ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Prepared for:

Izaak Walton Killam (IWK) Health Centre

Halifax, NS

On-site Survey Dates:

May 9, 2011 - May 13, 2011

May 31, 2011

Accredited by ISQua

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 Izaak Walton Killam (IWK) Health Centre.

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 Izaak Walton Killam (IWK) Health Centre 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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Table of Contents

About the Accreditation Report ii
Accreditation Summary 1
Surveyor's Commentary 3
Organization's Commentary 6
Leading Practices 7
Overview by Quality Dimension 10
Overview by Standard Section 11
Overview by Required Organizational Practices (ROPs) 13
Detailed Accreditation Results 14
Performance Measure Results 65
Instrument Results 65
Appendix A – Accreditation Decision Guidelines 75

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

Izaak Walton Killam (IWK) Health Centre

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

On-site survey dates	May 9 to 13, 2011
Report Issue Date:	May 31, 2011

Accreditation Decision	Accreditation with Condition (Report)

Locations

The following locations were visited during this survey visit:

1	Compass, 5940 South Street
2	IWK Health Centre (Main Campus)
3	Mental Health Services (7071 Bayer's Rd)
4	One Craigmore

Service areas

The following service areas were visited during this survey visit:

1	Addictions/Gambling
2	Ambulatory Care
3	Cancer Care
4	Diagnostic Imaging
5	Emergency Department
6	Hospice/Palliative Care
7	Intensive Care Unit/Critical Care
8	Laboratory
9	Maternal/Perinatal
10	Medicine
11	Mental Health
12	Operating Room
13	Organ and Tissue Donation Standards for Deceased Donors

14 Organ and Tissue Transplantation Services
15 Point-of-Care Testing Services
16 Rehabilitation
17 Sterilization and Reprocessing of Medical Equipment
18 Surgical Care
19 Telehealth

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

The Izaak Walton Killam Health Centre (IWK) can celebrate many successes, especially its commitment to quality improvement and patient safety through the active participation in the accreditation process. In 2008, when the IWK was last surveyed, the Accreditation Canada surveyors noted the dedication and openness to change and described it as "the air" at IWK. During our survey the past several days, we have certainly "breathed" this and experienced a group of dedicated, passionate board members, staff, physicians and volunteers.

The various teams are commended on their work, making the accreditation process comprehensive and welcoming our surveyor team.

The staff at IWK is enthusiastic and enjoyed speaking with surveyors to provide feedback and share ideas. There is great energy to continue to build morale and to continue the work already established in terms of quality improvement and a culture of safety.

OVERALL STRENGTHS

The IWK has implemented many enhancements, some as a result of the previous accreditation survey, having addressed all of their conditions, and many as a result of being committed to quality improvement. They strive to lead projects and initiatives that make patient and family care safer and better. To continue the momentum and to strive harder, new Accreditation Canada standard areas such as transplant and telehealth have being used for the first time by the IWK. When asked about successes that have been achieved, the organization reports a number of strengths.

The creation of a strong "All Hazards" Steering Committee and the opening of the Emergency Operation Centre are commendable. The new centre is ready 24/7 and is set up with physical and organization systems to guide key people in the management of a disaster or systemic emergency.

There is clear evidence of the use of data and information to make improvements. For example, a spike in "no show" rates in Diagnostic Imaging resulted in a new patient booking process. Other examples include blackout conditions in an electronic function prompting the development of additional back up plans and satisfaction survey feedback resulting in an initiative that improved report turnout times.

Renovation outcomes are positive with users having had ample opportunity to contribute to the design. The renovations are now complete in a number of areas in the paediatrics site. The improvements are visible and palpable when in these clinical areas. The posters for falls prevention in the waiting rooms are large and displayed in prominent places, encouraging safety.
There is a strong commitment to a patient safety and quality culture at all levels of the organization and efforts are tied back to the Strategic Directions. The IWK is engaged in research and academic teaching, adding to the promise of the future.

A variety of communication approaches are used in order to address interests and information needs. Most importantly there appears to be a strong sense of face to face communication, regular meetings and relationship building within and external to the IWK. Tools such as the Pulse intranet site provide strong linkages for communication and information.

Innovation, perseverance, creativity and willingness to possibilities are evident. Putting children at ease awaiting lab tests by offering “Read to Me” readers is extremely well received by patients and families. The IWK senior leaders, staff and physicians are “connected” internally and externally in providing specialized professional and respectful care. For example the Every One, Everyone Diversity & Inclusion commitment demonstrates an inclusive and collaborative approach. As well ethics tools for patients and families help facilitate reflection and support in times of distress. There are some excellent examples of interprofessional collaboration that support quality patient care such as rounds and Morbidity Occurrence and Mortality (MOM) meetings.

OVERALL AREAS FOR IMPROVEMENT

While the IWK has and will continue to experience change, there is an understanding and capacity for this. Master planning to improve areas such as the Neonatal Intensive Care Unit, Paediatric Intensive Care Unit, Women’s peri-operative and Mental Health areas will enhance space and service. There is interest in improving wait lists, appreciating this will need to be accomplished within existing resources. Bringing diagnostic and screening mammography to the IWK will improve coordination of care for women with the intent of being a “one stop” approach. Several operational reviews are underway or being planned that will focus on duplication of services, efficiencies and effectiveness. For example, there are 19 recommendations from the PICU review that once implemented will result in significant quality improvement of care. The lean methodology that is being used is demonstrating positive outcomes, and should be applied more widely across the IWK.

SUCCESSES THAT THE LEADERSHIP AT THE ORGANIZATION HAS ACHIEVED

In their commitment to quality and safe patient care, the Board has established a new Board Quality Committee. This committee held its first meeting in January 2011. Its initial focus is in the area of access and wait times. The data that is generated from AEMS (Adverse Events Management System) provides insight into patient safety and quality.

The IWK can take pride in its partnership efforts with Capital Health for the operation of the Breast Health Program. The first stage is now in place with breast surgery taking place at the IWK. The coordination of care, reduced wait times and a more comprehensive approach to breast cancer care is intended to advance research and services.

The recent multi-million dollar redevelopment of the paediatric site includes new Ambulatory, peri operative space, as well as inpatient units with single rooms with space and enhancements for families to room in.

The IWK was recognized as a Regional Finalist in Canada’s 10 Most Admired Corporate Cultures in 2010 and won the Healthy Workplace Leader by the Halifax Chamber of Commerce in 2008 and 2009.
The innovative “Twenty-four Hour Dial for Dining Program” won the IWK Food Services Team the 3M Health Care Quality Team Award in 2010. The IWK Public Relations was awarded three Hygeia Awards (Health Care Public Relations) for projects.

