Room
12 Public Health
13 Rehabilitation
14 Sterilization and Reprocessing of Medical Equipment
15 Surgical Care

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

The Interior Health Authority (IHA) is one of 6 Health Authorities in British Columbia and consists of 4 Health Service Areas:
- East Kootenay
- Kootenay Boundary
- Okanagan
- Thompson Cariboo Shuswap

The geography is large covering almost 215-thousand square kilometres and much of the region is rural and remote. The population served is approximately 722,500 and the staff of the organization is approximately 18,500 in number. This sets the context for the key priorities identified by the organization and the desire to address the continuum of care.

Overall Strengths and Successes
Interior Health is commended for its commitment to quality, risk management and patient safety. Quality is clearly integrated throughout the organization. In ensuring that quality improvement is applicable across the matrix structure, a unique approach has been developed as evidenced by the quality committee of the Board, a central quality committee, quality committees and plans in each of the health service areas as well as quality embedded in all professional practice activities. LEAN education has been provided and there are several excellent examples where staff have applied this knowledge.

A great deal of attention has been paid to the process of developing values and principles. The approach was a 'bottom up and top down' approach. Once developed, the Interior Health region has worked hard at ensuring that these values and associated principles were widely communicated to all internal and external stakeholders. Of particular note has been the "Interior Health Values Implementation Plan". This plan clearly articulates how the values are embedded into many organizational processes. This was confirmed through many interviews with staff. Some staff confirmed the application of the values in difficult decision making processes including resource allocation and ethics support and processes of care.

Interdisciplinary care was observed to be in place throughout the organization. In many areas, teams were very aware of the need to work across the continuum using a patient centred approach. This was most evident at the site level.

The use of telehealth is in place at many sites. This is an enormous strength especially in light of the geography served by Interior Health and the remoteness of several communities. Ongoing utilization of this technology is encouraged.

Additional examples of strengths and innovation are also of note. Human Resource recruitment and retention strategies and the commitment to a balanced work life are commendable. Shared care in areas such as mental health is also noted.

Throughout the survey visit, staff demonstrated extremely positive attitudes to their work and to the organization as a whole. While concerned about the current financial restraints, staff remain committed to excellence and patient centred care. Awards for excellence certainly encourages and supports this culture.

Challenges and Overall Opportunities for Improvement
Although there is evidence that clinical teams/networks support the continuum of care, there is a need for the organization to further articulate this concept. Although the continuum of care is well understood at specific sites, there is an opportunity to further develop this concept beyond sites and clinical care networks. For example, as the organization develops an enhanced focus on chronic disease management, there is an opportunity to apply population health concepts and incorporate primary prevention strategies. These inclusions will further enhance continuum of care strategies and plans. Further evolution of the matrix structure with a focus on coordinated care and service across networks and sites may assist in this regard.

Rural health service delivery presents unique challenges for the organization. Successes have been realized in several areas through the use of enhanced communication, telehealth, professional development opportunities and the development of practice standards and guidelines. Further implementation and follow up of these activities will assist in ensuring that excellence is consistent across the organization regardless of location. Ongoing attention to innovation in meeting the needs of rural communities in encouraged.

The increasing number of ALC days has prompted the development of expanding beds to specifically accommodate these patients. The organization is encouraged to consider the principle of 'providing the right care in the right place' while also considering the continuum of care opportunities. This issue is complex and will continue to require comprehensive and strategic approaches and intersectoral partnerships to developing appropriate alternatives and managing resources effectively.

There has been work done to address emergency transportation issues but it was noted be of continued concern in many areas. It is recognized that this is a complex issue and further complicated by the geography of the region and the requirement to transport critically ill patients to various sites. There is a need to further explore this issue within the provincial and inter provincial context and determine if consistencies can be achieved over time.

The organization has articulated the need to focus on primary care which has been noted as a key strategic direction. Work has begun in this area in supporting ongoing linkages and the development of primary care networks and integrated primary health care teams. As Interior Health addresses further development of strategies to address the continuum of care, enhanced focus on primary care services will be essential.

Communication - Internal and External
Internal communication throughout the organization is excellent. The governing body and senior management demonstrated excellent understanding of their roles and the need for ongoing communication. Regular reports and a focus on key performance measures have assisted in ongoing and meaningful communication. Staff throughout the organization also noted that information is readily available. Again, Interior Health has maximized its use of technology to enhance all levels of communication. This is seen as an enormous success by all staff and at all levels of the organization.

Beyond technology, several additional communication strategies have been implemented. Staff noted appreciation for the "Coffee with COOs" opportunity where managers and service area leaders meet and share information. Another example is the "Leadership Links" opportunity where the CEO holds teleconference meetings with all managers throughout the organization.

Staff noted appreciation for the commitment of communication resources which are available to assist and guide service specific strategies. Staff noted that they have access to communication expertise when needed and further, that these supports are flexible to sensitive community issues.

Interior Health has recognized the need to enhance physician engagement. In some areas, physician engagement and team integration has been well established. Specific activities are evolving in this regard. Medical advisory committees are in place and inclusion of medical staff input is evolving in some areas. An example is medical staff input in the capital equipment priorization process. Meaningful internal and external physician engagement strategies are under development and communication will be key to this work.

Communication links with external partners are well established in many areas. Partnerships are extensive across many sectors. This work is commended and essential in supporting population health issues and addressing health disparities. Interviews with several partners such as the RCMP and various academic institutions confirmed excellent communication coupled with excellent working relationships. It is difficult for large organizations to remain visible to all community groups. It will be important for the organization to remain linked with many partners within the community. These linkages will need to continue to be nurtured at the service delivery level as well as the corporate level.

Many clients/patients were in contact with surveyors throughout the survey visit. Overall, comments were positive and clients offered suggestions for improvement.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

The following commentary reflects Interior Health's perspectives on the surveyor's visit and the draft report. Overall, the survey and accreditation process has been an excellent learning experience for our organization. The vast majority of comments and observations resonate with our staff and accurately reflect the status of our compliance with Accreditation Canada standards. The following items / issues are presented in order to provide further understanding and clarity in regard to the survey visit. Given the size of our region and the complexities of relationships within our programs / services and external partners (government, ambulance services etc.) we feel that some information may not have been considered by the surveyors.
SURVEYER'S COMMENTARY paragraph 13 & CRITICAL CARE SERVICES Episode of Care Comments: Continue efforts in finding solutions to timely critical care transports and inter provincial repatriation barriers. Although IH has overall responsibility for its patients, it is the BC Ambulance Service who is responsible to provide critical care transport services—including inter provincial transfers. IH has no organizational responsibility for critical care ambulance services.
EMERGENCY PREPAREDNESS Public Health Services 14.10: "The plan has been tested through one or more simulations within the past year" should not be flagged as a gap." The Public Health Team have been implementing and testing the plan during the last year.
SURGICAL PROCEDURES & OPERATING ROOMS. Interior Health was extremely disappointed with the survey process in regard to surgery and operating rooms in September 2009. The lack of tracers and inappropriate actions and comments during the site visits prevented an accurate assessment against the standards. A re-survey of Penticton Regional Hospital, Royal inland Hospital, Vernon Jubilee Hospital and Shuswap Lake Hospital was conducted by an alternate surveyor in January 2010. This was a positive experience for the organization and the findings of this survey validated the excellent work in these services. The surveyor's commentary has not yet been received by Interior Health.
MENTAL HEALTH SERVICES Clinical Leadership: Indicates that there is a ten year mental health and addictions plan for the province. Interior Health is a primary stakeholder and is contributing to the development of the plan.
EMERGENCY DEPARTMENT SERVICES Episode Of Care – Patient Streaming: The Kelowna General Hospital received an award for their patient streaming project (not the organization). Also streaming, coupled with the use of a "System Wide Indicator of Congestion" tool provides analysis that guides optimization of patient flow in the Emergency and patient services in the six larger regional and tertiary hospitals.
LONG TERM CARE SERVICES: The following "unmet" criteria should be reassessed. Most of the information was not assessed by the surveyors. We would be pleased to provide documentation to confirm that we have met the criteria.
3.7: The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements. The Quality Review Tool is designed to encompass the 2009 Qmentum standards. It is used to assist facilities in reviewing current practices, identifying areas of strength and areas requiring further attention. The tool helps identify, prioritize and communicate gaps in care delivery to support the development of an action plan to address the identified issue.
Performance Management Framework Indicators: All Residential sites in Interior Health submit Ministry of Health required data through a secure portal. Quarterly reports for each health service area are created using this data which is reported to Senior Executive Team and the Board. Working Together: Protections staff and Residential Care staff have developed this document. Both disciplines have developed a process which includes joint visits and sharing of information. RAI Data Reports: The use of the RAI MDS v2.0 has been incorporated into Residential Care. IH has developed and is using a standard set of 8 reports using IHA RAI data collected from the CIHI site. Patient Safety and Learning System is now used in all IH owned facilities. All incidents involving residents and public are reported electronically then monitored at all levels depending on complexity. Area managers use PSLS reports

during the site review process and when applicable. There is an IH Incident Management Policy. Patient Care Quality Office has been developed to receive, record, track and resolve complaints through our Health Service Area Patient Care Quality Officers. Patient Care Quality Officers assist people through the complaints process and ensure they understand their rights and responsibilities as well as how to use the healthcare system to meet their needs.
9.5: The team has a process to evaluate client requests to bring in or self-administer their own medications. The IH policy "Complementary and Alternative Medications - Residential Care" addresses residents use of their own medications.
12.8: Following transition, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition planning. Once our client's are in their preferred bed, transfer is very rare.
HOME CARE: The following "unmet" criteria should be reassessed. Most of the information was not assessed by the surveyors. We would be pleased to provide documentation to confirm that we have met the criteria.
The team works together to develop goals and objectives: The development of the IH HCC goals and objectives was a collaboration. They are articulated in our Service Alignment Plan complete with targets and timelines.
The team supports student and volunteer placement on the home care team: IH places hundreds of students and volunteers in a variety of settings including HCC. We are involved in the Employed Student Nurse program. HCC works with the Professional Practice Office to offer a student placement orientation. An infrastructure to support business practices specific to Volunteer Services has been established. A total of 4,000+ volunteers participate in the volunteer programs throughout IH. A Volunteer Management Council is in place.
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities and make improvements. A comprehensive Quality review tool has been developed to guide operational decision making processes.
The team develops standardized processes and procedures to improve teamwork and minimize duplication. The interRAI provides a comprehensive standardized assessment tool shared across the sectors to assist in appropriate service allocation and care planning.
The team shares the assessment with the client, family, and service providers in a timely and easy-to-understand way. The interRAI assessment is completed as part of a collaborative assessment process and shared with other care teams.
The team obtains the client's informed consent before providing services. Consent is not obtained in a formal process however it is documented in clinical notes. Clients must sign a formal consent to having financial information disclosed in Long Term Care and Palliative Care.
The team educates clients and families about their rights, and investigates and resolves any claims that these rights have been violated. HCC handout is distributed to all clients upon admission to CC programs. Patient Safety Learning System (PSLS) is a formal safety event recording and reporting. An internal complaint mechanism is available for clients and families to access on the IH website. A patient care quality office is provided as an option to manage and submit complaints.
The team works with the client and family to identify service goals and expected results.
The team monitors whether clients achieve their service goals and expected results, and uses this information to identify and address barriers that are prevented clients from achieving their goals. As part of the admission, care planning, monitoring and InterRAI assessment process clients and staff collaboratively plan care and implement care strategies. Service plans are mutually developed and remain in the client's home.
Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety. Multiple risk/safety mitigation business practices are in place including the SAIL Program, Safety handouts on initial visit (Speak Up Listen Up Leaflet), Implementation of HARP (hazard assessment reduction plan) tool, pre-visit phone screen, clinical support tools to guide decision making regarding risk, active JOSH (Joint Occupational Safety and Health) committees across CC to manage risk and safety.

The team identifies and monitors process and outcome measures for its home care services.
The use of the InterRAI as a standard assessment tool provides outcome measures to guide clinical practice and resource allocation.
AMBULATORY CARE SERVICES (RENAL SERVICES) Episode of Care 9.4: When clients are incapable of giving informed consent, the team refers to the client's advanced directive or obtains consent using a substitute decision maker. An Advanced Care Planning team is developing further resources.

Overview by Quality Dimension

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	120	6	0	126
Accessibility (Providing timely and equitable services)	124	5	2	131
Safety (Keeping people safe)	435	79	8	522
Worklife (Supporting wellness in the work environment)	157	14	2	173
Client-centred Services (Putting clients and families first)	187	14	0	201
Continuity of Services (Experiencing coordinated and seamless services)	74	2	0	76
Effectiveness (Doing the right thing to achieve the best possible results)	634	71	9	714
Efficiency (Making the best use of resources)	60	7	2	69
Total	**1791**	**198**	**23**	**2012**

Overview by Standard Section

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

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	87	4	0	91
Effective Organization	94	9	1	104
Infection Prevention and Control	93	6	3	102
Managing Medications	100	35	0	135
Mental Health Populations	69	0	0	69
Ambulatory Care Services	97	15	8	120
Cancer Care and Oncology Services	97	12	0	109
Critical Care Services	85	23	1	109
Emergency Department Services	95	9	1	105
Home Care	85	18	0	103
Long Term Care Services	110	9	0	119
Medicine Services	95	9	0	104
Mental Health Services	108	0	1	109
Obstetrics/Perinatal Care Services	109	8	2	119
Operating Rooms	95	7	0	102
Public Health Services	100	5	5	110
Rehabilitation Services	91	12	0	103
Reprocessing and Sterilization of Reusable Medical Devices	81	15	1	97
Surgical Care Services	100	2	0	102
Total	**1791**	**198**	**23**	**2012**

Overview by Required Organizational Practices (ROPs)

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

Criteria	Required Organizational Practices
Infection Prevention and Control 1.2	The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends, and shares this information throughout the organization.
Infection Prevention and Control 6.5	The organization evaluates compliance with accepted hand hygiene practices.
Managing Medications 3.6	The organization evaluates and limits the availability of narcotic (opioid) products and removes high-dose, high-potency formats from patient care areas.
Managing Medications 10.2	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.
Managing Medications 18.3	The team uses at least two client identifiers before administering medications.
Managing Medications 19.4	Staff and service providers receive ongoing, effective training on infusion pumps.
Ambulatory Care Services 4.5	Staff and service providers receive ongoing, effective training on infusion pumps.
Ambulatory Care Services 8.3	The team reconciles the client's medications as part of the assessment process, with the involvement of the client.
Ambulatory Care Services 12.2	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Cancer Care and Oncology Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Cancer Care and Oncology Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Critical Care Services 4.4	Staff and service providers receive ongoing, effective training on infusion pumps.
Critical Care Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Critical Care Services 11.5	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Emergency Department Services 4.5	Staff and service providers receive ongoing, effective training on infusion pumps.
Emergency Department Services 8.3	The team reconciles the client's medications following triage, with the involvement of the client.

Criteria	Required Organizational Practices
Emergency Department Services 9.4	The team uses at least two client identifiers before providing any services or procedures.
Emergency Department Services 10.5	The team reconciles medications with the client at referral or transfer and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Home Care 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Home Care 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Home Care 11.4	The team transfers information effectively among service providers at transition points.
Home Care 15.4	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Long Term Care Services 4.5	Staff and service providers receive ongoing, effective training on infusion pumps.
Medicine Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Medicine Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Obstetrics/Perinatal Care Services 7.11	The team reconciles the client's medications upon admission to the organization with the involvement of the client.
Obstetrics/Perinatal Care Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Obstetrics/Perinatal Care Services 16.3	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Rehabilitation Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client.
Rehabilitation Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Rehabilitation Services 15.2	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

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

Findings

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

Planning and Service Design

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

Surveyor Comments

The organizations mission, vision, values are principles are well documented and shared throughout the organization.

Strategic planning is based on the General Letter of Expectations from the Ministry. This Letter of Expectation informs health service planning. Health service planning is completed by seniors leaders with input from a variety of areas. The service plan is organization wide and subsequent service alignment plans are developed by each of the service delivery areas. The input and completion of clinical service plans is variable throughout the organization. There is a need to continue to support clinical teams, networks and others in developing their plans and specific goals and objectives. This has been noted in several of the episodes of care assessments.

In some areas, it was identified that as capital and program expansion plans occur, there is a need to consider front line staff input and a complete system impact analysis.

The governing body noted that information received is timely and accurate. Of note that if additional information is required by the Board, it is always quickly made available.

The organization's community profile is accessible to partners and staff. During a partners interview however, it was noted that many partners were not aware of the reports. There is an opportunity to enhance communication and collaborative planning through increased sharing of the community profiles.

Community development and the promotion of health and wellness is evident in many activities throughout the organization. There are however, opportunities to enhance the consideration of this work across the continuum as structures evolve to further the integration of services. Matrix structures are complex and have been evolving to meet changing service delivery needs and achievement of operational plans. The organization is interested in further developing services across the care continuum such as primary prevention, primary care, acute care, community care and long term care. There may be opportunities to further develop structures that will address this issue. This is of considerable importance when addressing health disparities.

The organization is committed to reaching out to populations such as the Aboriginal community, who may encounter barriers to accessing health services. Public health services are encouraged to consider innovative and community driven ways to further this work.