SOME OF THE CHALLENGES

The IWK faces challenges as well as some opportunities. There is some uncertainty about fiscal pressures and the future. While the IWK has a track record of maintaining a balanced budget, service reductions or realignment and increased volumes in some areas will need to be addressed.

Mental health has increased in size and scope of services and a review of current and future strategies, along with appropriate space in master planning is a perceived need.

COMMUNICATION BETWEEN DIFFERENT LEVELS OF THE ORGANIZATION (the governing body, senior management, different levels of management, front line staff)

Communication is described as strong for staff, clients and partners in the community. Communication mechanisms include e-mail, newsletter, website, media releases and face to face opportunities. There is tremendous transparency within the organization in its sharing of information via the external IWK website and internally through Pulse for staff.

Tools such as SBAR (situation, background, assessment, recommendation) are used to provide information briefings for initiatives and projects. The communication plan ensures alignment with the strategic goals and quality dimensions. It includes key actions to ensure success while communicating progress on key directions and understanding the current priorities.

The relationship with the Board is based on evidence and a commitment to quality care. The Board appreciates the importance of patient safety and quality through the development of policies, the ongoing monitoring of Key Performance Indicators (KPIs) to enhance patient safety and performance.

THE RELATIONSHIP BETWEEN THE ORGANIZATION AND THE COMMUNITY

There are many examples of IWK's partnerships and collaborative initiatives, such as the primary health care network, the Art Gallery of Nova Scotia, Nova Scotia Provincial Libraries, Family Resource Centres, Capital Health/IWK Population Health Committee, Halifax Regional School Board, Immigrant Settlement & Integration Services, Boys & Girls Club to name a few. Some community partners share staff positions, while others provide space, or capitalize on opportunities to access funds and reach unique populations. The community partners are interested in deepening the relationship with IWK, and breaking down silos between the justice department, education and health. Preventative, proactive services with a population health lens approach is desired rather than a traditional medical lens. The leadership and staff work closely with their partners to navigate, support and enhance the continuity of care and services within and external to the IWK.

IN SUMMARY

The IWK is encouraged to celebrate the successes achieved to date and to set and hold a course for the future.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

We have just completed another successful Accreditation Canada Survey at the IWK Health Centre. This accomplishment is a direct result of the efforts of all of you – the IWK staff, physicians and volunteers who work hard each day to provide the best possible care to Maritime children, women, youth and families. It is wonderful when others from outside our organization note these impacts and recognize these efforts too – that's what happened through this most recent Accreditation Survey. A huge thank you is extended to each of you for your participation and cooperation during the accreditation process.

The scope of our 2011 on-site Survey by Accreditation Canada was far-reaching as six surveyors and one intern surveyor visited with many teams and services across the IWK, including several off-site service locations. The surveyors followed an extensive schedule as well as made impromptu visits to some areas as they 'traced' both clinical and administrative processes through their course, in order to validate our processes against 26 sets of Qmentum standards.

Overall, the accreditation process offers us a comprehensive evaluation of our services, validates the high standard of care and service we provide while also provides us with insight on where we need to direct our immediate focus for ongoing improvement. This report outlines our strengths and also touches on a few challenges the IWK faces. Setting priorities for these challenges will be a key factor as we move forward.

We wish to extend a sincere appreciation to the dedicated team of Accreditation Canada Surveyors who spent the week of May 9-13th, 2011 at the IWK. Your professionalism and engaging approach was welcoming during the survey and the insights you have provided in this report are an invaluable measurement of our work.

The IWK Health Centre is committed to having a strong culture of quality improvement and patient safety. The Accreditation Canada Qmentum Program provides us with the best practice tools and measures to evaluate our work and will enable us to remain committed to helping families be healthy and get the best care.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

Leading practices are commendable or exemplary organizational practices that demonstrate high quality leadership and service delivery. Accreditation Canada considers these practices worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue.

Leading Practices
- are creative and innovative
- demonstrate efficiency in practice
- are linked to Accreditation Canada standards
- are adaptable by other organizations

Izaak Walton Killam (IWK) Health Centre is commended for the following:

Scrub in at the IWK – Board of Director Event/Orientation

The Scrub in at the IWK was a huge success. Everyone involved was 100% engaged and excited about being a part of the IWK Health Centre. Board members were effusive with their accolades. This event allowed Board Members to experience the inner workings of the Health Centre to give them a first-hand experience they could not have received in a general orientation. The impact on each Board Member was that their perspective of the participating department/unit was at a much deeper level of detail. Also, level of understanding of the caliber of people working within the Health Centre was heightened. Equally, the staff were highly motivated to have the opportunity to speak to this level of governance. (Sustainable Governance)

Patient and Family Ethics Tool: Help with Ethical Issues

The IWK Patient and Family Ethics Tool was designed to meet the needs of patients and families in identifying, addressing and discussing ethics issues related to care. It was developed by the IWK Ethics Committee using a collaborative process with key input from members of the Family Leadership Council, Patient and Family Centred Care, and Diversity and Inclusion. The Ethics Tool is provided to all inpatients and is made available in all ambulatory clinics as well as being available for downloading from the IWK Health Centre website. The response to the Ethics Tool has been very positive and evaluation of the tool is ongoing. (Effective Organization)

Twenty-four Hour Dial for Dining Program

Nearly 40% of hospital food is thrown in the garbage, wasting not only food but also the financial and human resources required to produce it. This wastage may be partly attributed to the limitations of traditional hospital food service, in which meals and serving times are set by institutions based on convenience and efficiency, and patients are required to select meals two days in advance from a limited menu. Many patients are unlikely to meet their nutritional needs if they have little choice, can only eat at pre-determined times, must make meal choices days in advance of eating and are dissatisfied with the hospital's food service.

In 2007, traditional food service at the IWK Health Centre yielded low patient satisfaction (70%) and high food wastage (30-50%). These statistics prompted a multidisciplinary team to pilot a hotel style food service model in 2008, branded by the health centre as Dial for Dining. Patients, family members and staff can order what they want, when they want, 24 hours a day, from a menu with over thirty (30) entrees. Patients and guests simply pick up the phone to order their meal from a hotel style room service menu and the call centre staff will process their meal selections. Patients requiring special diets speak to staff specially trained in clinical nutrition. Computer controls are also in place to ensure patients only receive food appropriate to their specific therapeutic diet requirements.

In reviewing the literature, it appears the IWK is the first hospital in Canada to offer 24 hour food services, improving patient satisfaction by over 90% and decreasing food wastage by 92%. Dial for Dining embodies the IWK Health Care Centre's Vision of Healthy Families. The Best Care., as the program addresses patient and family members nutritional needs with a 24 hour service.

The food services department at the IWK Health Centre is a proud and innovative leader in healthy food services. Recognized provincially and nationally for its "outside the box" approach, 24 hour Dial for Dining opportunities are being reviewed and adopted by several hospitals within Canada.
(Effective Organization)

Using Collaborative Approaches for Addressing Challenging/Aggressive Behavior

The Compass team has found that implementing collaborative approaches for understanding and addressing challenging behaviors have had a significant impact on patient and staff safety, as well as quality of work life for staff, client and family recovery.

Although there are times in which seclusion is required in order to promote safety for all, the team recognizes that intervening proactively to prevent the use of seclusion is best practice for preventing injury. The use of collaborative approaches has provided a framework for recognizing triggers for aggression, intervening proactively to prevent situations of aggression and partnering with clients and families to better understand the unique situations for the children and families who access our services. Implementing collaborative approaches for addressing aggression has contributed to a significant decrease in seclusion rates: 80% decrease in seclusion rates.

However, the impact of collaborative approaches extends beyond seclusion rates. Staff's confidence and competence in managing challenging situations has improved significantly. Staff feel better about the quality of care and treatment provided to clients and families. In addition, the principles learned through this respectful model have been generalized to collegial communication practices. Team member to team member communication focuses on triggers to aggressive behaviors and outcomes of partnering with clients and families to prevent reoccurrence of aggressive behaviors.

Clients have also expressed improved outcomes from collaborative approaches to addressing aggression. Clients have shared with team members that they notice the Compass team uses a different approach. They feel listened to, respected, cared for and empowered as participants in their care. They have also shared that they feel better able to handle life situations as a result of the support of the team. Team members also notice that as clients become familiar with the principles of collaborative approaches, clients are better able to recognize potentially challenging situations and partner with their parents/team members to resolve potentially problematic situations.

Finally, collaborative approaches have had a positive impact for parents and families as well. Parents feel respected and important as their unique stories are valued and provide the base from which the team works with the clients/families to support recovery. Parents have shared, and team members have witnessed, that parents view their child's behavior in a different light, where parents seek to understand the trigger for their child's behavior, rather blaming the child for their behavior and expecting them to know better. This way of understanding behavior has had a positive impact on the parent-child relationship. In addition, parents feel they have options for intervening with their kids and feel empowered to talk with their children and work out issues that are causing problems in their unique situation.

In summary, utilizing collaborative approaches to address aggression is a leading practice as it has had a positive impact on patient and staff safety, the quality of care delivered and the outcomes of treatment at Compass.
(Mental Health Services)

Consult the Experts! IWK Launches its Youth Patient Faculty and "IWK Cup" Staff Education Video

The "IWK Cup" is a fun, positive, innovative, engaging sportscast-themed video with clear and important messages about what to do, and not to do, when it comes to effectively partnering with youth in their health. It was formally launched at the IWK's 2010 Annual General Meeting with great success and positive feedback from the community, staff, physicians and leadership. The youth also designed an innovative "Referee's Handbook" as accompanying guide, including their Top Ten practices.

The IWK Cup" articulately and effectively teaches a skills-based approach to youth centred practice, based fully on the perspectives of experienced youth patients. The Youth Patient Faculty fully embodies the principles of Patient and Family Centred practice in placing youth patients in the centre of dialogues regarding care and service, and recognizing and learning from their expertise in the experience of care.
(Medicine Services)

Prospective monitoring of pediatric cardiac surgery program complications

This program has resulted in the realtime availability of standardized surgical complication information. This allows early recognition of instances where complication rates are climbing, or when previously elevated complication rates are returning to normal. The use of standard definitions ensures everyone is "counting" the same events, and the use of categories of operations of the same "risk" rather than individual operations or individual complications allows us as a smaller centre to recognize and intervene when complication rates are increasing. It also provides useful benchmarking for our institution and others to use going forward, allowing us to narrow our "acceptable complication limits" as we move forward.
(Surgical Care Services)

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)	99	2	1	102
Accessibility (Providing timely and equitable services)	146	0	2	148
Safety (Keeping people safe)	588	13	99	700
Worklife (Supporting wellness in the work environment)	178	2	12	192
Client-centred Services (Putting clients and families first)	276	5	35	316
Continuity of Services (Experiencing coordinated and seamless services)	79	0	4	83
Effectiveness (Doing the right thing to achieve the best possible results)	972	45	103	1120
Efficiency (Making the best use of resources)	98	1	3	102
Total	**2436**	**68**	**259**	**2763**

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	91	0	0	91
Effective Organization	103	3	0	106
Infection Prevention and Control	101	0	2	103
Mental Health Populations	58	11	0	69
Ambulatory Care Services	113	2	5	120
Biomedical Laboratory Services	52	0	0	52
Blood Bank and Transfusion Services	47	2	9	58
Cancer Care and Oncology Services	107	1	3	111
Critical Care	124	2	3	129
Diagnostic Imaging Services	91	9	4	104
Emergency Department	118	1	2	121
Hospice, Palliative, and End-of-Life Services	104	1	29	134
Laboratory and Blood Services	162	12	2	176
Managing Medications	134	0	1	135
Medicine Services	102	1	2	105
Mental Health Services	102	6	3	111
Obstetrics/Perinatal Care Services	116	0	3	119
Operating Rooms	102	0	0	102
Organ and Tissue Donation Standards for Deceased Donors	48	0	67	115
Organ and Tissue Transplant Standards	42	0	99	141
Point-of-Care Testing	71	14	2	87
Rehabilitation Services	90	1	12	103
Reprocessing and Sterilization of Reusable Medical Devices	98	1	0	99
Substance Abuse and Problem Gambling Services	100	1	2	103
Surgical Care Services	101	0	1	102

Telehealth Services	59	0	8	67
Total	**2436**	**68**	**259**	**2763**

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
Effective Organization 8.5	The organization prevents workplace violence.

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

Both the Board and Expanded Executive Leadership Team described their efforts in developing the current strategic directions and priorities, as well as how they are considering a more innovative process for the future. This might include the potential use of social media and crowdsourcing in order to expand the input and approach in the development of the strategic plan. Rolling strategic directions posters were one example of a strategy used to literally "move" the strategic plan throughout the health centre.

The IWK is proud of its Diversity and Inclusion Portfolio and indicated that a diversity lens is used in conjunction with all projects and aspects of functioning.