Public health services are commended for their population health planning and use of program logic models which guide the development and implementation of public health operational plans. When communicating with various stakeholder groups, public health services are encouraged to tailor their strategies to specific populations with a focus on high needs groups where traditional communication strategies may not be effective.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders support and participate in ongoing community development to promote health and prevent disease.	2.4	
The operational plans identify the resources, systems, and infrastructure needed to deliver services and achieve the strategic goals and objectives.	4.4	↑
Public Health Services		
The organization regularly assesses the effectiveness of its communications strategies and uses the results to make improvements.	5.5	

Resource Management

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

Surveyor Comments

The organization has well defined processes in place to address resource allocation including operating and capital planning and monitoring. Reports are flexible, extensive and tailored to meet the needs of all levels of the organization. This is commended given the complexity of the organization and the need to address the resource and accountability requirements across the various domains of the matrix (i.e Health Service areas and networks/programs/departments). Financial reporting is linked with other performance indicators in some areas, thus providing relevant information when addressing resource allocation issues at all levels of the organization including local departments, health service areas, the senior executive team and the Board. An internal auditor position is in place and supports key internal audit processes. This position is directly accountable to the CEO and the Board.

Of interest is that several teams and staff were asked to identify a major ethical challenge currently confronting the organization. Repeatedly, the issue of resource allocation was identified. This is of concern especially related to current financial restraints. The organization is encouraged to continue to utilize the values it has adopted in making these difficult decisions. Criteria used to make these decisions are often provincially driven and yet, in several areas, leaders and the governing body have been innovative in addressing needs. An example is the current work underway to address cardiac services in the region and how resources were identified and allocated. Some staff and the Board noted the difficult matter of ensuring that primary prevention activities are not eliminated. Again, further coordination of these services in addressing the continuum of care may assist in ensuring that these services are not marginalized.

Also of note has been the inclusion of information related to financial policies, procedures, report reading and interpretation and many other key financial and resource allocation issues in the 'first 100 days orientation' process. This not only provides an excellent resource to all new managers but also provides an ongoing support to all leaders in the organization. The organization is planning to move towards increased interactive learning modalities. This is supported.

Of note has been the need to address physician engagement in many of the organizational processes. The Capital Planning priorization process now includes the seeking of advice from medical staff. This is an important consideration as regional and local physician engagement strategies evolve.

Partnerships are also in place with various community organizations. Of particular importance are the linkages with the 7 Regional Municipal Boards.

Lastly, the organization is commended for its commitment to the environment. A 'Green Travel Policy' has recently been implemented and staff have been supported with technology to attend meeting via phone, teleconferencing, and video conferencing.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

Members of the Board are appointed by the Ministry. The Board has however, developed a listing of criteria to assist with the process. These criteria consider the need for diversity (including geographic) as well as skill mix. A Board orientation process is in place and supported by a comprehensive manual. The manual clearly identifies roles and responsibilities as well as terms of reference for each of the Board positions and committees.

A Board evaluation process is in place. Board process improvements have been made as a result of the evaluation.

Key organizational performance measures are tracked and reported regularly using a Balanced ScoreCard approach. Also of note is that these key measures are linked to the organization's strategic priorities and constitute the CEO performance measures. These subsequently are used in the CEO evaluation processes.

The Board demonstrated a solid understanding of their governance role and their role in the selection of senior staff. Given the current unique situation of key staff vacancies, the Board has provided additional guidance in the selection process.

Interior Health, collaboratively with other health regions in British Columbia is evaluating which approach it wishes to take in monitoring the quality of work life culture throughout the organization. This work is encouraged with a decision in the near future.

A Human Resource (HR) Committee of the Board is in place. Regular reports are provided that address activity updates, including an HR ScoreCard, and an update on the action plan which is driven by the overall HR plan. The Organization's "People Plan" drives the HR action plan and has had the input of leaders throughout the organization. Further, an HR operational strategy (updated August 2009) is in place. This document provides additional detail in addressing key success factors and organizational enablers required to meet and sustain excellence in Human Resource Management. The team is commended for this work.

Issues related to performance evaluation have been addressed. The organization has used its values and principles in developing a system wide approach to updating all position profiles and fully implementing employee evalution/performance management processes. Plans are in place to now implement these activities across the organization. It is apparent that some areas of the organization have begun this implementation while others have not yet addressed performance evaluation issues.

Staff training opportunities are numerous. Of note is the organization's commitment to leadership training and support of staff who wish to experience alternate position opportunities. Plans are underway to expand e-learning opportunities. This is encouraged and felt to be of utmost importance given the geography of the region. Leadership, Learning and Organizational Development is one of the key themes in the human resource operational strategy.

Recruitment and retention efforts have been numerous and innovative. Commitment to teaching and supporting learning opportunities is evident throughout all aspects of the organization. Specific attention has been paid to work life balance. An excellent example of this has been the implementation of self scheduling tools. This has enabled staff to schedule their work hours in consideration of their life commitments. Another excellent example is the organization's commitment to flexibility in creating part time positions and job sharing where appropriate.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization monitors the quality of its worklife culture using the Worklife Pulse Tool.	8.7	
The organization administers the Worklife Pulse Tool at least every three years.	8.7.1	
The organization does not have any unaddressed priority for action flags based on their most recent Worklife Pulse survey results.	8.7.2	

The organization's leaders share the results of the Worklife Pulse Tool and use the results to make improvements.	8.8	↑
The organization's leaders develop and regularly update position profiles for each position.	12.5	
The organization's leaders regularly evaluate reporting relationships and managers' span of control.	12.8	
The organization's leaders implement policies and procedures to monitor performance.	12.9	
Sustainable Governance		
The governing body has a decision-making process that addresses how to resolve conflicts or disagreements, how to use group decision-making effectively, and how to analyze and learn from past decisions.	6.10	
The governing body regularly assesses its own team functioning using the Governance Functioning Tool.	7.4	
The governing body provides an annual, formal statement of its achievements.	7.5	↑
The governing body oversees the recruitment and selection of the organization's clinical leaders, e.g. Chief Medical Officer, Chief Nursing Officer, leaders in infection prevention and control.	9.2	

Integrated Quality Management

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

Surveyor Comments

Interior Health has developed an extensive and effective integrated quality management structure. Quality Management is clearly supported by the governing body supported with a corporate quality committee. A Quality Care Committee of the Board is also in place. Further, quality committees are in place to support quality management within the matrix structure. Examples include quality structures in each of the geographic service areas as well as horizontally across service networks. Impressive is also the recognition that quality management needs to support another dimension, namely areas that cross over several service areas as well as geographic areas. For example, as professional practice guidelines evolve, quality management principles are applied.

Data are collected throughout many areas of the organizations. A Balanced ScoreCard is developed on a regular basis and reported to senior leadership and the governing body. Key provincial indicators are reported as required and the British Columbia Health Quality Matrix is applied. Trend analyses are completed in many key areas.

A provincial patient safety reporting system is in place throughout the region. Of note has been the increased reporting of incidents. Staff report feeling comfortable in reporting incidents and increasingly so, near misses. A recent survey of staff confirmed that the culture of the organization has been progressively supportive in this area and that there is increasing trust that all issues will be dealt with in a constructive and learning manner. Trend analyses are completed using the incident reporting data. Investigations and findings are reported for each incident. These are available for staff, and managers are supported in sharing findings and using these experiences in a positive learning manner.

Open disclosure polices are in place and clear examples were provided where disclosure to patients and families has occurred.

Quality improvement and risk management is well integrated across the organization. LEAN education and subsequent activities have also occurred. Excellent examples were noted at the Kelowna General Hospital, such as the narcotic drawers on acute care wards, and the 4A/4B work area management.

Patients and families are, and continue to be encouraged to take an active role in patient safety. An excellent example provided has been the efforts to engage patients in ensuring that wrist band identification is accurate and in place at all times. Posters and patient reminders are evident throughout. Audits of missing wrist name bands has demonstrated significant improvement.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

The values developed and adopted by the organization came through input from all areas of the organization. The extent of the consultation process is commended. Also commended is how the organization then developed a detailed communication plan to ensure that all stakeholders and staff are fully aware of the values. This was confirmed through the site visits made. The values of Interior Health are much more than statements. A Values Implementation plan has been developed and implemented. Tracking of how the values have guided key decisions is underway. Numerous staff interviewed were able to quickly identify how the values have guided major issues such as resource allocation and clinical ethics decision making. Well done!

Access to research is available throughout the organization's library services and reports on the intranet. Communications staff noted the need to improve the accessibility to internal research activities and results. This is encouraged.

A clinical ethics framework is in place as is one to address research ethics. Work is currently underway to explore opportunities to link the research ethics process with an academic institution. This is supported.

An organization wide ethics committee is in place as are ethics committees in each of the service delivery areas. Awareness strategies have been implemented to some degree. An excellent example was provided by renal staff as to how these resources have been accessed and utilized in addressing difficult clinical decisions. Interviews with staff throughout the organization and across numerous clinical teams indicated however, a lack of awareness of these supports as well as a lack of understanding of the importance of clinical ethics supports. There is a need for ongoing work in this area.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders build the organization's capacity to apply the ethics framework by encouraging the governing body, leaders, staff, and service providers to develop and enhance their ethics-related knowledge.	5.8	↑

Communication

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

Surveyor Comments

A communication plan (2008/09 - 2010/11) is in place and clearly identifies 5 strategic objectives, associated expected outcomes and planned initiatives. The plan has been recently reviewed and updated.

Of note is the communication structure which supports internal and external communication needs throughout the organization at the system level, and at the geographic and the program/service levels. The communication staff are commended for their remarkable flexibility in supporting the strategic communication needs of the many programs and services. An excellent example where this support and expertise has been effective and is much appreciated is the Outreach Urban Health team.

Promotion of the values of the organization is evident in all areas.

Processes, policies and procedures are in place to guide staff in many communication activities.

The governing body is committed to transparency. Board members noted that guidance and support is provided by staff when communication requests are made to Board members.

Information management systems are planned and implementation executed using project management principles and approaches. For example, the Connex implementation currently has 30 implementation projects within it. Each of these has a communication strategy. Staff ensure that these communication strategies are complementary.

An internal 'Insidenet' (Intranet) is in place and is host to a myriad of information items for all staff. Internal tools are many on this site. Interior Health also hosts an extensive external website. The staff note the need to update the format of these sites to improve ease of access to information and locating specific items as required. This is encouraged.

Research and best practice information is accessible to staff on 'Insidenet'. There is a need to further enhance the scope of content in these areas such as posting all organizational research activities.

Staff/stakeholder satisfaction questionnaires are routinely done within reason. Stakeholder feedback can also occur via e-mail feedback.

Interviews, site visits, and conversations with staff during tracer activities confirmed teams desires to move forward in several areas such as:

- enhancing the posting of research results and clinical guidelines
- investigation of enhanced communication methods to reach out to medical staff, both internal and external to the organization
- continuing to deliver flexible communication approaches which are targeted to specific community stakeholders thus using communication to support the development of working relationships with community partners and residents
- further enhancement of the intranet and internet sites to improve location of information.

No Unmet Criteria for this Priority Process.

Physical Environment

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

Surveyor Comments

Construction projects are underway to help address issues regarding shortages of clinical space/beds. Interior Health Authority uses a Marsh Canada facilities review process to assist with the assessment of facilities plus the subsequent prioritization of maintenance projects. In September 2009, the Board received a presentation from its staff on the Enterprise Risk Management process which helps the Authority to identify risks, prioritize them and list the measures needed to be taken to improve the management of this risk. Enterprise Risk Management also facilitates the embedding of risk management in the functioning of the region.

It is noted that there is a focus on environmentally friendly initiatives. For example, one facility is cooled using circulating lake water. Other sites are utilizing geothermal methods of heating/cooling. The region has been using LEEDS gold standards for measuring compliance of new construction to environmental standards.

There are significant efforts to ensure the physical safety of staff and patients/ residents. Security staff, while not employees, do have to meet training standards. Provincial standards for security officers are observed.

Fire alarms are tested monthly and drills are held monthly on various shifts. There is annual training on the operation of fire extinguishers and every six months the board receives a report on fire drills that have been held in the Authority.

An emergency priority and contingency budget is in place. The last VFA report was conducted in 2003 and reported that the system needs updating. Processes are in place to handle biomedical waste.

Facilities are well maintained and clean. There is involvement of Public Health Inspectors.

Some sites are being built utilizing a P3 approach. In two sites (Kelowna General Hospital & Vernon) a major construction project is underway utilizing the P3 approach. The existing site's maintenance staff are being led by the contractor. There appears to be a smooth transition to this new structure. It was noted at both construction sites that the use of appropriate signage to inform public and employees of the projects, is in place. It was noted that at Vernon an employee was assisting traffic to find appropriate parking which assisted in decreasing any frustration or confusion that could have occurred without the assistance of this employee.

Attention to WHMIS sheets need to be strengthened as they are currently only sent from the regional warehouse upon request.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

There are plans in place for disasters and emergencies. There are a number of on call systems in place to facilitate accessing key people regardless of when they are needed. There are good linkages with other agencies, for example, a forest fire resulted in the evacuation of a community including a large nursing home. Key staff were promptly contacted as they were on call.

In August 2009, a fire near Brookhaven necessitated the evacuation of the facility with residents transferred to the Cottonwoods facility. The evacuation occurred in the middle of the night as necessitated by the danger of a forest fire reaching the facility. Staff worked well together at both sites to evacuate and receive the residents. Considerable efforts were made to make the temporary residence comfortable for the residents from Brookhaven. While the physical facilities may have been less than ideal the residents (both permanent and those from the evacuated site) were well cared for. There were extraordinary efforts of maintenance personnel to address a non functioning air conditioning system through an innovative, and creative solution involving city water. This was at a time when the temperature was very high. The presence of the Emergency Operations Centre in the receiving facility (Cottonwoods) was very well received by site staff.

While preparedness plans are in place, further work is needed to continue the preparation for the anticipated H1N1 outbreak.

The Interior Health Authority has an extensive on call system for key personnel and key functions. For example, when a number of managers/leaders were required to respond to the emergent evacuation of a special care home, this call system was implemented.

It is noted that in the rented space for community based programming, the site owner complies with provision of fire extinguishers and doing drills.

The degree of preparation of sites for reasonably anticipated disasters does vary throughout the region. The response of staff to the evacuation of a long term care facility in West Bank (Kelowna West) was good.

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

Criteria	Location	Priority for Action
Effective Organization		
The organization's leaders regularly test the organization's disaster and emergency plans with drills and exercises.	11.8	↑
Emergency Department Services		
The team participates in regular practice drills of the emergency preparedness plan.	2.6	↑
Public Health Services		
The plan has been tested through one or more simulations within the past year.	14.10	↑

Patient Flow

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

Surveyor Comments

There is a group of clinical leaders who are leading efforts to address bottlenecks in patient flow. They are initially focusing on emergency departments. They have a number of initiatives underway, and many are developed to address specific needs and/or issues of specific sites. Good work is being done but more needs to be accomplished.

Penticton General Hospital is one hospital that has expended considerable energy and creativity to address the problems of overcrowding in the emergency department. The increase in hours of physician coverage in the emergency department including overlapping coverage at mid day has along with an alternate payment physician model, helped to address their overcrowding situation. They are now meeting 80% of the time, their benchmark of 10 hours, from decision to admit, until a bed being available.

It is noted that the addition of two convalescent beds in residential care, and a community home IV program at residential sites have avoided hospital admissions. Plus, the use of tracking sheets for potential weekend discharges that led to access to home oxygen therapy on weekends has also avoided acute admissions. A number of other initiatives including the opening of 5 psychiatry beds, additional staff, plus participation in a provincial pilot site for the creation of a division of family practice are helping with over crowding or are anticipated to help the patient flow challenges.

While a discharge planner is not present at all sites, there is evidence of considerable staff collaboration to address the lack of acute care beds. Penticton General Hospital staff is one example of leadership and employees working extremely well together to enhance patient flow and minimize patients being inappropriate beds such as admitted to the emergency department.

Vernon Hospital cancels less than 2% of its elective surgical slate. However, there is overcrowding of patients such as there are some patients housed in an area that was previously a physical therapy area. It is noted that the surgical preoperative preparation approach helps patients feel much more comfortable going into their surgical experience.

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

Criteria	Location	Priority for Action
Emergency Department Services		
The team has strategies in place to effectively manage overcrowding and surges in the Emergency Department.	2.3	

Medical Devices and Equipment

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

Surveyor Comments

The organization has many initiatives planned as a result of internal audits that they conducted in 2007-2008 (Audit of Critical and Semi-Critical Medical Device Reprogramming - report Feb 2008). Part of the organization's action plan will be presented to Government in February of 2010. This includes operational service plans, core competencies and associated education and training. The internal audit and MDR team have self identified many improvement opportunities and associated practice changes as part of their prospective analysis work. At this time, many practices are site based and at times inconsistent with IH wide policy (flash sterilization for example).

For example, in Trail, flash sterilization is used much more frequently than in other sites visited or interviewed (Fernie, Cranbrook, Golden, Kelowna), this is largely and reportedly due to equipment/inventory shortfall.

In many environments there was evidence of local problem solving and quality improvement initiatives. In addition each area was able to follow key IH wide policies but in some cases this was made more difficult due to the variability that exists between their mostly manual systems. An example would be the ability to recall equipment in the event of a problem with sterilization, in each case, using the manual records the CSD staff were able to trace the sterilization of equipment sets back to individual patients, but this often took some detective work.

With flash sterilization there was inconsistency between sites as to the information recorded at the point of "flash sterilization". In some sites, patient labels were affixed to the sterilization record and in others this was not the case. In some cases, an entry in the OR information system identified the type of equipment "flashed" and the reason (Cranbrook had this) and in others it did not (in Trail). Records from the flash sterilizer were pulled and there was not a corresponding entry in the Patient's OR record despite there being a space in the record specifically for this purpose.

A staff member was involved in reprocessing (independently) and had not yet completed their reprocessing course, they were enrolled but still practiced independently and unsupervised.

Many of the staff working in Cranbrook and Fernie are long standing employees. Some records for some employees could not be produced when requested, nor was there verbal or written evidence of continuing competency evaluations.