Examples of how the organization has created incentives for innovation and overcoming challenges included STARS (Special Time to Appreciate and Recognize Staff awards), family faculty and youth advisory groups.

A Change Management Office is in place to ensure that the strategic plan "does not sit on a shelf". This office helps with the coordination of the approximately 50 various initiatives, providing Key Performance Indicator (KPI) data.

The approach to changes in the Model of Care delivery was described as a change that has required investment of time and energy. Although staff were initially sceptical, successes have been garnered in savings and a better understanding of the various roles and scopes of practice.

There are many examples of IWK's partnerships and collaborative initiatives, such as the Primary Health Care Network, the Art Gallery of Nova Scotia, Nova Scotia Provincial Libraries, Family Resource Centres, Capital Health/IWK Population Health Committee, Halifax Regional School Board, Immigrant Settlement & Integration Services, as well as the Boys & Girls Club to name a few. The leadership and staff work closely with their partners to enhance the continuity of care and services within and external to the IWK.

Examples of strategic direction plans for services were reviewed. These are impressive in format, including a "mini mission and values" as described by staff for the specific service. Clear identification of accountability for the deliverables would help make these service direction/operational plans stronger.

No Unmet Criteria for this Priority Process.

Resource Management

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

Surveyor Comments

Challenging times of fiscal restraint and uncertainty has not squelched the desire of the Board and Executive Leadership Team (ELT) to continue to understand and plan for the IWK's services. There is a plethora of data through the KPIs, and strength in the Board and ELT in order to align and influence at the local and provincial levels. IWK has been fortunate to date with strong financial performance, having built trust and strong working relationships with government. While there is currently some anxiety regarding the uncertainty of future funding and the challenge of decreased capital, contingencies and strong leadership are in place. The Board is to be commended on considering the implications decisions will have on the technology, people and reputation of the IWK, when determining financial allocations.

"Scrub in at the IWK" is an innovative experience where the board members participate in a simulation of a typical service delivery situation, such as being part of a trauma response in the Emergency Department. This is an example of how IWK supports the board members to truly understand the health care business and have a more enlightened perspective during their decision making.

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

The IWK ensures that staff understand the values of the organization as well as the embedded importance of family centred care and safety. Information, such as the results of the work life pulse survey, are communicated on the "PULSE" intranet and also in a bi-weekly newsletter called "Making Waves". For physicians a "Docs Digest" is used to provide high level information.

The Board decreased in size from 26 to 17 in order to be more efficient and effective. New board members receive a comprehensive orientation, and an education component is included in each board meeting.

Span of control is an area for consideration of the Executive Leadership Team, as there are some leaders with very large portfolios. Additionally, overtime rates in some areas are very high and this points towards work life balance being a challenge.

The IWK is actively working on strategies to monitor performance and employee development.

Currently there is a recent working draft of a workplace violence policy. In speaking with staff, there is concern about violence in the workplace and they are not aware of assessments and processes. No KPIs or specific reports related to workplace violence were provided as evidence in meeting the tests for compliance with this new Required Organizational Practice (ROP).

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

Criteria	Location	Priority for Action
Effective Organization		
The organization prevents workplace violence.	8.5	↑
The organization has a written workplace violence policy.	8.5.1	
The policy is developed in consultation with staff, service providers, and volunteers.	8.5.2	
The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and make improvements to the workplace violence policy.	8.5.7	
The organization provides information and training to staff on the prevention of workplace violence.	8.5.8	
The organization's leaders implement policies and procedures to monitor performance.	12.9	

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

The Board and Executive Leadership Team (ELT) analyze performance information. A new Quality Committee of the Board has been created in January 2011 to ensure quality, safety and access/wait times are monitored, and that the organization is supported in these areas. Board members appreciate the Key Performance Indicators (KPIs) as a means of trending and tracking performance.

Keeping patients safe is one of the IWK's Key Directions. The Adverse Events Management System (AEMS) has been in place for three years. This system is able to capture more than just adverse events, and allows for anonymous reporting (should this be desired). Timelines are in place to ensure progress on follow up actions and outcomes. Morbidity Occurrences Mortality (MOM) groups meet on a regular basis. They conduct case reviews from the AEMS reports and make recommendations.

The patient safety strategy map was approved by the ELT in 2009. The four quadrants include safety environment, collaboration, partnering with patients and families, as well as leading and learning. As work in patient safety evolves, for example templates from the Canadian Patient Safety Institute, the quality staff adapt existing tools to stay current.

Annual lean education in healthcare is provided by staff industrial engineers. The content of the education which occurs two to three times per year, includes theory, group work and applied learning taught over 2.5 days to approximately 12-20 staff per group. The objective of the lean management education is to ensure value seeking and understanding of quality and process improvement.

Resident and student education on quality and safety are provided, which is extremely important to this academic teaching facility.

Various patient safety culture tools have been implemented in order to align with the IWK patient safety strategy map and to meet Accreditation Canada's and organization-wide assessments.

Enterprise risk management has been expanded, with a more proactive approach in looking at potential impact, AEMS data, claims and Required Organizational Practices (ROPs).

A current patient safety pamphlet is in use and there are plans underway to create a bookmark with the "Okay to Ask - Okay to Tell" theme in order to be more responsive to patients and families and to provide openness in the interest of safety and comprehensive care.

As a result of feedback, a new patient experience feedback process has been established - called Anyone, Anytime, Anywhere. The intent is to build advocacy capacity in staff and to be as transparent and accessible as possible. Plans include using the word "feedback" more as opposed to "complaints", responding to all feedback in a timely manner, communicating time lines and expectations to patients & families, developing education, communication and capacity.

An example and tracer was followed during the survey. To evaluate potential improvement opportunities in the admissions process at the IWK, a team of Industrial Psychology Students examined aspects of the workplace from a human factors perspective. This project included many positive outcomes including a reduction in admitting/registration errors, a more rigorous staff training approach and online manual.

The "Scrub in at the IWK" was described by the Board as one of the best "hands on" ways of having a better understanding of the workings of the IWK, helping them to have a more informed view in their decision making. This initiative included Board members being prepared (dressed in scrubs) and actively observing simulated medical situations that happen at IWK. The video footage of the examples is a helpful education tool and demonstrates the impact that skilled professionals have on the lives of patients and families cared for at the IWK as evidenced first-hand by Board members.

Food services has in place a "Dial for Dining" program that has won a 3M Award .This service has been very effective and cost saving and patients have reported a 91% satisfaction rating with the food. They have also begun to provide supper services to two off site Mental Health Facilities and the cook travels to the facility. This department is focused on continual improvement and customer focused service. Food services also supports dietetic internships within the hospital as well as healthy food choices. They are installing a healthy choices vending machine in the Emergency Department as a trial.