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

Criteria	Location	Priority for Action
Operating Rooms		
The operating room team appropriately contains and transports contaminated items to the reprocessing unit or area.	12.5	↑
Reprocessing and Sterilization of Reusable Medical Devices		
The organization collects information at least annually about service volumes and patterns of medical device use.	1.1	
The organization reviews its operational plan and the information it collects about service volumes and equipment use to decide which sterilization and reprocessing services are offered within the organization.	1.2	
The team works with others in the organization to limit the use of flash sterilization to emergencies only, and never for complete sets or implantable devices.	1.3	↑
Supervisors and staff members involved in reprocessing have completed a recognized course in reprocessing and sterilization.	2.4	
The organization conducts baseline and annual competency evaluations of staff members involved in reprocessing and sterilization.	2.5	
The organization documents and retains records of education, training, and competency assessments.	2.7	
The organization regulates the air quality, ventilation, temperature, and relative humidity, and lighting in decontamination, reprocessing, and storage areas.	3.5	

When establishing or updating the team's infection prevention and control policies, the team works closely with the organization's IPAC staff, team, or committee.	4.2	
The team writes its SOPs in a clear, concise, and consistent way.	4.4	
The unit or area's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	5.2	↑
The organization maintains a dedicated bank of neurosurgical and ortho-spine devices.	11.4	↑
For each recall, the team issues a written, complete notification to all areas of the organization that use reprocessed medical devices that identifies the items to be recalled and the actions needed to recall the items.	11.7	↑
The team issues a complete and written report of all recalls.	11.8	
The team follows a policy to retain recall orders and reports in its files.	11.9	
As part of the quality management system, the reprocessing team engages in an annual review of reprocessing and sterilization activities, with formal reports provided to the organization's senior management.	12.2	

Horizontal Integration of Care

Findings

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

Chronic Disease Management

Integration of services to meet the needs of populations across the continuum of care.

Surveyor Comments

This team operationalizes the values of this organization.There were numerous examples where the value of respect was portrayed.

Measurable goals are developed. Many of these goals are determined provincially.

This team is able to identify gaps in service.

Mental Health Advisory Committees are present at sites.

Quality of service by partner organizations is monitored through processes identified in contracts.

Rural site partners say they are involved in development of programs or program change based on needs.

The Urban Outreach Program is a good example of a program where clients are assisted in finding the program most appropriate to their needs.

Significant evidence of many leaders in this program. There is truly impressive psychiatric leadership in all program areas.

Partners in Kelowna say that IH needs to take a leadership role in the provision of integrated mental health and addictions services in this area.

RCMP and IH mental health team meet regularly in most jurisdictions.

Mental health and addictions are well integrated with primary care physicians.This is a truly impressive integration and is unique in the country.

Many examples of staff being very clear about their scope of practice and working to that scope.

There appears to be good communication throughout the system. However partners said they would like more communication but mainly referenced same with respect to administrative structure rather than providers.

Partners said that peer support workers and their roles are not well understood by case managers.

Some partners said they would like to have more access to mental health training sessions offered by IH.

There are good examples of programs developed in response to need. (Riverview devolution)

The organization is encouraged to increase consumer involvement in all aspects of program planning, implementation and evaluation.

There are programs in all sites which are focused on the needs of the seriously and persistently mentally ill.

Many examples of partnerships in service delivery such as CMHA and Housing.

Good interdisciplinary team involvement.

Evidence of single access at some sites and also evidence that if IH is not able to provide the service there is appropriate referral to their service providers.

No Unmet Criteria for this Priority Process.

Population Health and Wellness

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

Surveyor Comments

Strengths:
Due to fiscal constraints, the Public Health team has relied heavily on partnerships with other organizations and services, as well as the community development process in order to meet a gap in services in the community. As a result, a wide variety of services are being delivered through a rather limited pool of individuals.

The Public Health team has received several awards over the last few years, including two Premier's awards in the areas of sewage reduction and food safety.

The team is beginning to use the Program Logic Model for some of the Core Public Health Programs as a means to plan and evaluate each program area.

The team is beginning to use tablets for inspectors in the field to use in order to collect information. The team is encouraged to continue to examine technology solutions to streamline processes, collect data, and the integration of information with other systems used in the organization.

Areas for Improvement:
The Public Health team is encouraged to develop innovative ways to promote its services to the various communities that it serves, especially the hard to reach populations. By relying on word of mouth and the web as communication strategies, the team is potentially missing communities, families, or individuals who would benefit from services.

The Public Health team is heavily engaged in continuing to plan its response to the H1N1 pandemic. The hand washing promotions are not very visible at the sites visited. Eye catching posters with instructions should be displayed at key entry points. The team is encouraged to proactively promote the primary prevention strategies for the H1N1 pandemic.

Recognizing that public health priorities are mandated from government and that the organization is facing fiscal challenges, the Public Health team is encouraged to continue to action the priorities in the public health plan.

The team is encouraged to examine other communication mechanisms other than reliance on website and pamphlets in order to provide information to the public.

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

Criteria	Location	Priority for Action
Public Health Services		
The organization investigates reports about public health issues or complaints in a timely way.	13.3	

The organization assesses satisfaction with public health programs and services.	16.3
The organization regularly assesses partners' satisfaction and the effectiveness of different partnerships in achieving priority public health outcomes.	16.4

Direct Service Provision

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

Findings

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

Ambulatory Care Services

Clinical Leadership

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

Surveyor Comments

The Integrated Health Centre in Penticton is an example of a successful model for management of chronic disease management for the renal, diabetic and heart failure patients. The team has engaged in a project with The Robert Wood Johnson Foundation at the Institute for Healthcare Improvement to Improve Self Management Support in an Integrated Chronic Disease Program with 8 US sites. The work completed with this project has been beneficial in improving the quality of care delivery for this population and it would be beneficial to spread the work from this across the IHARP.

Access to timely Nephrologists visits has been challenging within the IHA and patients remain on wait lists. One of the strategies that have been implemented to support the role of the Nephrologists and access to care has been the Advance Practice Nurse role. This role assists with access to care in rural areas by triaging new patients and developing plans of care including diagnostic work up etc. Feedback on the role has been positive and this has filled a gap in access to care for renal patients. Further exploration on ways to expand this service or other professional's roles to assist in intake and triaging to increase access to care across the IHARP would contribute to timely renal care with appropriate healthcare professional.

The implementation of designated leadership roles at the director level for the Renal Program has been successful in creating the opportunity and environment for dialogue for standardization of practices and spread across the IHA and enhancing alignment with the BC Renal Agency directions. Team members are actively engaging with colleagues across the IHA to share approaches, ordersets and protocols on best practices for the renal population.

Their is a need for programming in the home care sector to ensure patients who need support for pertoneal dialysis, especially new clients receiving appropriate care in the community rather than having frail patients return to the hospital setting for care.

My voice program is currently being piloted at the Penticton site for patients who can document their end of life request.

The care coordination role that has been implemented at the Vernon CDU site has been positive in supporting the staff and patient care needs.

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

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	
The team's goals and objectives for ambulatory care services are measurable and specific.	2.2	

Competency

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

Surveyor Comments

The IHA staff continue to verbalize challenges related to physician visibility and engagement in ambulatory clinic settings at specific sites. The use of Telemedicine has enhanced this and is well noted in Kamploops and Kootneys with regular physician led clinics using telemedicine technology. To ensure consistency across the IHA in using Telemedicine, equipment repairs to the system needs to be completed and build upon other successful implementation with telerenal across the IHA.

The educator at the Penticton site was seconded to develop education materials for staff especially in orientation; this material would be beneficial to all the programs in the IHARP to ensure standardized material and approaches to education.

There are several examples across the IHARP where staff have been given seconded opportunities for role changes and education to assume new positions. These opportunities are well received by staff and allows individuals to learn more about the health system and how they can influence care in different settings.

Staff have verbalized that they receive education related to infusion pumps, however, documentation of this is not consistently available.

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

Criteria	Location	Priority for Action
Staff and service providers receive ongoing, effective training on infusion pumps.	4.5	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.5.1	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.9	
The team has a fair and objective process to recognize team members for their contributions.	5.5	

Episode of Care

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

Surveyor Comments

The wait list for services and access to care at this point are being managed and patients do not have to wait for long periods prior to accessing care. Clinic visits in most cases can be managed within a 2-3 weeks from time of referral. The longest waits are for the Nephrologists.

There has been considerable work completed on the Ethical support in the IHA however often the understanding at the staff level by clinicians is inconsistent.

The medication reconciliation process has not been implemented in the IHARP. The team generates a medication list from the community pharmacy and PROMIS (Patient Records, Outcome and Management Information System) database and reviews with patients.

The team have focused on creating a more patient centred care approach. This is evident in the Dialysis Patients Bill of Rights.

The teams with the programs across the IHA are interdisciplinary and committed to quality care.

The Vernon site has completed a draft Clinical Practice Standard on Community Dialysis Unit Safety and Security (September 2009).

The team have identified the need to work collaboratively on complex renal patients who have other co-morbidity or behavioural issues. This work is important to complete at the site level where possible rather than transfer patients to regional centres for hemo dialysis.

The Shared Care Agreement between East Kootenay Internists and The Kootenay Boundary Nephrologists is a positive direction to support access to care and address gaps.

The Penticton Integrated Care Centre have expanded their services to include an cardio pulmonary wellness program.

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

Criteria	Location	Priority for Action
The team identifies, and removes where possible, barriers that prevent clients, families, service providers, and referring organizations from accessing services.	6.1	
The team monitors and works to reduce the number of clients who fail to present at scheduled appointments.	7.4	
The team monitors and works to reduce the length of time clients wait for services beyond the time the appointment was scheduled to begin.	7.5	
The team regularly reviews the needs of clients who are waiting for services and responds quickly to those who are in an emergency or crisis situation.	7.6	
The team reconciles the client's medications as part of the assessment process, with the involvement of the client.	8.3	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	8.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	8.3.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	8.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	8.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	8.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process upon admission.	8.3.6	
Medication Reconciliation at Admission	8.4	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	8.4.1	

The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	8.4.2	
When clients are incapable of giving informed consent, the team refers to the client's advance directives if available or obtains consent using a substitute decision maker.	9.4	↑
The team adheres to applicable legislation, organizational policies, accepted standards of practice, and codes of ethical practice when delivering services to clients.	10.6	
The team works with the client's referring service provider and other teams to manage pain experienced by the client outside of the ambulatory care environment, e.g. in the home.	10.7	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	12.2	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	12.2.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	12.2.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	12.2.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	12.2.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	12.2.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	12.2.6	

Decision Support

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

Surveyor Comments

The information from the BC Renal, IHA, and information from the PROMIS is used to support activities and program development for the IHARP.

The teams are becoming more comfortable with data and benchmarking themselves against each other as it pertains to renal care; the information from PROMIS is being used and continual focus on quality of entry will ensure that this information can be used with confidence to make changes in clinical and the overall program.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The leadership has been enhanced with the IHARP at the director level and this has had an impact in aligning the key priorities and activities of the renal program with the British Columbia Renal agency. The four renal programs within IHARP are working on standardized approaches to care and sharing best practices across the health authority and with other centres in BC. The alignment and structures that have been put in place are providing opportunities for support and engagement in the IHARP to enhance seamless care and accountability for resources.

PROMIS is being used across the IHA by staff in all areas to capture and document information related to the patients cared for. The PROMIS provides information that is used to identify funding from the BC renal and also is used to generate reports on key outcome indicators related to care (eg. catheter versus fistula rates) to further drive performance. Ongoing education and attention to quality with the date entered into PROMIS will enhance the utilization of the information in many areas related to renal care for the IHA.

No Unmet Criteria for this Priority Process.

Cancer Care and Oncology Services

Clinical Leadership

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

Surveyor Comments

Strengths:
The teams are site-based and they receive tremendous support at a site level. The teams also receive support and guidance from the BC Cancer Agency Community Oncology Program.

The Kelowna Oncology Inpatient Unit is acknowledged for their LEAN work. This involved redesign of their work environment, reducing clutter, reorganizing supply rooms and laundry supplies.

The team is committed and passionate about providing high quality and responsive care to cancer patients and their families. They ensure that care is managed across the continuum, including community services such as home care as well as hospice and palliative care. There are excellent linkages and collaboration between the community oncology outpatient sites and the inpatient oncology unit.

The team ensures that a high standard of care is provided.

The sites have been challenged with space issues but have been creative in re-designing their work flow.

The teams are acknowledged for their use of teleheatlh to support patient care, eg: Cranbrooks linkage with Vancouver Cancer Centre.

Areas of Opportunities:
The team functions as a site based model. There is no overarching plan. There is wide variances in nursing and pharmacy staff. They would benefit from being organized regionally in order to faciliate the development of a strategic plan and team goals and objectives; identification and monitoring of performance indicators and the opportunity to provide a forum to collectively utilize expertise, knowledge and best practice. Focus on this would support alignment with the health aurthority and the BCCA.

The team is being challenged with meeting the financial, human resource and physical space standards in order to meet the volume of service they are providing. Pharmacy services is being challenged with meeting increased volumes of chemotherapy preparation and outpatient medication dispensing.

The cytotoxic preparation area at the Vernon pharmacy is an open area adjacent to the Pharmacy and needs to meet standards for preparation of chemotherapy.

The area should be rectified as soon as possible. Furthermore, pharmacy staff at the Vernon site need to ensure that they adhere to wearing the appropriate protective equipment when in the chemotherapy preparation area.

The organization needs to ensure that the resources support the volume and level of service being provided.

Space for private and confidential conversations needs to be examined at all sites.

Governance and funding needs to be looked at. Clarity and articulation of accountabilities and responsibilities between the BCCA and IHA as it relates to the operations of the community oncology program needs to be explored.

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

Criteria	Location	Priority for Action
The team regularly reviews its services and makes changes as needed.	1.6	
The team works together to develop goals and objectives.	2.1	
The team's goals and objectives for its cancer care and oncology services are clearly written, measurable, and directly linked to the organization's strategic direction.	2.2	

Competency

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

Surveyor Comments

Strengths:

Staff participate in BCCA educational opportunities. They appreciate this calibre of education.

The teams provide excellent orientation programs for new staff. Each site team ensures that staff receive the necessary information and education in order to provide safe quality care.

Opportunities:

Managers have received performance appraisals however many front line staff have not had a recent appraisal.

It was noted that at the Vernon site, there was a concern about the gap in communication and coordination between nursing and pharmacy resulting in tension and frustration. When there are changes in how the provision of chemotherapy is scheduled or when the demand for service changes, it is important that nursing and pharmacy communicate with each other to ensure that they are aware of these changes and can make adjustments to work flow and processes if required.

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

Criteria	Location	Priority for Action
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.6	
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.8	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.8	

Episode of Care

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

Surveyor Comments

Strengths:
All patients receive comprehensive education prior to their first chemotherapy treatment.

Excellent patient and family information material has been developed by all sites.

The teams are truly interdisciplinary and value of contributions of all members.

They are dedicated and committed volunteers.

Patients are very happy with their care. They appreciate the open and honest communication. They are fully aware of how to access care after hours.

Areas of Opportunities:
To support quality and safe patient care, documentation of telephone advice is recommended. It was noted that telephone advice and discussions is not consistently recorded in the patient record.

The patients in Trail would welcome some dedicated parking spaces for cancer patients similar to the dedicated spaces for seniors, as they often have to walk a fair distance.

The medication reconciliation process has not been formally implemented within the Oncology Program. The BCCA has developed a medication reconciliation plan which the organization may wish to consider.

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

Criteria	Location	Priority for Action
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.4.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.4.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	

Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	

Decision Support

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

Surveyor Comments

Strengths:

The team follows the BC Cancer Agency (BCCA) evidence based practice guidelines.

The team maintains very detailed patient records.

They have excellent processes to ensure solid linkages across the continuum of care.

Opportunities:

All Community Oncology sites would benefit from having the Cancer Agency Information System (CAIS) available to them to facilitate access to patient information. There are plans to have CAIS implemented at all sites. An agreement has been developed between BCCA and IHA and is just awaiting final sign off from IHA in order for the CAIS system to be implemented at the remaining community oncology sites.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Strengths:

The BCCA provides some feedback and data to the site oncology teams. This feedback includes workload data and patient satisfaction. The team reviews the information from the BCCA to make improvements.

Areas of Opportunities:

The team is encouraged to monitor and review outcome measures.

The BCCA conducts satisfaction surveys including the collection of data from the IHA community oncology sites. The IHA community oncology sites are encouraged to share this information with patients, families and staff.

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

Criteria	Location	Priority for Action
The team identifies and monitors process and outcome measures for its cancer care and oncology services.	16.1	
The team compares its results with other similar interventions, programs, or organizations.	16.3	
The team shares evaluation results with staff, clients, and families.	16.5	

Critical Care Services

Clinical Leadership

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

Surveyor Comments

Throughout the region there are several interdisciplinary care teams focused on critical care services. Each of the teams were able to demonstrate strong clinical practices and innovations. A small team of clinical leaders, which was formed to prepare for the previous accreditation, has continued to meet to share information and address common issues. As this group has become more familiar with each other, their ability to respond to crisis situations and to engage in joint problem solving has grown. This is particularly evident when issues regarding critical care bed access arise. This group has been instrumental in implementation of the VAP protocol. Also of

note is the process used by this group to share innovative practices which have been developed in one unit and then spread the initiative to other units. For example, the Penticton critical care team developed a Rapid Response Team which used the staffing resources which were specific to their site. The model was used by the Vernon and Kelowna sites and with modifications to suit the unique features of each site, was implemented in both sites. This model of spread is an example of the "collaborative / learning" approach used on many occasions by this group.

At the site level, most - but not all - units have a clinical leadership group (ICU Committee, Interdisciplinary Team) which serves as the decision-making group for establishing goals, projects, protocols, etc. Effective physician leadership was evident in all sites. This group / team is the body which discusses equipment requirements, resource requirements and staffing levels. The team approach in each unit was clearly evident. The team members are to be commended for this.

At the regional level, there is a lack of a clear critical care services team. Each unit has developed its own approach and adheres to its own standards. It is encouraging to find that preliminary work has been completed to assess the nature of critical services being delivered including the challenges and opportunities facing Critical Care Services. To date, this work has included an analysis of the range of critical care services offered in the region, the number of critical care beds available, the staffing levels and the cost profile of delivering critical care services. The review has identified that variation exists across the region in the provision of critical care services. This review is still a work in progress and the team is encouraged to continue this work. The preliminary recommendations will address clinical standards and protocols, service structure, resourcing and performance management. The team is encouraged to continue its planning and development work.

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

Criteria	Location	Priority for Action
The team collects information about its clients and the community.	1.1	
The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.	1.2	
The team's scope of services is aligned with the organization's strategic direction.	1.3	
The team regularly reviews its services and makes changes as needed.	1.5	
The team works together to develop goals and objectives.	2.1	

The team's goals and objectives for its critical care services are measurable and specific.	2.2
The team has access to a service environment that promotes the comfort and well-being of the client.	9.4

Competency

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

Surveyor Comments

Although there is a lack of a regional critical care team, each site has developed an approach to staffing and development which addresses key success factors. It is impressive to note that there are relatively few critical care nursing vacancies. This is not a typical finding in Canadian hospitals. Although the communities in which these units are located are clearly attractive recruitment features, there are other factors which contribute to the recruitment and retention success of these units. A clear focus on orientation, staff development and clinical support roles such as clinical coordinators, etc, are just a few of the features which help attract and retain staff.

Orientation and continuing education services appear to be available for all staff. There is a strong group of active and committed nurse educators. In the larger sites, these educators have developed a number of methods of addressing the learning needs of the staff including learning packages, on-line education, in services, visual teaching tools, etc. Good record keeping is also evident. The rural sites are supported by the rural nurse educators who have an excellent reputation, but it appears that their area of service is vast. It was difficult to determine if their availability is in alignment with the learning needs of the staff in these sites. The approach to new graduate orientation is to be commended. This model shows support for the novice learner, providing a safe and graduated approach to the development of critical care skills. This model is certainly part of the overall success of the recruitment and retention of critical care nurses.

One area of concern relates to the approach taken with infusion pump training. Although all staff receive training for infusion pumps during orientation, only one unit (Kamloops) appears to have a process for assessing infusion pump skills / knowledge on an ongoing basis. Given the risk associated with IV infusions, the educators should consider how to address this required organizational practice.

The policy and process for completion of regular performance reviews is an evolving entity. Managers are struggling with the process and in some cases the sheer volume of reviews to be completed. The transition to an on-line process has created new challenges. The managers are encouraged to focus on this. The organization is encouraged to provide skills development opportunities for managers as they work to achieve this standard.

At the site level, there are clearly identified interdisciplinary teams. Team members have clear roles and responsibilities. Team development, in most sites, appears to occur through the process of daily rounds which serve both a clinical goal and a teaching goal. One unit (Penticton) has opted for a weekly rounds approach. Although all patients are reviewed by their attending team on a daily basis, it is not a formalized team round. This unit may want to consider if a daily rounds methodology would add benefit to team functioning.

Most sites have appropriate workspace for their team, or will soon have appropriate space, when unit construction/renovation is complete. An exception to this observation is the small unit in Salmon Arm. In this site, space significantly compromises team functioning. The organization is to be commended for ensuring that front line staff have been actively involved in the facility design planning process in both Kamploops and Vernon.

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

Criteria	Location	Priority for Action
Staff and service providers receive ongoing, effective training on infusion pumps.	4.4	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.4.1	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.6	
Team leaders regularly evaluate the effectiveness of staffing and use the information to make improvements.	5.2	

Episode of Care

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

Surveyor Comments

Based on client interviews in each site visited, the team is to be commended for their patient-centred approach to care. To quote one patient - "They treat me like a V.I.P." Patients feel that they are informed about their care, they understand their care goals and discharge plans. They report that their family members have received timely and relevant information. They have observed good hand hygiene practices amongst the staff. They offered a few suggestions for the team to consider. (1) Remember to speak in plain language as much as possible. (2) Include the patient in hand hygiene by offering hand sanitizer on a regular basis. (3) Long term ICU patients would benefit from social / recreational programming.

The sites are to be commended for their progress in developing standard protocols for key critical care scenarios. Of particular note are the AMI protocols which have been introduced regionally with the assistance of the Patient Safety Coordinator. The process of development and implementation involved key stakeholders, encouraging participation and ownership. The regional roll out has been successful. This model of protocol development and implementation will serve as a good foundation for future regional work. Also of note is the development and implementation of the regional No Refusal policy for critical care. There was clear evidence in all units of this policy. Although it will still require implementation support to ensure that all staff / physicians use the protocol appropriately, it is clearly a valuable patient care decision tool.

Although most critical care protocols have not been developed for regional use, many have been developed at a site level and have subsequently been shared with other sites. Implementation in other sites has been voluntary. Examples include protocols for sedation, sepsis, acute coronary syndrome, insulin infusion, etc. These protocols serve as key quality improvement tools. The team is encouraged to look at further opportunities to develop regional protocols and to evaluate the clinical outcomes associated with such tools.

Without exception, there was evidence of daily progress notes on all client charts. The team is to be commended for this practice.

Team members in most sites expressed frustration with the critical care transportation system. There are significant concerns with respect to the timely transport of patients to the appropriate critical care units. Delays due to coordination, transport availability, weather / road conditions, etc compromise the patient's access to timely and appropriate care. There does not appear to be disagreement about this issue between sectors of the organization and numerous approaches have been taken to resolve these very difficult issues. The organization is encouraged to continue in its efforts to find solutions. The teams are encouraged to measure the "time to critical care treatment" as a key indicator of access. On the other end of the critical care continuum of care, team members expressed concerns regarding the process for inter-provincial repatriation of critical care patients. Funding issues between provinces have, at times, left patients, who are unable to pay for critical care transportation back to their home province, stranded in Interior hospitals. The organization is encouraged to review this policy with a view to improving the patient's experience.

The team is encouraged to evaluate their approach to the use of standardized measures for pain assessment. Multiple scales appear to be in use (0-10, 0-5). Scales are not always used. Scores are not documented in a way which makes it easy to see if there are trends in pain control.

With concern, it is noted that at the Kelowna site, IV infusions and epidural infusions are administered using the same infusion pump. As a safety measure, epidural infusions should be administered with dedicated pumps, which are not used for any other purpose. The team recognizes this as a safety gap.

There is no evidence of a formal process for medication reconciliation. This required organizational practice should be addressed as a key safety process for implementation in all patient care settings. This will require a formal plan for the organization.

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

Criteria	Location	Priority for Action
The team uses standardized criteria to determine whether potential clients require critical care services.	6.2	
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	

The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.4.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.4.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process upon admission.	7.4.6	
Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team meets Accreditation Canada's recommended target for medication reconciliation at admission.	7.5.2	
A qualified team member fills the prescription and dispenses the medication in a timely and accurate way.	10.3	↑
The team follows the organization's established policies on storing and disposing of medications safely and securely.	10.6	↑
The team uses standardized criteria when determining whether to discharge clients from critical care.	11.1	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.5	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.5.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.5.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.5.3	

The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.5.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.5.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.5.6	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	11.7	↑

Decision Support

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

Surveyor Comments

Strong medical leadership was evident in each of the sites. Patient care is primarily managed by internists or intensivists. In some sites, other medical staff participate in patient care management.

Although there are different client record systems in each site, all sites were able to demonstrate comprehensive records easily available to all staff. There is evidence of documentation from all team members on the single patient record.

The Patient Safety Coordinator for Critical Care is a key facilitator for the development of evidence based guidelines for care. As the organization continues in its work to develop a regional approach to critical care, the coordinator will be able to play a more active role in the development of regional guidelines.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

In the absence of a regional team, there is no process for the team to identify goals or to identify resource requirements. This is currently accomplished at the site level. With the evolution of the critical care review, there is opportunity to create a regional team which can take on these essential planning activities.

The site teams, supported by the Patient Safety Coordinator, are to be commended for their implementation of the Safer Healthcare Now bundles, including VAP, Hand Hygiene, and Central Line Infections. The staff of the ICU's, in particular, are to be commended for their participation. The bundles are well understood by staff. Results are clearly posted for staff to review and there appears to be a process for review of data, issues and outcomes at staff meetings. The Hand Hygiene Champions have taken on a controversial role and seem to be achieving significant improvements in hand hygiene practices. Well done.

All site teams were very familiar with the process for reporting incidents, near misses and sentinel events. All were able to articulate the process for disclosing such information to patients. In fact, most staff seem very comfortable with the process and are aware of the policy and know how to access resources when a sentinel event occurs.

Although the team has an informal process for sharing data amongst other Interior Health critical care units, there does not appear to be a process or opportunity for a broader sharing of information with other partners such as other health authorities, BC Ambulance, etc. The nurse managers appear to be well linked with the national critical care nursing association. They recognize the value of participating in this national forum.

The team is encouraged to evaluate the overall quality and outcomes of critical care services. This should be developed at the regional level, ensuring that all units participate and are able to share results and developed shared solutions to any issues identified.

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

Criteria	Location	Priority for Action
The team identifies the resources needed to achieve its goals and objectives.	2.3	
The team shares benchmark and best practice information with its partners and other organizations.	14.4	
The team identifies and monitors process and outcome measures for its critical care services.	16.1	↑
The team monitors clients' perspectives on the quality of its critical care services.	16.2	
The team compares its results with other similar interventions, programs, or organizations.	16.3	↑

Emergency Department Services

Clinical Leadership

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

Surveyor Comments

Strengths:

Program Leadership: Within the strategic planning framework, information from the community regarding needs for Emergency services has been obtained from a number of sources including community focus groups. The regional network has developed a helpful inventory of services in rural sites on site by site basis. Service review is done regularly through the ED Coordinating Committee. There is a Terms of Reference for the Emergency Services Network. Exceptional leadership is apparent at the regional level.

Physical Space Planning: New departments are being developed for Kelowna and Nelson. Staff is involved in the planning. These innovations will respond to space needs well into the future.

Program Planning: An active network management team uses a variety of sources including benchmarking of daily work data to drive planning. Various data such as waiting times, left before being seen, percentage of patients exceeding the standard 10 hours of wait time to admission, are used.

Recruitment strategies: Through the Professional Practice office funding has been obtained to offer a four month emergency and critical care course to nurses interested in pursuing. This has resulted in significant improvement in the recruitment of nurses interested in this career path. The physician recruitment program in Kamloops has had positive results. Incentives offered by the communities (Red Carpet program), has had positive effects on recruitment.

Areas of Opportunities:
Isolation capability for ID patients: The more crowded departments struggle with this. At Nelson and Kelowna the department physical structure presents some problems with obtaining good isolation of infectious diseases patients. This will be improved in the new departments.

Services for Rural sites: Much has been done to support rural sites. Interior Health is encouraged to continue to grow these efforts. This applies particularly to Education programming both in direct patient care and support areas such as Information Technology. In these areas support may be described as uneven with some sites receiving excellent support while others struggle.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Strengths:
Patient flow Strategies: In the larger hospitals there are daily or more frequent meetings between the leaders in Emergency, Medicine and Discharge Planning to coordinate and problem solve regarding patient flow issues through the hospital. This process has greatly improved patient flow.

Orientation / Skills Enhancement: There is an excellent document entitled "IH Emergency Department Orientation Checklist" that is a comprehensive checklist for all new nurse hires in the Emergency Department. It also serves as the basis for annual skills review and provides direction for the annual learning plan for individual nurses.

Communication: "Sharepoint" is a tremendous resource for staff information, education opportunities, links with actual on-line courses and a private discussion portal for staff. it is a resource for communicating policy and procedure issues. This is a new resource being implemented presently.

Areas of Opportunities:
Although evidence of training on infusion pumps exists in many departments with regular documented training sessions, in some centres there is no documented evidence of ongoing training.

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

Criteria	Location	Priority for Action
Staff and service providers receive ongoing, effective training on infusion pumps.	4.5	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.5.1	

Episode of Care

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

Surveyor Comments

Strengths:
Rural access: After hour access in some of the smaller units (Sparwood), where staffing is not available is facilitated by a communication system whereby the patient can call another department (Fernie), which is staffed, receive advice or have a doctor or EMS service provider respond.

Prompt access to critical care in East Kootenay: In addition to CTAS, the EMS service in Kootenay East, (Cranbrook and Fernie), have implemented a process whereby the EMS service follows a Life, Limb, threatened Organ (LLTO) protocol in that they may notify STARS the Emergency medevac service in Alberta, prior to the ambulance arriving at the hospital site.

Intradepartmental information: The "Smartboard", a screen that documents what is happening for each patient in the units of the larger departments, is a valuable source of information for staff and consultants as well as a safety measure for patients. The screens though large and clear are strategically placed so that only staff can view information thereby maintaining patient privacy.

Patient Streaming: The patient streaming project has resulted in very usable information for benchmarking a number of data including patients who left without being seen, time to physician initial assessment, LOS data and patient satisfaction. This has been a powerful tool to improve patient flow through the larger departments such as Kelowna where there is significant pressure of patient volume in a physical space which is scheduled to be replaced. Coupled with congestion analysis on a daily or more often basis these measures have optimized patient flow in the Emergency and in patient services of the six larger regional and tertiary hospitals.The initiatives here have resulted in an award for the organization. At Salmon Arm and Vernon modified forms of streaming have been introduced with resultant improvement in patient flow and provider / patient satisfaction increase.

Areas of Opportunities:
Medication reconciliation: This is done at different levels in different departments in the region. At Kelowna a thorough process of medication documentation that supplements pharmanet information is followed by a comparative review of old meds and new meds that are being started. As yet data that follow Accreditation Canada protocols are not being gathered. At the rural pilot site in Fernie, there is a similar gathering of information, comparison but no data gathering. Kamloops is rolling out med reconciliation Grand Forks has been a pilot site. There is also uncertainty as to what direction the pilot project is now taking and when full implementation will take place.

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

Criteria	Location	Priority for Action
The team reconciles the client's medications following triage, with the involvement of the client.	8.3	
There is a demonstrated, formal process to reconcile client medications following triage.	8.3.1	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	8.3.4	
Medication Reconciliation following Triage.	8.4	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation following triage.	8.4.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	8.4.2	
The team reconciles medications with the client at referral or transfer and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	10.5	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	10.5.1	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	10.5.4	

Decision Support

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

Surveyor Comments

Strengths:
Standardized records: The standard emergency record across all sites greatly facilitates information recognition and transfer for patients going between sites.

Areas of Opportunities:
Staff IT education: Some frustration was expressed at a couple of sites regarding the availability of IT expertise from Interior Health for education purposes. An example provided was of incorrect order sets on Meditech because of inadequate training. It was pointed out that because education is offered only on a monthly basis, if a new staff is hired the day after the training takes place, she has to wait a month to get the training. This applies equally to updating of existing staff. Nelson and Trail have collaborated to do training at two weekly intervals so that staff can go between hospitals for training.

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

Criteria	Location	Priority for Action
Team members receive education and training on information systems and other technology.	12.4	

Impact on Outcomes

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

Surveyor Comments

Strengths:
Data benchmarking: Benchmarking of data is done consisitently in the larger departments as a means of facilitating patient flow and safety.

Adverse event reporting: The monitoring of near misses etc is greatly facilitated by use of PSLS reporting. However its use is compromised if the provider identification, patient identification and/or of date is absent in the report. This makes tracking and using the event for education almost impossible for the manager.

Strengths:
Although two client identifiers are generally used, this is not totally consistent. Identity armbands are encouraged for general use to function as a good second identifier along with verbal identification.

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

Criteria	Location	Priority for Action
The team uses at least two client identifiers before providing any services or procedures.	9.4	↑
The team uses at least two client identifiers before providing any service or procedure.	9.4.1	
Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	14.3	↑

Home Care

Clinical Leadership

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

Surveyor Comments

Strengths:
Staff state that they are very appreciative of having access to the supplies and equipment needed to deliver care.

Individual sites are prioritizing services to meet the needs identified in the communities that they serve.

Areas of Opportunities:
The leaders are encouraged to share and communicate more broadly the goals and objectives of its home care program. Staff awareness and involvement can increase the success of identified goals.

The team is encouraged to look at ways to find efficiencies in the processes currently used, using LEAN processes, or seeking out best practices in other parts of the country.

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

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	
The team supports student and volunteer placement on the home care team.	4.6	

Competency

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

Surveyor Comments

Strengths:
There is a guide in the chart kept in the client's home which outlines steps for staff to follow in the event of various emergencies or situations which could arise.

the team has a lot of resources for education and staff state that they are very proud of the Sharepoint program. Leaders are encouraged by the use of technology to enhance orientation and other development opportunities.

The staff feel that the SAIL (Strategies and Actions for Independent Living) program is a success and that the role of Home / Community Support Workers has been enhanced by this program.

Areas of Opportunities:
The organization should continue to seek the resources to enhance or maintain the multi-disciplinary approach used in the Home Care program, and should attempt to provide the same level of interdisciplinary support across the health authority.

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

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	

Episode of Care

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

Surveyor Comments

Strengths:
It is recognized that efforts are underway to use a standardized pain assessment tool across the continuum of care.

The team uses the Inter-Rai tool when conducting assessments and will be able to collect and monitor various indicators over time.