An algorithm has been developed for the disclosure of sentinel events. The disclosure is done by physicians.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

TThe Ethics Framework includes components of: the ethics committee, education, review of policies and consultation, as well as a relationship with the Research Ethics Board for IWK. A new Ethics Education Plan is being rolled out in May 2011. The ethics education delivery plan includes short, medium and long term goals, however specific timelines, dates and accountability are not identified. The Ethics Committee includes five non-staff members from the community to ensure transparency and openness with processes. The Research Ethics Board is also commended for including community non-staff members in their membership.

The IWK has an internal ethics consultation service, which is supported by ethicists from Dalhousie University. Organizational and clinical ethics issues are brought forward by phone to a centralized line or contact with ethics consultants.

A Patient and Family Ethics Tool has been established. It is available in hard copy at the IWK and downloadable on the external website. While there are many tools and templates available to staff for addressing ethical dilemmas and ethical decision making, tools specifically designed for patients and families are rare. In testing the central ethics telephone line as part of the survey tracer, the response was timely and appreciated. Staff in clinical areas were able to articulate the consultation support for ethics available to them.

No Unmet Criteria for this Priority Process.

Communication

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

Surveyor Comments

Community partners describe communication with the IWK as two-way, feeling that they are heard and information is shared with them.

The Board indicates they feel informed and prepared, and are provided with adequate communication, documentation and time to review materials prior to meetings.

The Pulse Intranet is intuitive and used to access information, news, policies and data. Additionally, community members on committees report using the external website, appreciating that tools and information are available as downloads.

In demonstrating the use of the Adverse Events Management System (AEMS), the drop down menus and selections made using the system straight-forward. Furthermore, the results communicated electronically via internal (firewall protected) e-mail were timely and distributed as required.

The Public Relations Team supports the development of the communication plan, the management of communications in relation to issues or concerns, electronic communications and social media, as well as other projects for the organization. Managing and leveraging the IWK reputation and image both internally and externally are an important part of their role. The public relations team maintains close ties with government contacts as needed. Additionally they coordinate special events, for example public launches of programs or other community focussed gatherings.

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

The IWK brings the physical plant in line with new code standards at the point of new builds or renovations. Contractor activity and site access is guided by policy ensuring safety for all persons. The IWK completed a major construction project in 2009 and is currently underway with some smaller renovations. Secure hoarding isolates the construction area from the hospital and is built to control dust and other airborne contaminants. Engineering works with Infection Prevention and Control (IPC) services to minimize the impact on hospital services and to keep people safe. When the unexpected occurs, such as the escape of asbestos in area remote to the actual work, the engineering team collaborates with the clinical team to execute a safe and comprehensive response. Effective debriefs ensure that lessons learned result in improvements.

Engineering has put several contingencies in place for backing up utility failures, in some cases multiple levels of backup systems such as generators, secondary generators and battery packs. In 2010, their back-up systems were tested when a hospital power failure occurred in tandem with a generator failure. Rapid diagnosis of the problem minimized the impact on patient care while demonstrating the effectiveness and weaknesses of the back-up systems. A thorough review of this situation resulted in changes to communication systems, backup power systems, and departmental responsibilities for unique requirements. The organization was inclusive in the debriefing and transparent in the dissemination of information resulting in a valuable learning opportunity that has strengthened their ability to respond to utility failures.

A proactive decision to change the oxygen infrastructure from a water dependent system was taken due to the inability to satisfactorily control water availability.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

A strong model for emergency preparedness has been created. The All Hazards Steering and Advisory Committee supports the development and maintenance of emergency support plans. This work is done jointly between the committee and formal unit specific Working Groups for all areas within the facility. The use of a Hazard Risk Assessment Tool assisted the committee in proactively identifying and prioritizing hazards for the development of risk management plans. Noted is an extensive list of emergency preparedness exercises and drills that have taken place in the last three years. An evacuation exercise in a high risk clinical unit is planned for this month. An Emergency Operation Centre has been designed and setup for use by the emergency response team during the management of any large scale crisis.

Recent use of the centre for two situations has demonstrated its value. Structured systems help the response management team assess the probabilities and impacts on human, property, business, and overall elements of the situation. Further work is planned to refine, co-ordinate and integrate the multiple versions of written plans for all code situations in existing and renovated space.

Post construction complications with the fire alarm system have resulted in temporary suspension of the fire drill program. New employees continue to be oriented to the code red and green requirements and current staff are encouraged to reread their departmental fire plans annually. There are no fire drills scheduled at the IWK site, the team is encouraged to restart this practice as soon as possible.

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 educate staff, service providers, and clients and families about fire safety and the prevention of fire.	11.6	↑

Patient Flow

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

Surveyor Comments

The IWK is actively collecting data on wait times in accessing services within the hospital. Discharge planning services, the information technology department and medical support are collecting data on the time between when a referral request is made and when the referral consultation is completed (Wait 1), as well as the time from decision to treat to actual treatment or surgery (Wait 2). This information is being used to define minimum standards locally and benchmark this data on a national basis. This data is being used to direct focused efficiency reviews in certain departments or surgical specialities. This type of data collection is consistent with provincial initiatives. It is hoped this data will guide future decisions around funding reallocation and transfer of services elsewhere. The team is a strong advocate of the idea of informed decision making and is very committed to its successful implementation.

No Unmet Criteria for this Priority Process.

Medical Devices and Equipment

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

Surveyor Comments

The biomedical department has implemented the Asset Information Management System (AIMS) which is a database for preventative maintenance including calibration, hazards, alerts and recalls, adverse events, contract information, and repair histories. They have criteria in place to assist in determining the priority for preventative maintenance (PM) based on risk level, as well as the PM interval. This approach has been shared with the Leadership Forum. Consequently those items which are deemed high or medium priority are included in the PM program and the remainder are repaired as appropriate on a case by case basis. The related policy was revised and implemented on May 5, 2011. The database identifies those pieces of equipment requiring a PM and the work gets distributed amongst the staff in the department. There are 10 FTEs in the department, one main Biomedical area and two satellites close to the units. PM completion trends are monitored and have demonstrated a progressively higher capture rate since monitoring began with a current completion rate of just in excess of 90%. The biomedical department is currently assessing each new Braun Infusion Pump prior to their roll out in the organization in June. A committee has been struck with wide spread representation to plan for the changeover from the old pumps to the new Braun pumps and with the training plan. A train the trainer approach will be utilized.