There are palliative care services provided at various sites, some of which use innovative approaches to collaborate and provide coverage in rural areas.

Areas of Opportunities:
The team is encouraged to continue to standardize processes and procedures to improve teamwork and minimize duplication within available resources.

Efforts should continue to implement the formal medication reconciliation process in the Home Care Program at all sites.

Although client consent is either implied or provided, the organization should consider the use of consent forms for all services provided to clients.

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

Criteria	Location	Priority for Action
The team develops standardized processes and procedures to improve teamwork and minimize duplication.	3.4	
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process upon admission.	7.4.6	
Medication Reconciliation at Admission.	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	
The team shares the assessment with the client, family, and service providers in a timely and easy-to-understand way.	7.8	
The team obtains the client's informed consent before providing services.	8.3	↑
The team educates clients and families about their rights, and investigates and resolves any claims that these rights have been violated.	8.7	↑
The team works with the client and family to identify service goals and expected results.	9.1	
The team monitors whether clients achieve their service goals and expected results, and uses this information to identify and address barriers that are preventing clients from achieving their goals.	9.9	

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6	
The team transfers information effectively among service providers at transition points.	11.4	
There is documented evidence that timely transfer of information occurs.	11.4.3	

Decision Support

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

Surveyor Comments

Strength:
Many research activities are currently underway in the Home and Community Care sectors within the Interior Health Authority.

Area of Opportunity:
The leadership team identified a desire to have a common medical record for all clients as their top wish for technology and information systems.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Strengths:
One of the teams is doing a pilot of taking pictures of the clients, with their consent, for use in the home chart and in the office. The picture then serves as one of the two client identifiers used prior to providing services or procedures.

The team uses an electronic system to measure and monitor progress of wound care.

Area of Opportunity:
The Home Care team may want to develop an easy-to-understand document to outline the role of the client in promoting safety. Clients should be encouraged to remind staff to wash hands if they do not observe this prior to receiving services or procedures.

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

Criteria	Location	Priority for Action
Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	15.3	↑
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	15.4	↑
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.4.3	
The team identifies and monitors process and outcome measures for its home care services.	16.1	↑
The team monitors clients' perspectives on the quality of its home care services.	16.2	
The team shares evaluation results with staff, clients, and families.	16.5	

Infection Prevention and Control

Infection Prevention and Control

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

Surveyor Comments

Evidence of feedback to staff in Cranbrook and Fernie re: infection rates lacking, for example, are not consistently available to staff, other than on the Inside Web.

IPAC education at regional orientation for all staff. Site based IPAC orientation for RN's only in East Kootenays.

Negative pressure rooms had mute alarms while in use.

In Kamloops, although one brand of brushless cleanser for OR use was well favoured by OR staff, a cheaper, less satisfactory product was purchased. Staff felt their input was not valued. There were also similar feelings in Salmon Arm.

At Vernon, extra instruments are not segregated from general pool after use in spine surgery.

This was also similar in Kelowna.

Patient and family education was not documented consistently in patient charting.

Strengths:
1. High functioning IPC officers throughout region.
2.Regional data collection.

Opportunities:
1. More physician involvement.
2. Ongoing and increased use of web seminars to reduce travel times and costs.

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

Criteria	Location	Priority for Action
The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends, and shares this information throughout the organization.	1.2	↑
Staff and service providers know the infection rates.	1.2.2	
Staff, service providers, and volunteers attend the IPAC education program at orientation and regularly thereafter.	5.4	↑
The organization evaluates compliance with accepted hand hygiene practices.	6.5	↑
The organization shares results from the audits with staff, service providers, and volunteers.	6.5.2	
Information provided to clients and families is documented in the client record.	7.3	
The organization verifies the qualifications and competencies of staff involved in reprocessing reusable medical devices.	12.1	
The organization maintains a dedicated bank of neurosurgical and ortho-spine devices.	12.14	↑

Long Term Care Services

Clinical Leadership

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

Surveyor Comments

Long term care staff are well connected with community staff. There is good evidence that comprehensive assessments are carried out when clients apply for admission. Information is shared with appropriate staff. Care plans are developed on each client and reviewed as appropriate. Goals and objectives are set with staff, resident and family.

Staff indicate adequate supplies are available to perform their job. Student placements are encouraged. Job descriptions are current and reflect full scope of practice. Staff verified that they work at full scope. There is evidence that pneumococcal vaccine has been discussed with resident/family and if not previously immunized, then encouraged to do so on admission. Evidence that this has been discussed.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

The educators at Polson Place are to be commended for developing a self learning package that can be accessed by all staff. It includes a number of modules. It is also used by supervisors when areas are identified that staff require additional training.

The health authority provides access to a number of online courses as well as a people management series that is available for managers.

Videoconferencing is available to most sites.

Ponderosa Lodge gives report at change of shift standing around desk. No designated space for staff to meet.

Job descriptions are complete and current.

Education is provided for staff when residents are admitted with new conditions or equipment. Ongoing education does not have the same priority in all sites.

Weekly meetings are held at all sites.

Professional licensure is documented, yearly. Minimum standards are in place for unregulated workers.

New staff recieve appropriate orientation. The 30 day program used at Polson Place is commendable (a self directed program that staff complete as part of orientation). Opportunity exists for staff to identify areas that require additional training.

Staff appreciation events are carried out in all sites.

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

Criteria	Location	Priority for Action
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.5	
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	
Staff and service providers receive ongoing, effective training on infusion pumps.	4.5	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.5.1	
The team monitors and meets each team member's ongoing education, training, and development needs.	4.8	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.9	

Episode of Care

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

Surveyor Comments

The organization has a good process in place to inform clients/families about services provided and expectations. An information package has been developed.

The first available bed policy has facilitated better access to beds, however some staff expressed concern that this creates additional work as some residents are in the facility for short periods and then moved, resulting in a lot of turnover.

Staff at Polson Place have found that the process works well.

A team approach is used to determine priority for placement. Emergency situations are given priority.

Assessments are completed on admission and care plans developed shortly after; family, resident and multidisciplinary team are involved.

Although medication reconciliation forms are still in pilot stage, the facilities have a process to reconcile meds at transfer points.There is evidence of this process.

Diagnostic services are available and timely.

Work is currently underway to implement a more appropriate tool to measure pain.

Care plans are reviewed as necessary or yearly at a minimum.

There is evidence at all sites that pressure ulcers are managed and preventive action is taken to prevent skin breakdown. Care aides are recognized for their role in identifying potential risk. Pressure ulcers are monitored and tracked.

Charts are complete and signed off by appropriate service provider.

Good access to pharmacists and mechanisms are in place to respond to after hours requests.

Medication errors are recorded and follow up is documented.

Staff at Westview Place have developed a process to ensure nitro patches are removed as ordered. A daily sheet is kept, listing all residents that have a patch. When patch is removed, it is attached to the sheet and recorded. The night nurse verifies.

Signed forms are on the chart to indicate CPR has been discussed.

Advance directives are documented and reviewed as appropriate.

Some sites have joint meetings with residents and family to discuss safety.

Large activity rooms are available at all sites, with organized activities in place.

One residential care site has recommended adding Vitamin C and D for all residents.

A formal ethics committee does not exist on site. However most sites have a process to deal with ethical issues and resources are brought in when necessary.

A good process exists to support residents and family at end of life.

An end of life sub committee exists at some sites.

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

Criteria	Location	Priority for Action
The team has a process to evaluate client requests to bring in or self-administer their own medication.	9.5	
Following transition, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition planning.	12.8	↑

Decision Support

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

Surveyor Comments

Records are well documented and signed off by appropriate discipline.

Info is shared with multidisciplinary team.

Information systems are available in all sites and training is provided to staff when new systems are implemented.

Staff have good access to research and best practice info. This info is used to develop guidelines and improve service.

Sites have not been involved with research activities but staff are aware of the process, should a request be made.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Staff receive training on appropriate methods of lifting and transferring.

Ceiling lifts are in most rooms and beds are low.

All sites would benefit from a program to update staff on TLR yearly.

Picture identification is used at all sites. Staff will verify with another team member when necessary.

Patient safety and risk is a high priority at all sites. There is evidence of this in care plans.

Falls prevention strategy has been implemented and a process is in place to review and improve as required.

Safety is discussed at all team meetings.

There is evidence that written info is available for clients and families.

Education is on going for high risk activities. A process is in place for staff to identify when additional support or training is required.

The new incident reporting system is very effective. Managers are using the data to review adverse events and follow up with recommendations for improvement.

A policy exists to disclose incidents to family.

When info is collected about the service, it is shared and used to make improvements.

Resident council meetings include an opportunity to discuss any concerns and opportunities for improvement.

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

Criteria	Location	Priority for Action
The team monitors clients' perspectives on the quality of its long term care services.	17.2	
The team compares its results with other similar interventions, programs, or organizations.	17.3	↑

Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

Overall, the medication management in the region is very good. There is a collaborative, multidisciplinary approach to care. A regional focus on improvement is very evident.

The Pharmacy and Therapeutics Committee (P&T) has undertaken a systematic approach to standardization across the region, while at the same time, considering local populations and needs. There is a focus on improvement in areas of greatest impact and highest risk to patients. Decisions of the P&T Committee are communicated widely. There are strong links with the local Patient Safety Committees. Comprehensive tool kits are developed to implement practice changes. There is an up-to date formulary available online to all staff, in hard copy to all areas, and to all physicians. Pre-printed orders are widely used throughout the region, and are recognized as an excellent prescribing and monitoring tool.

There is an excellent, system-wide program for reporting and tracking medication incidents. There are examples of medication incidents resulting in changes to practice to improve patient safety.

The medication distribution system is a mixture of automated dispensing with Pyxis cabinets, unit dose cart exchange, and ward stock systems using controlled dose cards in smaller facilities. This mixture of systems results in decreased efficiencies in workload, inefficient utilization of space, and lack of standard processes of medication administration. The region needs to consider a long range plan to expand the use of automated systems to maximize the use of technicians and improve safety and accountability in the medication administration system. In Oliver, the Computerized Physician Order Entry system (CPOE) and bar coding to the bedside with resultant paperless charting and MARs is to be commended. It is the only CPOE-bedside barcoding system in place in Canada.

The region is to be commended for its implementation of the centralized purchasing system. This has resulted not only in cost savings but in efficiencies in operations. Drug recalls, drug shortages, changes in formulary, can all be managed much more easily.

The preparation of sterile products in the region needs to be evaluated and a long range plan developed. The safety standards of USP Chapter <797> need to be incorporated into practice to minimize risk to patients. The current sterile preparation areas range from nearly meeting the standards, to being high risks areas. There is also large variation between sites as to the level of IV admixture provided. When planning for new programs, the IV preparation areas and resources need to be considered.

There have been some very good safety initiatives, but in some cases, there has not been a good uptake on implementation. Examples are the banned abbreviations and medication order writing standards. There are many examples in the charts of orders that contain unacceptable abbreviations or symbols, or are unacceptable orders ("meds as at home" or "meds as per Medicheck"). There are recent examples of significant medication errors due to the use of improper order writing. Prescribers and transcribers have to accept responsibility for improving their own practice.

The major challenge of the Medication Management system is lack of resources. The staffing level of pharmacists in the region is far below the national level as indicated in the Lilly Survey (Lilly Survey, 2009). This makes it difficult to roll out new procedures and to follow up to ensure the standardization. There is a wide appreciation of nurse educators, but it is felt there are not enough to keep up with the demands of all the changes. Pharmacists acknowledge that they are not practicing to the full scope of their ability as they spend a great deal of time in the pharmacy rather than in patient care areas. There needs be the infrastructure in place to maximize the use of pharmacy technicians. As well, any planning for expanding service in the region needs to be sure to include consideration of the resource level implications.

In spite of the challenges, there is an overall positive approach to medication management and a determination to continue to work collaboratively in the region to improve patient outcomes. All health disciplines are to be commended.

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

Criteria	Location	Priority for Action
The organization orients staff and service providers to the medication use process before they are permitted to work independently.	1.9	↑
The organization evaluates and limits the availability of narcotic (opioid) products and removes high-dose, high-potency formats from patient care areas.	3.6	↑
The organization has removed the following products: hydromorphone ampoules or vials with concentration greater than 2 mg/ml (exceptions include palliative care); and morphine ampoules or vials with concentration greater than 15 mg/ml.	3.6.2	

The organization places label enhancements or warnings on medication packages and storage bins with problematic names, packaging or labels.	4.3	↑
Medication storage areas are clean and orderly.	6.1	
The organization separates or isolates look-alike, sound-alike medications; different concentrations of the same medication; high-risk/high-alert medications; and discontinued, expired, damaged, and contaminated medications pending removal.	6.5	↑
The organization regularly inspects its medication storage areas.	6.7	
Medications for client service areas are stored in labelled, unit dose packaging.	7.4	↑
Unit dose oral medications remain in the manufacturer's or pharmacy's packaging until they are administered.	7.5	↑
The organization has a policy and process to manage medications brought into the organization by clients and families.	7.7	
The pharmacy establishes and follows a policy and process to monitor bulk chemicals which includes eliminating those that are not regularly used or that are considered dangerous.	8.1	↑
The organization complies with the Workplace Hazardous Materials Information System (WHMIS) regulations for bulk chemicals in the pharmacy.	8.2	↑
The organization securely stores anaesthetic gases in a segregated area with adequate ventilation.	8.4	↑
Prescribing professionals write or electronically enter complete medication orders, reorders, or reassessments upon admission, end of service, or transfer to another level of care.	10.1	↑
The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	10.2	↑

The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	10.2.7	
The organization develops and follows a policy to maintain accurate allergy information in each client medication history.	10.6	↑
The organization develops and follows a policy to maintain clinically accurate, known adverse drug reactions for each client in the ongoing medication profile.	10.7	↑
The pharmacy and other service providers accept verbal orders for medication only in emergencies.	10.9	↑
The pharmacy and other service providers accept telephone orders for medication only in emergencies.	10.10	↑
The organization monitors compliance with its policies and processes for prescribing medications.	10.13	↑
The organization has a policy for weight-based dosing in pediatrics that includes verification based on milligrams per kilogram.	11.5	↑
The organization provides workspace to pharmacy staff to support safe and effective preparation of medications.	12.1	
Pharmacy staff compound sterile medications and intraveneous admixtures in the pharmacy using aseptic technique and appropriate safety materials and equipment.	12.3	↑
Pharmacy staff prepare intravenous products in a segregated admixture area using a certified laminar flow hood.	12.4	↑
The organization has explicit selection criteria for establishing which clients are permitted to self-administer medications.	17.1	
The organization identifies minimum qualifications for staff and service providers who administer medications.	18.1	↑
The team uses at least two client identifiers before administering medications.	18.3	↑
The team uses at least two client identifiers before administering medications.	18.3.1	

Service providers seek an independent double check before administering high-alert/high-risk medications.	18.5	↑
The organization tracks lot numbers to identify and inform providers when a client has received a recalled vaccine.	18.9	
The organization has and follows a proactive risk assessment process to evaluate the risk potential for new medication delivery devices.	19.1	↑
The organization limits the variety of general-purpose infusion pumps, syringe pumps, and patient-controlled analgesia (PCA) pumps available.	19.2	↑
The organization establishes and follows criteria to determine which client populations, medications, and rates of infusion require delivery via an infusion control pump.	19.3	↑
Staff and service providers receive ongoing, effective training on infusion pumps.	19.4	↑
There is documented evidence of ongoing, effective training on infusion pumps.	19.4.1	
The organization minimizes the use of multi-dose vials in client care areas.	19.5	↑
The organization has a quality control process to monitor adherence to its policies related to medications with heightened potential for adverse events.	21.3	
The organization monitors medication use with an ongoing medication utilization review.	22.2	

Medicine Services

Clinical Leadership

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

Surveyor Comments

Strengths:
Many hospitals in the Interior Health Region are experiencing a significant increase in the number of patients who require services other than acute. The result is that a number of acute beds are being used as ALC, convalescent, and for other such services or they are simply remaining in medical beds. There are many individual initiatives taking place to help alleviate the situation including the implementation of the early discharge plan, morning meetings, early morning rounds, and implementation of the anticipated discharge date upon admission.

The "I care" program being piloted within the region shows a lot of promise as it is aimed at addressing these and other related issues for this particular clientele.

The “Partners in Care Project” also offers a lot of promise in optimizing care to patients, by ensuring effective communications between physicians, nurses and other care team members, decreasing gaps in coordination and continuum of care, and decreasing the fragmentation of care and work processes. It will also address environmental factors that affect staff and patient safety and remove barriers that prevent optimal patient and family focused care.

There are also a number of “lean” projects that are aimed at creating work efficiency and are proving to be very successful.

There appears to be sufficient resources that reflect a safe approach to the delivery of patient care. Equipment and supplies appears to be sufficient. Staff members are very skilful and knowledgeable of their professional role. Skill maintenance is an issue for some of the smaller sites. The education coordinators play a significant role in addressing this.

Also worthy of note are the Community OT/PT Liaison workers whose primary role is to act as a liaison between acute care and community care providing 7 days per week OT/PT coverage for several areas including emergency department, inpatient wards for pre discharge home, maternal and child unit, etc.

Areas of Opportunities:
Locally the various medicine teams work well with partners in the delivery of care and the attempt to discharge to appropriate community based alternatives or solutions. Of concern is that many patients occupy acute care "beds" which is not the most appropriate service option. The team and the region are encouraged to continue to seek effective client focused alternatives which will continue to involve significant planning and collaborative partnerships with internal and external stakeholders. It is recognized that the 2008/09 - 2010/11 Service Plan document demonstrates the organization’s commitment to this matter.

In terms of the overall delivery of the medicine program, including the specialized services within the program at the larger hospitals, the team is encouraged to consider a regional approach to address the overall leadership, direction and coordination of the program.