The operating room alerts physicians to those situations where there is limited instrumentation so they can take this into consideration when booking cases to limit or negate the use of flash sterilization, for example when only two specialty instruments are available the operating room aims to restrict the number of bookings requiring this instrumentation to two. This process has improved the situation but overbooking of the procedures based on the amount of instrumentation available still occurs. This should really be done on an exception basis not as a routine practice. Flash sterilization needs to be discouraged and either additional instrumentation needs to be purchased or scheduling changed to allow for the cleaning and sterilization of the equipment prior to the next case. Logs are kept with regards to flash sterilization. The organization is encouraged to evaluate why flash sterilization is occurring and how to prevent or reduce the frequency of flashing.

Staff in Supply Processing Department (SPD) and Biomedical Engineering are very proud of the work they do.

SterilMed has been contracted to reprocess selected single use items. This is a relatively new arrangement with a savings of approximately $10,000 per month and is about to be evaluated now that it has been in place approximately a half year. SPD staff receive approximately 4-6 months of training upon hire before they become independent and are required within an 18 month period to be certified. They have an on line course from Purdue available to them. Annual re-certifications are not performed as the staff are trained on an annual basis.

The Adverse Event Management System (AEMS) is utilized to report all critical incidents or adverse events.

SPD is cleaned on a weekly basis and the staff member assigned to the cleaning also assesses and documents the air quality, temperature etc. Incineration is the approach of choice in those situations where prior contamination is suspected.

All manufacturers' information on the cleaning of items is available to the staff immediately within the department. The staff also have a narrative and a picture of how to disassemble an item for cleaning and how to put it back together etc.

The SPD department at IWK participated in Accreditation Canada's pilot of the Reprocessing and Sterilization of Reusable Medical Devices Standards.

Audit information is available to SPD staff and there is a real spirit of transparency in that department.

Infection Prevention and Control has audited all 11 areas where reprocessing occurs within the hospital and will be sharing the results of the audit in the near future. Consideration should be given to centralizing reprocessing or reducing the areas where reprocessing is done. The IPC audit results may have recommendations that will be helpful in this area.

When equipment is returned to the department there is verbal information shared regarding the repair. If for some reason staff are not available to accept the equipment written documentation is left with the item.

Telehealth:
The organization has an arrangement with Health Information Technology Services Nova Scotia (HITS-NS) a provincial service who has accountability for preventative maintenance of the telemedicine technology. They maintain the equipment on a yearly basis. The organization has been conducting telehealth sessions since 1996.

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

Criteria	Location	Priority for Action
Reprocessing and Sterilization of Reusable Medical Devices		
The team participates in periodic audits.	12.9	

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

There is a new mental health strategic plan for IWK that is in its early stages. Specific goals, objectives, deliverables and measures have not yet been established. Specific details of putting the plan into practice are not yet identified, however the group is very enthusiastic. The team expressed a desire to work towards decreasing the stigma surrounding mental health. The strategic planning process involved the community and began in September 2010. An environmental scan and literature review was conducted and approximately 51 consultations took place. A "world cafe" was held with a high level of turnout and participation. A provincial level mental health strategy is also unfolding and the team is reassured that many of the key issues that are being identified within that process are aligned with the work of the IWK.

The team is proud of their work. For example they are working hard to link with general practitioners (GPs) in the community; they have a child mental health advocate and a First Nations outreach worker, who provide education and training both internally and externally. Programs like the "Incredible Years" have been helping children with disruptive behaviour.

The challenges faced by the organization include an old, deteriorating physical plant on 4 South. There is hope for a new Children's Village to be built, which would provide a better environment for care and service. The team described the potential for the "stars aligning" in terms of using information from the service review, garnering capital funds, building new facilities, as well as setting and attaining goals that will move the mental health strategy forward.

Community partners are interested in identifying mental health issues sooner in the hope of being more proactive and reducing negative outcomes, such as involvement of the justice system. There is a desire to have more resources dedicated towards schools. And that IWK's business planning process takes into consideration programs like The After Hours Central and Schools Plus, so they are maintained in all regions. There is a desire from the community to have more consistency in the transitions from treatment to the community setting. The community partners appreciate that policies and mandates can be limiting, however they are optimistic and hopeful that the IWK can play a key advocacy and leadership role in moving the mental health agenda forward.

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

Criteria	Location	Priority for Action
Mental Health Populations		
The organization sets measurable and specific goals and objectives for its services for mental health populations.	1.4	
The organization defines how it will achieve its strategic direction, goals, and objectives for mental health populations.	1.5	
The organization supports the achievement of its goals and objectives for mental health populations.	1.6	
When developing partnerships in the community, the organization has a process to assess the quality of services provided by the partner organization.	3.2	
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	5.5	
The organization maintains a clinical information system and longitudinal client records.	12.1	

The information system is used to establish clinical priorities by classifying clients according to condition and other factors such as co-morbid conditions.	12.2
The information system is linked to evidence-based guidelines and provides reminders that identify clients in need of services or follow-up.	13.1
During client appointments, the information system provides service providers with information about adherence to applicable evidence-based guidelines and care pathways.	13.2
The organization works with primary care providers, partners, and other organizations to integrate information systems.	13.4
The organization uses the information system to generate regular reports about performance and adherence to guidelines, and to improve services and processes.	13.5

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 team uses a list of corporate project goals and objectives. However, the written goals presented are not measurable or specific to ambulatory services.

The teams visited did not use table top sterilizers but biomedical services manages and tracks all preventative and schedule maintenance for equipment.

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

Criteria	Location	Priority for Action
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

Unit aides in the women's ambulatory area are particularly well trained and consistent in their approach to cleaning and reprocessing scopes.

Staffing levels appear quite generous. The program may benefit from reviewing nursing work in orthopaedic ambulatory pre-operative visits. Perhaps the pre-operative history and physical can be completed by the primary care provider or referring physician within two weeks of surgery.

Performance reviews are not being done currently as the process in under review corporately. Feedback is given when indicated. Most position profiles are generic.

Staff in ambulatory care clinics do not use infusion pumps nor do they work in any other areas where infusion pumps are used. Furthermore, in the areas visited the teams do not use table top sterilisers.

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.	4.9	

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

All patients receive two reminder letters prior to the appointment. If the patient misses the appointment, they are contacted by phone and their response is documented. If the appointment is a first assessment, the referring doctor is notified that the patient did not attend the scheduled appointment.

In the areas visited, medication therapy was not a significant purpose for the visit.

The clean and dirty utility space is in the same room. Although staff are diligent in paying attention to the imaginary dividing line, there could be some concern about airborne contaminants.