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

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	
The team’s goals and objectives for its medicine services are measurable and specific.	2.2	

Competency

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

Surveyor Comments

Strengths:
Interdisciplinary teams are well established and function effectively in the delivery of service to the population they serve. Of particular note is the significant focus of the team on establishing client focused goals and approaches that are aimed at ensuring that the outcome of patient care and planning results in the clients return or placement in the most appropriate setting for the care required.

Recruitment initiatives are successful for most professions except in a few of the more isolated areas.

Communication between members of the team is very good. Transfer of information as well as joint interdisciplinary planning is evident.

Some units are very crowded due to the older unit design and the increase in supplies and equipment. In some of the older buildings, meeting room and other space is inadequate for the high number of professionals and students that provide care. The application of LEAN principles in some areas has proven successful and has assisted in the maximum utilization of available space. It is recommended that this methodology be applied in other areas.

Programs for the recognition of staff vary from site to site. There is a region wide recognition program.

Staff and managers in all settings were observed as highly competent and dedicated to their particular role in the delivery of care to the patients. Creativity was also apparent both in the units in the larger hospitals and in the smaller multi functioned sites.

Areas of Opportunities:
With the exception of one site where there is a pilot project, the majority of the charting systems are paper based. The organization is encouraged to continue, when feasible, with the implementation of one consistent system. It will be important to avoid the maintenance of both the old system and the new following the implementation for the newer one.

Staff members receive training on new programs as required such as the implementation the stroke protocols and the cardiac program. Very few education programs are considered mandatory with the exception of CPR. Of recognition is the 100 day program for managers.

Staff appear to have had effective training on infusion pumps during their orientation and there is an effort to ensure that only one type of pump is available on the unit. However, it is apparent that there are many different types of pumps throughout the organization. The team is encourage to be particularly vigilant to ensure that staff receive training on each different infusion pump that may be introduced on the unit.

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

Criteria	Location	Priority for Action
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.8	

Episode of Care

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

Surveyor Comments

Significant coordination occurs to ensure that ALC patients are assessed and referred to the appropriate discharge location. Staff are very resourceful and as teams they attempt to utilize all appropriate channels to ensure that the ALC patient received the right service in the right place. At the unit level this approach to care planning works well. The region is encouraged to continue their efforts to ensure a regional focus continues due to the complexity of the problem and the multiplicity of possible solutions some of which are beyond the scope of the individual care team.

The team responds in a timely way to requests for service. This is somewhat compromised due to the lack of appropriate service for ALC patients, and the resultant negative impact on bed capability for medical patients. "Hallway Medicine" is required on a regular basis.

In some instances, patients are placed on other units as overflow for the medical unit. Care is taken and criteria applied to ensure that patients that are sent to that unit have a care plan that fits within the scope of the unit and the skill levels of the staff on that unit.

MEDICATION RECONCILIATION

The team is commended for the use of pilots and completing the foundational work on the planned full implementation of the medication reconciliation policy. There is a great deal of knowledge about this required practice and in some locations there is evidence that medication reconciliation is being completed. However, the implementation is not consistent within units or throughout the region. The team is encouraged to implement this in a consistent manner throughout the organization ASAP.

Patients and families that were spoken to were consistently complimentary for the quality of care provided by the staff.

There are measures employed by the team to evaluate pain but these measures are not consistently applied to allow ongoing comparative analysis.

There did not appear to be consistent documentation regarding consent. Some charts had written consent for some invasive procedures and others did not. Implied consent resulting from a discussion between the care provider and the patient was not documented.

Service planning was apparent in all cases. Good documentation on charts and Kardex was evident.

Discharge planning and integrated follow-up plans are evident in most cases. The organization is acknowledged for the diligence in this area.

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

Criteria	Location	Priority for Action
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.4.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.4.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	
Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	
The team uses standardized clinical measures to evaluate the client's pain.	7.7	
The team follows the organization's process to identify, address, and record all ethics-related issues.	8.8	↑
The team has a process to evaluate client requests to bring in or self-administer their own medication.	10.5	

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

Decision Support

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

Surveyor Comments

Good communication exists amongst the care team providers in the delivery of day-to-day care. In addition the "I Care" Team provides a venue for sharing client information for the purpose of achieving client care outcomes relative to receiving the most appropriate service.

The team has adopted and implemented the Cardiac and Stroke protocols throughout the region based on the review and implementation of evidenced based best practice.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

There was evidence of staff awareness of managing risks. Staff were able to demonstrate the need to report actual errors and "near misses".

The falls prevention program is implemented throughout the region and appears to be working well. There will be monitoring to evaluate the effectiveness of the program.

Two client identifiers are used before providing any service or procedure.

The focus on safety was evident on all units whether it was the proliferation of signs/posters for staff and patients, the focus of a "lean" project, or individual action by staff members or discussion between patients and staff.

No Unmet Criteria for this Priority Process.

Mental Health Services

Clinical Leadership

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

Surveyor Comments

A number of good examples where improvements have been made based on information from clients and or evaluations, e.g. modification to case management program to allow for a transitional case manager.

One psychiatrist made the point that this is a very lean organization with respect to mental health resources.

There is good involvement of partners in the provision of care.

Based on experience and research there has been recent improvements made to Code White response.

Partners focus group was very complimentary to the relationship they have with the mental health and addictions team but were less complimentary about what they described as the bureaucracy.

There are many examples of this team working with others in relation to mental health and addictions awareness.

In Kelowna, the not for profit partners say that Interior Health has to assume the leadership role in the integration of the mental health and addictions service system.

There is evidence that program evaluations have been conducted and that Interior Health is making improvements based on recommendations from these reviews.

There are ongoing discussions as to how best provide staff education in an environment of restraint. A staff newsletter had just been distributed with this matter as the main topic.

Positive interaction with a psychiatrist and three student nurses at the Hillside site was observed.

There is a job description for the role of the psychiatrist in the mental health team.

This team is extremely knowledgeable about the people to whom they provide services. Some of this information gathered locally and some is gathered provincially.

There is a ten year mental health and additions plan for the province.

The organization is committed to excellence in service provision and this commitment to quality is very evident in this program area.

Good relationship with partners at the service level and around health promotion initiatives.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Excellent relationship between psychiatrists and family physicians in the provision of care to mental health consumers.

Southhills is a beautiful new care site while the 1E unit is an old care environment.

Many opportunities for mental health team and sub committees to get together for planning and improvement purposes.

Good interdisciplinary team interaction at all sites visited.

When staff attend educational events and or conferences there is a requirement that they share their learning's throughout the team.

There is a human resource system which tracks licences and flags when a licence has lapsed or needs to be renewed. This is followed up by the appropriate manager.

Evidence of interdisciplinary teams at all sites.

The organization has developed a list of core competencies for addictions workers and plans to focus future performance appraisals on these competencies.

Staff receive both general and specific orientation. There is a buddy system as well as a mentoring system.

There is a newly developed process for performance appraisals and there is evidence that most of the performance appraisals in the mental health team have been done or are in process.

This organization is currently going through a period of restraint. There is evidence that significant and serious consideration is being done.

There is a working alone policy.

There are processes for work refusal in collective agreements and these are referenced in the working alone policy.

There is a staff recognition program. Up to 20 years of service there is a presentation of service pins at teas, twenty year plus staff receive their recognition at a dinner in Kelowna.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Good response times in most programs.

There is an urgent response team in many sites.

In consultation with a psychiatrist a family physician can get his patient directly admitted to 1S.

Assessments of clients on 1S and in Southhills are accomplished within 24 hours of admission.

Presence of specialty programs include eating disorders and neuro psychiatry.

Medication reconciliation id done on admission and on discharge.

In Kelowna, the psychiatrists will be taking a full week to review the patients that are waiting for admission by GP referral.

Seclusion and restraint policies are under review. A least restraint policy is currently in effect.

Individual goals are developed for each client in each service and goal attainment is monitored.

The is one client record for each client. Some service providers namely GP's only have read only access. The organization is encouraged to work toward full participation of these providers by giving them full access to the client record.

A telepharmacy system is in place at the Kelowna Urban Outreach Team. This is a very interesting initiative which enhances care. It had numerous built in checks and balances which also use technology.

Improvements need to be made to the transition of clients from the ER to the inpatient unit (Kamloops).

Southhills staff accompany clients 'home' on discharge.

Some clients at Southhhills do administer their own medications.

There is evidence at some sites of good integration of mental health and addictions professionals. In some sites there is a joint intake or assessment done.

There is a single entry process in one service area.

There is a need to look at the reception of mental health clients in all ER's in the region and to build on the practices in some sites of having a dedicated mental health professional on call for the ER.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

Good evidence of a number of research initiatives.

Information is shared electronically throughout the system.

A new electronic health record platform is being implemented. There is a lot of work underway on forms consolidation.

There are regional and local consumer and family advisory committees.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Improvements made to code white response and in the development of policies with respect to seclusion and restraint.

A falls prevention strategy is being implemented throughout the region.It is starting in mental health with the psychogeriatric population.

Two identifiers are checked before medication is dispensed.

Two identifiers are used before ECT is administered.

There are many quality improvement initiatives underway. These include work on Code White as well as increasing the understanding of other IH services about the needs of mental health clients (ER Initiative).

This team also undertook to implement the tracer methodology so as to identify areas for improvement .

No Unmet Criteria for this Priority Process.

Obstetrics/Perinatal Care Services

Clinical Leadership

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

Surveyor Comments

BCPNP collects information provincially to understand the populations and the needs on a provincial and regional basis. The role of the BCPNP is to facilitate and support the ongoing development of perinatal services at the regional and local level. These provincial goals are facilitated in Interior Health by regional goals that are implemented by site interdisciplinary teams. These teams are interested and focussed on the needs of their community and use

available information to evaluate their performance and develop the services required. At the team level, safety, quality, morbity and mortality, competency and service outcomes are monitored. The structure is being revamped with direction from Interior Health on the alignment of programs and the implementation of networks. This work is encouraged and will provide the necessary structure in which decisions will be made. Key partnerships are being developed and leadership teams at the local level take responsibility for the development, implementation and monitoring of their services. The leaders understand the challenges and opportunities in providing perinatal services to the communities of Interior Health.

Information can be requested of the provincial program and tailored to the needs of the local community. The local areas are very much directed by the provincial and regional agendas. Skill sets and resources at the local level for QI activities are uneven. The teams are committed to best practice and keen to provide the best service in their communities. Efforts are being made to maximize full scope of practice for team members. Teams are at different stages of this work.

There has historically been good support for clinical education in this program which has positively impacted the skill base. Concerns about funding cuts for education were expressed.

Local autonomy and accountability is wanted and accepted by the teams. Processes and strategies by IH to facilitate the network will be important.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Staff described orientation as tailored to individual needs. There is some variability across the sites in the extent of the orientation. Emphasis has been placed on specialty training and ensuring all staff have basic requirements to work in this specialty. All disciplines demonstrate an interest and commitment to continued learning. Decisions need to be made on the required educational programs that must be provided for all staff with strategies for skills maintenance. This work is in progress. The teams are to be commended for their commitment to creating access for staff for courses like NRP, fetal assessment, and obstetrical nursing. NRP and Infant Surveillance are required. A train the trainer model supports education at the local level. Staff described positive use of internet based learning opportunities. Smaller sites cited challenges in making continuing education available to their staff. Creative strategies will be necessary to support continuing education of all professionals in rural sites.

Performance feedback is not available to all staff. Some sites have made great progress and others are struggling to be able to provide this for all staff. All voiced a commitment to and understanding of the importance of this for staff. Safety sessions are held for staff and safety is a topic at staff meetings.

Students are encouraged and supported in many sites across this service. This has been seen as an important recruitment strategy and has been positive. Staff are encouraged to participate in university education programs. Medical students are present in some sites. The beginning of a medical school will be positive for the service. Recruitment and retention of qualified care providers in all disciplines is a key focus in the development and maintenance of perinatal services in this region.

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

Criteria	Location	Priority for Action
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.10	
The team has a fair and objective process or program to recognize team members for their contributions.	5.6	

Episode of Care

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

Surveyor Comments

Workload is monitored closely. There is a focus on creating a good workplace. Staff described a good place to work. However one group talked about being overtired.

Kamloops has a referral level 2b NICU and no in house accommodation i.e. mothers or families. There has been one safety incident for a parent walking to the hospital to feed her infant.

Lactation information and support is uneven across the region and usually not outside of day time hours. Some units have access to a lactation consultant and /or have trained staff on the unit. Specialty information and training can be a challenge in rural sites and as the staff group becomes smaller these challenges increase. The focus on standards is seen as positive. The breast feeding working group which had its first meeting this week is seen as positive. This work is encouraged.

There are many challenges in the transport system. The region continues to work with the provincial system to address the issues for the local areas.

Access to prenatal classes is uneven. Much of the access is a cost to the consumer and in some areas the content of the courses is unknown to the perinatal service. Not all classes include a hospital tour. Consistent access to a standardized course inclusive of a hospital tour would be beneficial to parents. This is known to the region and is a priority for action.

The expectant parent event at Trail is noted as a creative way of engaging the community and creating an understanding of the services provided. The teen health clinic in the school in Lillooet and the options for sexual health clinics are creative strategies to improve access to care for the population.

Medication reconciliation has been implemented in Williams Lake and is yet to be rolled out in the other sites. The falls prevention strategy is in the rollout stage. Where implemented, staff are positive, parents understand their teaching. This work is encouraged.

There were areas of excellence in educating patients on issues of safety and rights, but it was uneven across the sites. Many parents described feeling well informed and able to be involved in decision making about their care.

Where available, social workers described being a part of the team. Hearing screening is made available to all newborns. Every effort is made to reach all babies.

All perinatal units receive prenatal medical information at 20 weeks. This is updated as changes occur. In Vernon, this information, along with the admission information, is merged with the information from child and family services about mothers at risk thereby creating a comprehensive picture of the needs of the mother and new baby. The Social Worker has created connections with the community agencies facilitating comprehensive support and safe care for mother and new baby.

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

Criteria	Location	Priority for Action
The team identifies, and removes where possible, barriers that prevent clients, families, providers, and referring organizations from accessing services.	6.1	
The team reconciles the client's medications upon admission to the organization with the involvement of the client.	7.11	↑
There is a demonstrated formal process to reconcile client medications upon admission.	7.11.1	
The process includes generating a documented, comprehensive list of the current medications that the client has been taking prior to admission to the organization.	7.11.2	
The process includes a timely review of this prior-to-admission medication list with the list of new medications ordered at admission.	7.11.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.11.4	
These processes are a shared responsibility, involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.11.5	
Medication Reconciliation at Admission.	7.12	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.12.1	

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a single documented, comprehensive list all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	11.5	↑

Decision Support

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

Surveyor Comments

There is a mixed system, IT and paper at Kelowna that requires double charting. A care path is used to support the provision of care and the communication of patient information. Some concern has been expressed about the currency of some provincial guidelines. Records reviewed were complete and current. Prenatal care information is provided to the inpatient service at 20 weeks and updated as changes occur. Public health, audiology, and social work contribute to the team delivery of service.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Recent additions of pediatricians and few nursing vacancies are positive realities for this service across the region. The PSLS has been positively received in this service and staff and managers describe the benefits to their service in promoting safety and quality. This is a newly developed strategy and full benefits have not been realized to date. There is an interest and commitment in maximizing this process as a quality tool.

There is inconsistent effort across this service and sites in seeking feedback on the service from clients. A formal process is encouraged to access this valuable information. Safety education for patients is well documented by some teams and not others. The poster on safety and abduction and the parents' role in safety is displayed in some units and used as a tool for parent education. This is seen as useful by parents and further rollout is encouraged. Education of parents is a focus in all teams visited. Written materials are provided by some teams and valued by parents.

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

Criteria	Location	Priority for Action
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	16.3	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	16.3.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	16.3.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	16.3.3	

Rehabilitation Services

Clinical Leadership

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

Surveyor Comments

There is evidence that the team have access to population data that is used in planning services (Stroke program at RIH, outpatient services at KGH).

There is evidence that the teams collaborate with other services, programs, providers and organizations to ensure continuum of care for their clients. A good example of this collaboration is the ABI team, who have worked with mental health, substance abuse and other community stakeholders to bring in speakers to develop their knowledge and ability to deal with clients who have a diagnosis of ABI and also have substance abuse issues. This is also a good example of planning programs and scope of service around population needs. Another good example presented is the development of a stroke program at RIH which recognizes the population demographics and their projected aging population issues.

There is evidence of good documentation and information flow to facilitate ongoing care. Staff have access to computer information as well as chart notes and one on one communication.

The regional Rehab Services have developed a Service Alignment Plan that has identified goals and objectives that are aligned with Regional direction. This was developed with representation from the various disciplines within the team as well as regional support personnel. They need to continue to work on developing performance indicators for this document and to measure their success as indicators have not been identified for some of the key outcome areas. They have developed time lines and are monitoring progress related to the objectives. They should consider identifying responsible individuals/group to facilitate responsibility to achieve their objectives. They are encouraged to share the Alignment plan with front line staff as the staff interviewed during the survey did not appear to be aware of the document.

There is also evidence of leadership objectives for service improvements (Okanagan), developed with good input from the disciplines which make up their treatment teams and again the leaders are encouraged to share this information with front line staff where appropriate.

The site treatment teams should consider developing measurable and achievable team goals for rehab services that align with the Regional Rehab Services Alignment Plan, and leadership goals and objectives. There is evidence that this is starting in a number of health service areas. The teams are encouraged to expand on the number of service teams that develop annual team goals that reflect regional direction. The disciplines through their Professional Practice groups have developed discipline specific goals and are encouraged to integrate those goals into the interdisciplinary team goal setting process.