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

The teams follow clinical guidelines recommended by expert bodies such as SOGC, Canadian Paediatric Society, CAPHC, Canadian Association of Paediatric Opthamology, Paediatric Society of North America

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

Patient satisfaction is evaluated annually. Surveys are conducted over the span of a month, any patients and families who use the service during that period are surveyed.

All medications are double checked by two nurses prior to adminstration.

No Unmet Criteria for this Priority Process.

Biomedical Laboratory Services

Diagnostic Services - Laboratory

Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

The laboratory is very well organized. Staff are friendly and proud of their work. They have grasped the concepts and understand what a quality management system is all about. Clients are overall satisfied with the service. There is good rapport between lab and clinical staff and physicians. The turn around time is excellent due to the availability of the pneumatic tube system, the layout of the laboratory and staffing arrangements. The core lab setup has pros and cons but of particular note is the way the staff move around to wherever necessary to help each other and get the results out regardless of whether it is part of their assigned duties. This practice is to be commended. Samples are processed in an exceptionally timely manner generally seen in laboratories with front end automation, which this laboratory does not have nor is it recommended due to the number of capillary samples tested. Some opportunities do exist to further streamline work in some areas and use of lean processes is encouraged. Staff are also encouraged to remember to document troubleshooting activities including resolutions.

The practice of manually transcribing results in some areas should be reviewed as there is a risk of transcription errors.

A prime example of the client satisfaction with lab services occurred when the NICU was exploring having a blood gas analyzer in the unit point of care testing which is common practice in many NICU's. Following discussions between laboratory and NICU it was determined that the turn around time for results was quite satisfactory and that there would be no added benefit or significant reduction in timeliness of results.

No Unmet Criteria for this Priority Process.

Blood Bank and Transfusion Services

Blood Services

Safe processes to handle blood and blood components, from donor selection and blood collection through to providing transfusions.

Surveyor Comments

TTransfusion medicine (TM) is a well-managed area. Staff are well trained and informed and understand their roles and responsibilities. The team is well represented on various provincial and other external transfusion committees.

Space is adequate and equipment is 'up to date'. There are both pros and cons to the 'core lab' arrangement. The layout allows for easy communication and a good team atmosphere between 'departments'. However the noise levels and potential distractions, especially for TM staff who need to be 100% focused at all times, need to be monitored.

The role of the transfusion nurse specialist is very effective in ensuring that there is good coordination of activities between the laboratory and clinical areas and that standards are followed in all areas. This is an excellent resource especially for the training and monitoring of nursing staff in blood administration.

Considerable work was done to complete the Massive Transfusion Protocol. This is a good example of teamwork and cooperation between the laboratory and clinical areas. It is suggested that a separate form be used for documenting completion of blood and blood product administration procedures (i.e. confirmation consent was obtained, time and results of vitals, reactions, observations, amount of blood transfused, etc.). This could be maintained on the clinical chart to ensure that all aspects are clearly documented for easy reference.

Continuous monitoring of room temperatures and environmental conditions is not currently done. This is essential, especially since platelets and other blood/blood products are stored at 'room temperature'. It is also recommended that issues with equipment or quality control results be documented as well as any actions taken. In addition, while temperatures of refrigerators and freezers in the blood bank are monitored and recorded, the acceptable ranges should be stated on the record sheets and there must be documentation of actions taken if temperatures fall out of range. There is minimal documentation of the details surrounding any equipment problems, or the remedial actions taken.

Blood/ blood products for home transfusion are prepared and released by the laboratory. This is a provincial initiative and the province establishes and monitors the program including the development of criteria for the service, policies and procedures and training of community nurses in the field who are administering the blood. The laboratory was actively involved in the development of the program.

The transfusion medicine staff perform look backs and trace backs in a timely fashion once notice is received. A recall procedure is in place in the event a recall of blood or blood products is initiated for any reason.

There is a process for the reporting and investigation of transfusion reactions.

Documents are in various stages of the transformation from paper to a document controlled system. Much work is yet to be done but it is well on its way.

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

Criteria	Location	Priority for Action
The organization has a written procedure to identify the recipient in the case of urgent requests or other situations where the recipient's identity is unknown. CSA Reference: Z902-10, 10.2.2	14.5	↑
The team provides all recipients with written information about the blood or blood product they receive. CSA Reference: Z902-10, 11.2.2	18.4	↑

Cancer Care and Oncology Services

Clinical Leadership

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

Surveyor Comments

The Oncology Group has formed a Haematology Oncology Interdisciplinary Committee (HOIC) and this operations committee oversees the strategic KPIs, utilization, satisfaction data, AEMS information, sick time, overtime, workload data, cost of lab tests etc. The Nephrology Program has a similar committee structure entitled NIPC. This body plans for the program of services consistent with the strategic directions of IWK. Staff are aware of their job descriptions and the Clinical Coordinator, whom is responsible for performance appraisals (PA), reported that she has almost completed her two year cycle of PAs. They utilize a peer review approach in Haemotology/Oncology/Nephrology.

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 Oncology Team has interdisciplinary membership and a relentless focus on coordination of care, continuity and transitions. This is a particular strength of the team as care coordinators from ambulatory care participate in unit patient rounds, contributing their knowledge of the patient and family and ensuring continuity of information and care. There are nine dedicated care coordinators in the ambulatory and inpatient areas (four for oncology, one for bone marrow, two for haematology, one for bleeding disorders and one for long-term care follow-up).

The team has decided to align themselves with APHON (Association of Paediatric Haematology Oncology Nurses) around standards, certification of staff, education etc. Staff become certified through APHON. The other C17 hospitals (provide services for children and adolescents with cancer and serious blood disorders in Canada) have also aligned themselves with APHON thus facilitating similar standards and benchmarking opportunities.

The orientation process for new staff includes using a buddy approach prior to allowing a nurse to work independently. All staff receive orientation on new and existing equipment at the beginning of their orientation. The ambulatory area in oncology has both the care coordinators and clinical care providers in that area. Individuals in these positions cross experience each other's roles to ensure they maintain all of their skills. Peer reviews are conducted. Yearly recertification is conducted on quality measures (for example checklists and road maps), education components and practice components. Staff are expected to have a minimum of 20 chemo administrations over a two year period time frame. Staff in the ambulatory area far exceed that number of administrations, however, this is the standard recertification threshold.