Teams are actively involved in supporting student placements and are looking into interdisciplinary student placements in the future. They recognize the need to network with the university and colleges to ensure that they continue to train students as an excellent source of recruitment. The team talked about improvements to student training that now incorporates rehab philosophy and treatment into educational curriculum.

Professional Practice committees have developed Regional Priority Guidelines for service delivery to ensure effective and efficient provision of services.

Rehabilitation Services in Interior Health are involved in a number of innovative activities to stretch their service through use of travelling services to rural and remote areas. They use telehealth for prehab for joint replacements as an outreach and shared service. Staff in rural areas report that the clients are asked to evaluate the service and that it has been well received. They also have access via telehealth for wound care. Physiatrists feel that the addition of hospitalist services have enabled them to focus more on the Rehab needs of their clients.

Physiatrists are also working on developing a telehealth service to improve access to rural areas and will need to be supported by the Region to make this a reality. A physiatrist at RIH commended the clinical skills of the rural and urban staff who are developing expertise to assist the Physiatrists in their telehealth outreach service.

All of these efforts are to be commended. Despite all of their efforts to stretch their staff they do report that resources in some areas need to be augmented for good quality care delivery. In particular they feel there is a need for more capacity in Neuropsychology, Speech Language Pathology, Physiatry throughout the system, Physiotherapy and Occupational Therapy in the rural setting.

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

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	
The team's goals and objectives for rehabilitation services are measurable and specific.	2.2	

Competency

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

Surveyor Comments

Each site was able to identify the interdisciplinary rehab teams and had a good understanding of the roles of the various team members. At each site the Rehab Teams meet for regular rounds and/or discharge planning. There was evidence in the charts of interdisciplinary team involvement in developing service plans for their clients.

The staff were able to talk about the educational opportunities they had available to them on site, regionally and externally. They are to be commended for their initiatives in bringing educators into the health region to stretch their educational funding and to train more staff.

There are formal annual processes in place to make sure that all rehab team members are credentialed and/or licensed to work in the region.

The region is encouraged to develop a process to evaluate their team functioning. In Kamloops, the team have FIM outcome data for Rehab within the RIH, residential care and community, this is a tool they can use to evaluate the team function and compare their results with their peers. They have excellent results that need to be celebrated. Teams are encouraged to develop formal processes to evaluate their team functioning.

KGH has been trying to implement the FIM assessment for outcome measures and are encouraged to continue to work on implementing this process. It will provide the region with reliable data comparisons between the two tertiary centres (KGH and RIH) and the ability to measure their outcomes relative to their peers across Canada. It will also provide the team with a means of focusing on priorities for improvements. It is a valid tool that all Rehabilitation Service teams can use to measure their outcomes throughout the region.

Practice Leaders and Managers have access to regional orientation programs that they found to be very useful to them in developing their operational management skills. New staff receive orientation to their service areas and to the region. On reviewing the documentation the orientation package is comprehensive.

Nursing staff report that the documented evidence of ongoing training on infusion pumps is kept by the Nurse educator on site. They reported that they receive education on the use of infusion pumps during their orientation to the job and for any new infusion pumps introduced to the unit. They also talked about their ability to receive mentorship from fellow colleagues on the use of pumps (Nicola Valley Health Centre) as well as access to Nurse Educators(RIH and KGH) for training on infusion pumps. At Ponderosa there are a number of nurses trained in the use of infusion pumps. If a trained nurse is not available they have back up from the community nurses for setting up infusion pumps.

The teams need to develop ways to advertise and celebrate their successes.

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

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

Episode of Care

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

Surveyor Comments

The average wait time for admission to Rehab at the RIH is 3 days with similar access at KGH. Physiatrists at KGH on average respond to referrals within 24 hours. If the client is not accepted to Rehab or admission is delayed, an explanation is provided to the referring unit. If the client needs to meet set criteria before admission to Rehab, the specific details are provided to the referring unit (e.g. patient's sitting tolerance times). There were some concerns raised at the KGH that there are barriers to admission to Rehab from the Medical units and that the process and documentation could be improved upon. It was observed that there were clients in the hallways and that some of the units are operating at over 100% occupancy which can create tension for client flow issues.

There was evidence of detailed assessments on each client's chart reviewed. Assessment formats can vary by site.

All clients interviewed stated that they were actively involved in setting their goals and that staff were receptive to their input. Clients indicated that the staff in Rehab kept them informed of their progress and adapted the service plan to address their goals.

The Physiatrists at KGH indicated that they would like to be able to provide services to rural and remote areas by telephysiatry as they feel that would be a valuable and effective service and are presently negotiating a fee schedule for the service.

Staff were aware of the Ethics Committee and were aware that education has been available on the regional ethics framework. They felt that they could bring ethical issues to their managers and their professional licensing bodies. At RIH the staff have access to their Medical Director in Rehabilitation who has been actively involved in providing guidance and support on ethical issues. She was able to provide excellent examples of ethical issues and process for resolution. Of interest was their ability to incorporate PDSA cycles into treatment protocols and again provided an excellent example within the stroke program to illustrate how effective the process can be.

The clients interviewed were not aware of the complaint process but felt comfortable that if they had an issue they could bring it forward to the staff. The teams are encouraged to provide clients with information both verbally and in writing about the complaint process.

All of the clients interviewed were aware of their discharge plans and felt that they and their families, had the opportunity to contribute to the plan.

Medication reconciliation has not been fully implemented in Rehabilitation Services. There is evidence that Rehabilitation Services is included in the regional plans but is a lower priority for the regional roll out.

There was no consistent formal process to evaluate the effectiveness of transitional or end of service. In the cases that the client continues their out patient service within the site, staff were more aware of the effectiveness of their discharge planning through discussion with the outpatient/community staff. The exception to this was at the RIH where regular FIM assessments were completed post discharge for their neurological clients. The teams are encouraged to develop a formal process to evaluate the effectiveness of discharge planning.

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

Criteria	Location	Priority for Action
From their first contact with the organization or team, clients and families are informed of the team member who is responsible for coordinating their service, and told how to reach that person.	6.2	
The team reconciles the client's medications upon admission to the organization, with the involvement of the client.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to admission.	7.4.2	
The process includes a timely comparison of the prior-to-admission medication list with the list of new medications ordered at admission.	7.4.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made where necessary.	7.4.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	7.4.5	

Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	
The team has a process to evaluate client requests to bring in or self-administer their own medication.	10.5	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	11.5	↑

Decision Support

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

Surveyor Comments

Charts reviewed provided evidence of up-to-date records for each client served. There was evidence of interdisciplinary collaboration in setting and implementing client care plans. There is evidence of discussion and decisions related to regular rounds in the round's summary notes. There is good evidence of interdisciplinary discharge planning and that clients and families are involved in the process.

Staff have ready access to client records and have developed effective processes to provide information for staff to ensure continuity of care when clients transition to alternate service providers. Staff in acute care, residential services, convalescent care and community spoke very highly of the quality and timeliness of the information they receive on Rehabilitation clients when they are admitted to and discharge from, Rehab Services.

Staff commented on their ability to access evidence based guidelines and best practice information through their Professional Practice network. There is evidence that Professional Practice groups used evidence based work to develop their Regional Priority Intervention Guidelines. They are commended for including an evaluation component into this process.

Staff were knowledgeable about the proper process for submitting research through the Ethics Committee and were able to obtain approval for a research project at RIH.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

Clients were aware of safety and their role in promoting safety. They identified that the two identifiers most frequently used by staff were to verbally ask for their name and to check their arm band. Clients felt that they had the right to ask questions to ensure their safety.

The Region has developed a very comprehensive Falls Prevention Program which they are in the process of rolling out to all of their sites (hospitals, residential care and community). There were a number of areas that had just started to receive their information posters but had not implemented the Falls Prevention program at the time of the survey interviews. The staff at Cottonwood have designed a falls awareness process where they set up a room staged with up to 40 falls risk situations and have used a system of rewards and prizes for staff to identify the various risks hazards, an excellent way to increase awareness of fall risks.

All staff interviewed were aware of the incident reporting system and felt comfortable that there is a "no blame" culture within the region. Although staff did not appear to be aware of the term "sentinel event" they were aware of the process for reporting incidents and the need to identify severity of an incident. There is evidence that incident reports are trended and that managers are provided with the data on their specific incidents and the trended data. There is also evidence that management and staff work at developing strategies to reduce risks as a result of trended data information (e.g. new mattress evaluation to reduce skin breakdown, falls prevention).

The region has a disclosure policy and staff were aware of the process.

The region implements a client satisfaction survey and teams are provided with the results of the survey. There is some evidence of satisfaction surveys specific to Rehabilitation Services but this is more of a site specific and discipline specific initiative rather than a regional program strategy. There is evidence that work is on going to develop a regional Rehabilitation Services client satisfaction survey.

RIH has access to outcome measures through their use of the FIM and receive reports that compare their outcomes to their peers and national data. They are encouraged to share this data with the front line staff. They are encouraged to post the results of their FIM data for staff, clients and families as they have reason to celebrate their achievements.

There was evidence that the staff provide clients and families with educational information through posters posted in client care areas.

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

Criteria	Location	Priority for Action
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.2	↑
The team has implemented a falls prevention strategy.	15.2.1	
The team monitors clients' perspectives on the quality of its rehabilitation services.	16.2	

Surgical Procedures

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

Surveyor Comments

The organization is committed to introducing Licensed Practical Nurses (LPN) to the Operating Room (OR). The LPNs at Penticton Regional Hospital work to full scope of practice. They have organized a training program that is ready to start and have identified candidates for the training. Lake Hospital, Salmon Arm, Operating Room (OR) nurses and Postanesthesia Recovery Room (PAR) nurses rotate through both areas. While OR staff have been trained for PAR based on PAR standards, PAR standards state that two trained PAR RNs (Postanesthesia Recovery Room Registered Nurses) should recover patients, not one OR RN and one PAR RN. Staff for both areas are on call often impacting the next days OR Slate. It should be noted that all sites face the challenge of accessing surgical beds for the elective slate. The PCC is encouraged to identify whether it would be more cost effective to have an evening shift.

Patients are held in PAR overnight or for extended periods of time waiting for a bed. Surgical patients are spread throughout the hospital and not always cared for by staff who have surgical expertise. Royal Inland Hospital, Kamloops, PAR is the back-up contingency for ICU, this arrangement works well.

The Health Authority (HA) needs to consider the protection of surgical beds based on OR utilization. The Surgical Council is responsible for the planning and defining the scope of services. As they are not operational, local sites may be resistant to support initiatives due to competing priorities. A process needs to be in place to support the implementation of surgical quality initiatives.

The Surgical Council is working to support the development of OR Management Committees at each site that have representation from the OR/Surgeons. One member of this group will sit on the council thereby enabling and improving communication on key initiatives. In the Royal Inland Hospital, Kamloops the inpatient units have focused on team work and leadership development.

The Council has introduced the Surgical Product formulary for managing urgent requests for equipment. The Surgical network is key in planning, setting standards and proving oversight to the surgical program within the Health Authority. The use of perioperative aides in the OR works well within the Health Authority.

Changes have been made at the Royal Inland Hospital, surgical inpatient units to better reflect the needs of the patients, particularly in how patient assignments are done. Ceiling lifts should be made more available on inpatient units. Restricted areas are not clearly identified in Salmon Arm, Kamloops and Penticton.

OR manager charting is used by all sites providing consistency in documentation. Pre-surgical screening program was developed at all sites. Utilize Standard forms including a booking/consent form are also used at all sites. Consent forms are part of booking package. It was noted that some surgeons at Vernon are refusing to use the new consent form.

The surgical program has recently reviewed and the orientation program content was updated. There are positive changes in the patient assignment based on acuity at Kamloops.

Staff have verbalized that they are comfortable identifying concerns to their managers.

In Lake Hospital, Lake Hospital, Salmon Arm, razors are no longer in the OR. Clippers are now provided. In Penticton shaving is done in the OR due to lack of physical space.

In Vernon and Salmon Arm, pre op antibiotics were documented. The anaesthetists in Kamloops express concern that they are responsible for administering the pre-operative antibiotic in the OR.

In Kamloops, it was noted that the perioperative pause was not done. The team may have documented the preoperative pause but it was not properly conducted.

Pre-Surgical Screening is gathering the best possible medication history from the patient. There is a plan in place to roll out medication reconciliation.

Pre Surgical screening is standardized across the Health Authority and sites use the same forms. Pre surgical screening and day care surgery have pamphlets available. All patients spoken to stated that they felt well prepared for surgery.

In some sites the nurses have to access the medications for the anaesthetist as they do not have Pyxis.

At Penticton, It was observed that a surgeon was in the restricted area without a cap.

The consent form has a place to indicate if a substitute decision maker has provided consent.

OR staff that was visited stated that they recently had laser safety training from the company rep and there is a local laser safety officer. While smoke evacuation is available, it is not consistently used. There are some issues relate to physician compliance.

Sites had criteria for managing the urgent / emergent add on cases. Salmon Arm expressed concern doing surgery on patients that may require ICU back up.

The most responsible physician (MRP) role may be an issue at Jubilee Hospital, when the family physician (FP) takes over from the surgeon. This may delay discharge.

All sites have significantly reduced the use of flash sterilization due to the purchase of more instrumentation and the re-ordering of the slate. Any use of the flash process results in documentation and completion of an entry in the Patient Safety & Learning System (PSLS). Without having a bar coding tracking system, the team has processes in place to track in terms of a recall. The team at Kamloops needs to ensure that policies relating to CJD are in place. All staff spoken were aware of the PSLS and use it. The organization needs to use the data to identify improvement opportunities.

The Surgical Council have identified performance indicators that are being collected for the HA with the expectation that they will be monitored and reported on, also with the Quality Office, they have identified key initiatives for the surgical program, such as the surgical safety checklist and OR medication checklist.

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

Criteria	Location	Priority for Action
Operating Rooms		
The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	2.8	
The surgical suite has three levels of increasingly restricted access: accessible areas, semi-restricted areas, and restricted areas.	3.4	↑
If hair removal is required prior to surgery, the team does so in a location outside the operating room.	6.1	↑
Immediately prior to the procedure, the team conducts a preoperative pause to confirm the client's identity and nature, site, and side of the procedure.	6.8	↑
Team members follow a dress code within the surgical suite.	8.1	↑
The operating room team uses aseptic technique at all times during the procedure.	8.4	↑

Surgical Care Services	
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.8
The team meets applicable legislation for protecting the privacy and confidentiality of client information.	12.2

Performance Measure Results

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

Instrument Results

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

Governance Functioning Tool

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

Summary of Results

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

12	Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0	
16	Our governance processes make sure that everyone participates in decision-making.	100	0	0	
17	Individual members are actively involved in policy-making and strategic planning.	100	0	0	
18	The composition of our governing body contributes to high governance and leadership performance.	100	0	0	
19	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0	
20	Our ongoing education and professional development is encouraged.	60	0	40	⚠
21	Working relationships among individual members and committees are positive.	100	0	0	
22	We have a process to set bylaws and corporate policies.	100	0	0	
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24	We formally evaluate our own performance on a regular basis.	100	0	0	
25	We benchmark our performance against other similar organizations and/or national standards.	33	0	67	✖
26	Contributions of individual members are reviewed regularly.	100	0	0	
27	As a team, we regularly review how we function together and how our governance processes could be improved.	100	0	0	
28	There is a process for improving individual effectiveness when non-performance is an issue.	50	0	50	✖

29	We regularly identify areas for improvement and engage in our own quality improvement activities.	100	0	0	
30	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	83	0	17	
31	As individual members, we receive adequate feedback about our contribution to the governing body.	83	0	17	
32	We have a process to elect or appoint our chair.	0	0	100	
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	

Patient Safety Culture Survey

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

Summary of Results

Number of survey respondents = 1100 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	16	17	67	▲
2 Good communication flow exists up the chain of command regarding patient safety issues	25	17	58	▲
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	78	13	9	
4 Senior management has a clear picture of the risk associated with patient care	28	22	50	▲
5 My unit takes the time to identify and assess risks to patients	11	10	80	
6 My unit does a good job managing risks to ensure patient safety	9	12	79	
7 Senior management provides a climate that promotes patient safety	20	21	59	▲
8 Asking for help is a sign of incompetence	91	5	4	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	95	3	2	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	19	20	61	▲
11 I am less effective at work when I am fatigued	5	5	90	
12 Senior management considers patient safety when program changes are discussed	18	31	50	▲
13 Personal problems can adversely affect my performance	18	16	66	▲
14 I will suffer negative consequences if I report a patient safety problem	82	12	6	

15	If I report a patient safety incident, I know that management will act on it	20	27	53	⚠
16	I am rewarded for taking quick action to identify a serious mistake	33	38	29	✗
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	31	31	38	✗
18	I have enough time to complete patient care tasks safely	31	23	46	✗
19	I am not sure about the value of completing incident reports	65	15	20	⚠
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	45	17	37	✗
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	41	20	39	✗
22	I have made significant errors in my work that I attribute to my own fatigue	78	12	10	
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	11	12	78	
24	I believe health care errors often go unreported	14	21	65	✗
25	My organization effectively balances the need for patient safety and the need for productivity	26	29	44	✗
26	I work in an environment where patient safety is a high priority	14	15	71	⚠
27	Staff are given feedback about changes put into place based on incident reports	38	28	35	✗
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	25	21	54	⚠
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	28	24	47	✗
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	16	21	62	⚠
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	68	18	13	⚠
32	My supervisor/manager overlooks patient safety problems that happen over and over	70	17	13	⚠

33	On this unit, when an incident occurs, we think about it carefully	10	20	70	▲
34	On this unit, when people make mistakes, they ask others about how they could have prevented it	14	25	61	▲
35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	10	17	73	▲
36	On this unit, when an incident occurs, we analyze it thoroughly	19	26	55	▲
37	On this unit, it is difficult to discuss errors	63	20	17	▲
38	On this unit, after an incident has occurred, we think long and hard about how to correct it	17	28	55	▲
B.	**These questions are about your perceptions of overall patient safety**	**% Good/ Excellent**	**% Acceptable**	**% Poor/ Failing**	**Priority for Action**
		Organization	Organization	Organization	
39	Please give your unit an overall grade on patient safety	57	36	7	▲
40	Please give the organization an overall grade on patient safety	37	47	16	✕
C.	**These questions are about what happens after a Major Event**	**% Disagree**	**% Neutral**	**% Agree**	**Priority for Action**
		Organization	Organization	Organization	
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	12	23	65	▲
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	18	41	42	✕
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	16	35	50	✕
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	27	45	29	✕

45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	23	22	55	
46	Changes are made to reduce re-occurrence of major events	11	23	67	

Worklife Pulse

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

Summary of Results

Number of survey respondents = 1950 respondents

How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 I am satisfied with communications in this organization.	39	22	39	✕
2 I am satisfied with communications in my work area.	31	16	52	△
3 I am satisfied with my supervisor.	22	17	61	△
4 I am satisfied with the amount of control I have over my job activities.	26	18	56	△
5 I am clear about what is expected of me to do my job.	14	15	71	△
6 I am satisfied with my involvement in decision making processes in this organization.	46	24	30	✕
7 I have enough time to do my job adequately.	37	22	41	✕
8 I feel that I can trust this organization.	45	29	26	✕
9 This organization supports my learning and development.	38	26	36	✕
10 My work environment is safe.	18	17	65	△
11 My job allows me to balance my work and family/personal life.	22	21	57	△

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were…	13	41	46	✗

	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is…	58	34	8	
14 In general, would you say your mental health is…	54	32	14	
15 In general, would you say your physical health is…	52	35	13	

	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	78	17	5	

	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	85	8	7	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	87	8	5	

	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	8	29	62	△

	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	35	25	40	✕
21 Working conditions in my area contribute to patient safety.	17	30	54	△

Indicator Results

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

Medication Reconciliation at Admission

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

Medication Reconciliation at Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
RED	Boundary Hospital & Community Care Centre, Grand Forks (Emergency Department Services)	Emerg IH	01/04/2009 30/06/2009	75
YELLOW	Boundary Hospital & Community Care Centre, Grand Forks (Emergency Department Services)	Emerg IH	01/07/2009 30/09/2009	85
GREEN	Boundary Hospital & Community Care Centre, Grand Forks (Emergency Department Services)	Emerg IH	01/10/2009 31/12/2009	95
GREEN	Elk Valley Hospital, Fernie (Emergency Department Services)	Emerg IH	01/04/2009 30/06/2009	92
GREEN	Penticton Regional Hospital, Penticton (Surgical Care Services)	Surgical IH	01/07/2009 30/09/2009	100

Medication Reconciliation at Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
GREEN	Penticton Regional Hospital, Penticton (Surgical Care Services)	Surgical IH	01/10/2009 31/12/2009	100
GREEN	Royal Inland Hospital, Kamloops (Surgical Care Services)	Surgical IH	01/04/2009 30/06/2009	97
GREEN	Royal Inland Hospital, Kamloops (Surgical Care Services)	Surgical IH	01/07/2009 30/09/2009	97
GREEN	Royal Inland Hospital, Kamloops (Surgical Care Services)	Surgical IH	01/10/2009 31/12/2009	97

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

Surgical Site Infection

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

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

Surgical Site Infection: Post-Surgical Infection - Cardiac Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

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

Surgical Site Infection: Post-Surgical Infection - Cardiac Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0

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

Surgical Site Infection: Post-Surgical Infection - Cardiac Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

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

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

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

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	4.7
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	3.7
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	7.1
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	4.9
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	3.2

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

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	8
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	14
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	7.7
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	4.3
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	7.9
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	3.3
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	3.4

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

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	10
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.9
	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	4.4
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	2

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

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	2.8

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

Surgical Site Infection: Post-Surgical Infection - Hysterectomy

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	4.2

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

Surgical Site Infection: Post-Surgical Infection - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	7.7
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	2.2
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	6.7

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

Surgical Site Infection: Post-Surgical Infection - Hysterectomy

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	1.7
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.8

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

Surgical Site Infection: Post-Surgical Infection - Hysterectomy

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	3.6
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	4.3
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

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

Surgical Site Infection: Post-Surgical Infection - C-Section

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0

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

Surgical Site Infection: Post-Surgical Infection - C-Section

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3
	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	3.8
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	3.1
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	8.8
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.79

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

Surgical Site Infection: Post-Surgical Infection - C-Section				
Flag	**Location**	**Team Name (standard section)**	**Dates (dd/mm/yyyy)**	**% post-surgical infections**
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.78
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0

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

Surgical Site Infection: Post-Surgical Infection - C-Section

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	11
	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	1.9
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3.9

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

Surgical Site Infection: Post-Surgical Infection - C-Section

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	2.8
	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	10
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.5
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.4

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

Surgical Site Infection: Post-Surgical Infection - Total Joint Arthroplasty

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	2.1
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	3.3
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	4.5
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	3.4

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

Surgical Site Infection: Post-Surgical Infection - Total Joint Arthroplasty

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	3.7
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3.8
	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	1.3
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.2
	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	3
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	1.2

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

Surgical Site Infection: Post-Surgical Infection - Total Joint Arthroplasty

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.73
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.5
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.93
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.96
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	2

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

Surgical Site Infection: Post-Surgical Infection - Craniotomy				
Flag	**Location**	**Team Name (standard section)**	**Dates (dd/mm/yyyy)**	**% post-surgical infections**
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	4.1
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

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

Surgical Site Infection: Post-Surgical Infection - CSF Shunts

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	20
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

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

Surgical Site Infection: Post-Surgical Infection - Spinal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.6
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	2.5
	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.2

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

Surgical Site Infection: Post-Surgical Infection - Spinal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.1
	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	3.5
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	2
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

Surgical Site Infection

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

Surgical Site Infection: Prophylactic Antibiotics - Cardiac Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	57
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	75
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	66
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	75
YELLOW	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	80
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	25

Surgical Site Infection: Prophylactic Antibiotics - Cardiac Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	38
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	45
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	63
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	64
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	79
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	79
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	55

Surgical Site Infection: Prophylactic Antibiotics - Cardiac Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	58
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	74
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	90
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	20
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	36
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	23
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	67

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	65
RED	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	67
RED	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	79
RED	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	68
YELLOW	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	83
YELLOW	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	81

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	75
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	59
YELLOW	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	85
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	59
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	70
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	67
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	63

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
YELLOW	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	81
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	74
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	55
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	78
YELLOW	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	84
YELLOW	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	83
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	26

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	59
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	45
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	69
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	50
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	67
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	33

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	35
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	68
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	62
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	77

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	94

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	98
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	93
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	96
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	96
RED	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	38
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	100

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	96
YELLOW	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	82
YELLOW	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	87
YELLOW	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	85
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	94
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	45
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	20

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	92
YELLOW	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	86
YELLOW	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	87
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	100
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	100
YELLOW	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	83
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	93

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
YELLOW	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	89
YELLOW	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	80
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	100
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	65
YELLOW	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	85
YELLOW	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	89

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	96

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3
RED	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
RED	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	3.3
RED	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	65

Surgical Site Infection: Prophylactic Antibiotics - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	53
RED	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	17
RED	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	35
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	4.8
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3.1
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	7.8

Surgical Site Infection: Prophylactic Antibiotics - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	6.1
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	20
YELLOW	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	80
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	33
RED	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	31
RED	Kootenay Lake Hospital, Nelson (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	23
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0

Surgical Site Infection: Prophylactic Antibiotics - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	51
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	78
RED	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	69
RED	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	67
RED	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	13
RED	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	43

Surgical Site Infection: Prophylactic Antibiotics - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	33
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	11
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	9.4
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	17
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	33
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	3.8
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	13

Surgical Site Infection: Prophylactic Antibiotics - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	10
RED	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	25
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	24
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	56
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	50
RED	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	54

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Total Joint Arthroplasty				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	90
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	98
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	96
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	97
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	92
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	94

Surgical Site Infection: Prophylactic Antibiotics - Total Joint Arthroplasty				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	96
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	95
YELLOW	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	83
YELLOW	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	85
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	91
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	92
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	97

Surgical Site Infection: Prophylactic Antibiotics - Total Joint Arthroplasty				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	99
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	96
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	96
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	92
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	95
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	95
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	99

Surgical Site Infection: Prophylactic Antibiotics - Total Joint Arthroplasty				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
YELLOW	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	88
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	94
YELLOW	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	88
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	93

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Craniotomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	71

Surgical Site Infection: Prophylactic Antibiotics - Craniotomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	71
RED	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	65
YELLOW	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	83
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	75
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	65
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	50
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	61

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Spinal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	62
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	100
YELLOW	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	83
YELLOW	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	88
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	91
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	91

Surgical Site Infection: Prophylactic Antibiotics - Spinal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
YELLOW	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	85
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	91
YELLOW	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	81
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	78
YELLOW	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	88
RED	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	80
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	92

Surgical Site Infection: Prophylactic Antibiotics - Spinal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
YELLOW	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	89
YELLOW	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	89

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Health Care Associated Infection Rates

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

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	100 Mile House District Hospital, 100 Mile House (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	100 Mile House District Hospital, 100 Mile House (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
GREEN	100 Mile House District Hospital, 100 Mile House (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Arrow Lakes Hospital, Nakusp (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	2.6
GREEN	Arrow Lakes Hospital, Nakusp (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Arrow Lakes Hospital, Nakusp (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	2.5
GREEN	Boundary Hospital & Community Care Centre, Grand Forks (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	2.7
GREEN	Boundary Hospital & Community Care Centre, Grand Forks (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3.4
GREEN	Boundary Hospital & Community Care Centre, Grand Forks (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.2
GREEN	Creston Valley Hospital & Health Centre, Creston (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	3.5
GREEN	Creston Valley Hospital & Health Centre, Creston (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.6
GREEN	Creston Valley Hospital & Health Centre, Creston (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	4.3
GREEN	Dr Helmcken Memorial Hospital, Clearwater (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Dr Helmcken Memorial Hospital, Clearwater (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.6
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.3
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.6
GREEN	Elk Valley Hospital, Fernie (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Elk Valley Hospital, Fernie (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
GREEN	Elk Valley Hospital, Fernie (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.5
GREEN	Golden & District Regional Hospital, Golden (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Golden & District Regional Hospital, Golden (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
GREEN	Golden & District Regional Hospital, Golden (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	2.4
GREEN	Hillside Psychiatric Centre, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Invermere & District Hospital, Invermere (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Invermere & District Hospital, Invermere (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.6
GREEN	Invermere & District Hospital, Invermere (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	1.6
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	2.2
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.5
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.97
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.5
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.3
GREEN	Kootenay Lake Hospital, Nelson (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.29

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Kootenay Lake Hospital, Nelson (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.59
GREEN	Kootenay Lake Hospital, Nelson (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	2
GREEN	Lillooet Hospital & Health Centre, Lillooet (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Lillooet Hospital & Health Centre, Lillooet (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	5.3
GREEN	Lillooet Hospital & Health Centre, Lillooet (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	4.9
GREEN	Nicola Valley Health Care Centre, Merritt (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Nicola Valley Health Care Centre, Merritt (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.4

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Nicola Valley Health Care Centre, Merritt (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.75
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.61
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.59
GREEN	Princeton General Hospital, Princeton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Princeton General Hospital, Princeton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3
GREEN	Princeton General Hospital, Princeton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	2.4
GREEN	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.2
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.69
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.63
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.42

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.26
GREEN	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.53
GREEN	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.78
GREEN	South Okanagan General Hospital, Oliver (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	1.2
GREEN	South Okanagan General Hospital, Oliver (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.74
GREEN	South Okanagan General Hospital, Oliver (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.64
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.8

Health Care Associated Infection - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.37
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.79

Threshold for Flags
RED: > 8/1000
YELLOW: >= 6/1000 AND < 8/1000
GREEN: <= 6/1000

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	100 Mile House District Hospital, 100 Mile House (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	100 Mile House District Hospital, 100 Mile House (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	100 Mile House District Hospital, 100 Mile House (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	100 Mile House District Hospital, 100 Mile House (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	2.4
GREEN	Arrow Lakes Hospital, Nakusp (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Arrow Lakes Hospital, Nakusp (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
GREEN	Arrow Lakes Hospital, Nakusp (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Arrow Lakes Hospital, Nakusp (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Boundary Hospital & Community Care Centre, Grand Forks (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	4.5
GREEN	Boundary Hospital & Community Care Centre, Grand Forks (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3.4
GREEN	Boundary Hospital & Community Care Centre, Grand Forks (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	5
GREEN	Boundary Hospital & Community Care Centre, Grand Forks (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	1.9
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.69
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.74

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.2
GREEN	Cariboo Memorial Hospital, Williams Lake (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0.42
GREEN	Creston Valley Hospital & Health Centre, Creston (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Creston Valley Hospital & Health Centre, Creston (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	2.4
GREEN	Creston Valley Hospital & Health Centre, Creston (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.85
GREEN	Creston Valley Hospital & Health Centre, Creston (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Dr Helmcken Memorial Hospital, Clearwater (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Dr Helmcken Memorial Hospital, Clearwater (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
GREEN	Dr Helmcken Memorial Hospital, Clearwater (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Dr Helmcken Memorial Hospital, Clearwater (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	1.2
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	2.4

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.5
GREEN	East Kootenay Regional Hospital, Cranbrook (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0.97
GREEN	Elk Valley Hospital, Fernie (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Elk Valley Hospital, Fernie (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	1.8
GREEN	Elk Valley Hospital, Fernie (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	2.3
GREEN	Elk Valley Hospital, Fernie (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0
GREEN	Golden & District Regional Hospital, Golden (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Golden & District Regional Hospital, Golden (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
GREEN	Golden & District Regional Hospital, Golden (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Golden & District Regional Hospital, Golden (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0
GREEN	Hillside Psychiatric Centre, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Invermere & District Hospital, Invermere (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	1.5
GREEN	Invermere & District Hospital, Invermere (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Invermere & District Hospital, Invermere (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Invermere & District Hospital, Invermere (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	2.6
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.45
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.76
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.53
GREEN	Kelowna General Hospital, Kelowna (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0.68
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.48

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.25
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.86
GREEN	Kootenay Boundary Regional Hospital, Trail (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0.74
GREEN	Kootenay Lake Hospital, Nelson (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.29
GREEN	Kootenay Lake Hospital, Nelson (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.29
GREEN	Kootenay Lake Hospital, Nelson (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Kootenay Lake Hospital, Nelson (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0.3

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Lillooet Hospital & Health Centre, Lillooet (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Lillooet Hospital & Health Centre, Lillooet (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
GREEN	Lillooet Hospital & Health Centre, Lillooet (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Lillooet Hospital & Health Centre, Lillooet (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0
GREEN	Nicola Valley Health Care Centre, Merritt (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	Nicola Valley Health Care Centre, Merritt (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	2.7
GREEN	Nicola Valley Health Care Centre, Merritt (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Nicola Valley Health Care Centre, Merritt (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	1.3
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.15
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.31
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	1.5
GREEN	Penticton Regional Hospital, Penticton (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0.57
GREEN	Princeton General Hospital, Princeton (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	2.5
GREEN	Princeton General Hospital, Princeton (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	3

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Princeton General Hospital, Princeton (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Princeton General Hospital, Princeton (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0
GREEN	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	3.7
GREEN	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0
GREEN	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	Queen Victoria Hospital, Revelstoke (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.37
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.36
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.42
GREEN	Royal Inland Hospital, Kamloops (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0.6
GREEN	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.52
GREEN	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.53
GREEN	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.78

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Shuswap Lake Hospital, Salmon Arm (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0
GREEN	South Okanagan General Hospital, Oliver (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0
GREEN	South Okanagan General Hospital, Oliver (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.74
GREEN	South Okanagan General Hospital, Oliver (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0
GREEN	South Okanagan General Hospital, Oliver (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	1.7
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/01/2009 31/03/2009	0.58
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/04/2009 30/06/2009	0.15

Health Care Associated Infection - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/07/2009 30/09/2009	0.29
GREEN	Vernon Jubilee Hospital, Vernon (Infection Prevention and Control)	Infection Control (IH)	01/10/2009 31/12/2009	0.5

Threshold for Flags
RED: > 8/1000
YELLOW: >= 6/1000 AND < 8/1000
GREEN: <= 6/1000

Next Steps

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

- ☐ We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.

- ☐ In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.

- ☐ You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

Appendix A – Accreditation Decision Guidelines

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

1. population focus
2. accessibility
3. safety
4. worklife
5. client-centred services
6. continuity of services
7. effectiveness
8. efficiency

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

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

Accreditation Canada High Priority Criteria
Accreditation Canada recognizes High Priority Criteria in several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

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

Based on the above, the three accreditation decisions for 2009 Qmentum surveys are:

Option 1: Accreditation
An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

(a) 10% or less of high priority criteria unmet per standard section, and
(b) compliance with all of the Required Organizational Practices, and
(c) compliance with collection of all the performance measures

Option 2: Accreditation with Condition: Report or Focused Visit
An organization will receive Accreditation with Condition: Report or Focused Visit if any of following criteria is met:

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

The condition and time frame for submission of the report or visit is based on the nature of the recommendations.

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

Option 3: Non Accreditation
An organization will not be accredited if the following conditions exist:

(a) More than 30% of high priority criteria unmet per standard section and
(b) More than 20% of unmet criteria for the organization