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

Numerous checklists, forms etc. exist to assist in a standardized approach to care. Care coordinators assist with eliminating barriers to care and promote continuity and transition planning. Patients and families are provided with a Welcome to 6 Link Inpatient Unit Booklet upon admission to familiarize them with the unit and processes. They also receive other pamphlets to assist in orientation such as Patient Safety -Tips to Keep You and Your Family Safe During Your Visit. The unit has a comprehensive Admission/Visit Assessment Form that is utilized on admission and serves as an educational tool and orientation for the family.

Medication reconciliation (med rec) is usually initiated by the pharmacist for elective admissions, then the nurse practitioner for Oncology and then the RN or MD, if the staff mentioned before them have not completed the form. If an urgent admission, the med rec process is started in the emergency department. If the patient is an internal transfer the meditech list is printed off and this is signed off by both the sending MD and the accepting MD, and included in the transfer communication. There is also a med rec form for discharge situations so the primary care physician or other centre is aware of what medications the patient was prescribed.

There is a standardized established approach to pain assessment. This is reinforced on the assessment forms and with reminders on the chart binder. Family are aware of the assessment information as they participate in completing the assessment form. Consent form signatures are witnessed by hospital staff but the physician obtains the consent and provides information around the procedure/test. There is an Ethics Consult Team available as well as an Ethics Journal Club.

This resource is centre wide.

There is a process for documenting complaints and this is shared with the HOIC.

A Hospice, Palliative and End of Life Service Team is available on a consultation basis to support staff, as well as patients and their families. This is a regional service.

A plan of care is written on the kardex which resides on the chart but does not form part of the permanent record.

Chemotherapy is prepared by the pharmacy and delivered to a dedicated chemotherapy room on the unit, which is separate from the regular medication room. Two nurses check the physician order, the mixed bag or syringe, the "Road map" to ensure that the chemotherapy is correct and also recheck the calculations and dosage with the body surface are calculations. Both nurses also check the patient identifiers together to ensure correct patient.

Spill kits are available as well as the appropriate supply disposal containers. There is a Pyxis System in place for medications.

The care coordinators are primarily focused on the transitioning and continuity of care for the patient and family. There are dedicated coordinators who see the patient from the "beginning" to the "end", or when care is transferred when the patient is of an age that their care can no longer be provided at IWK. Dear Doctor Letters are also completed by the physician on discharge or transfer of a patient.

Patients and families can access their health records after they have completed a form in Health Records and they are accompanied by a staff member while they review the chart, in case they have questions or require clarification.

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

Criteria	Location	Priority for Action
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

The team has an excellent and inclusive process to review each patient on the unit. The interdisciplinary approach in patient rounds was impressive. The full team is available to ensure that all team members are aware of what is happening and to ensure continuity of care.

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

Satisfaction surveys have been mailed out but the response rate is low. The responses that are returned are reviewed by the HOIC or the MOM committee. The philosophy around patient feedback or complaints is to try to resolve it at the local level.

The HOIC has reviewed why lab costs are high in the program.

No Unmet Criteria for this Priority Process.

Critical Care

Clinical Leadership

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

Surveyor Comments

The NICU has developed department specific goals and objectives that are aligned with the organization's strategic goals. The goals are well-written but are not specific or measurable. Nevertheless, great work is being done by this team!

NICU has recently selected new cardiac monitors to be implemented in September. Nurses and physicians actively involved in selection of preferred vendor.

NICU is currently reviewing appropriateness of admissions and partnering with other NICUs at level two and modified level three to encourage retrotransfers. Currently over 300 admissions in the last year were one day or less.

Most of the equipment in PICU is newly acquired. PICU is a bright, quiet, comfortable, spacious environment.

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

Criteria	Location	Priority for Action
The team’s goals and objectives for its critical 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

Staffing in PICU and NICU seems quite generous. Neither the PICU nor the NICU have had any difficulty recruiting and retaining staff. The teams include Child Life Specialist, OT, PT, dietician, medicine, pharmacy, nursing, unit aides, and clerical support. The manager is in process of completing all performance reviews (240 staff).

PICU has had some focussed team building sessions.

Following a new staff member's orientation period both the new staff member and their unit educator must be in agreement that the new member is ready to be counted in the staff complement. For the first two weeks the new staff member has a lighter assignment than the normal patient load. Educational support to the staff in this unit is exceptional.

NICU had a recent difficult patient situation regarding end of life care. Staff had access to an employee and family assistance program, as well as facilitated group debriefing. Ethics consultants were accessed.

NICU space is well organised and remains comfortable for patients, families and staff. PICU has had a significant renovation of medication room that provides adequate space, is well organized, as well as being conducive to privacy, confidentiality and efficiency.

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

Memorial services can be arranged at the health centre.

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

Criteria	Location	Priority for Action
If the team offers outreach services in the form of a rapid response or medical emergency team, it defines the role of this team and communicates it to other teams in the organization.	3.2	

Decision Support

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

Surveyor Comments

Intensivists cover the PICU and neonatologists cover the NICU for three to four weeks at a time in order to provide continuity of care to babies and families. The process also enhances learning opportunities.

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 components of the Safer Health Care Now bundles for ventilator associated pneumonia and central line infections that are not applicable for babies and children have been appropriately excluded from implementation.

There is a notation on the medication administration record (MAR) when a medication is classified as high risk and requires a double signature.

No Unmet Criteria for this Priority Process.

Organ and Tissue Donation

Donation services provided from identification of a potential donor to donor management and organ recovery.

Surveyor Comments

The PICU staff has received education and direction on whom to notify and how to activate the process when there is the potential for organ and tissue donation. All appropriate policies and procedures are in place to support organ and tissue donation.

No Unmet Criteria for this Priority Process.

Diagnostic Imaging Services

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 clerical staff fax requisitions back to the referring clinician daily when a patient has not arrived as scheduled, thus ensuring patients who need diagnosis and treatment are not lost within the system. The number of “no shows” is counted for each modality. Trends monitored and changes in the processes made accordingly. For example process improvements in ultrasound include sending patients a letter providing information about their appointment date and time as well as the required preparation; providing a reminder call to the patient two days in advance of the appointment; and informing the referring clinician of when the appointment has been made for their patient. The spike in "no shows" for ultrasound has come down following implementation of these new steps in confirmation of a booking. This improvement increases productivity, manages risk and maintains optimum capacity.

There are isolated examples of verification processes in high risk activities such as when the diagnostic imaging nurse gives oral sedation for CT they verify the patient's weight prior to calculating the dose and giving the sedation. An opportunity exists for the team to proactively identify high risk activities that should have verification processes in place throughout the department.

No Unmet Criteria for this Priority Process.

Diagnostic Services - Diagnostic Imaging

Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

The Nova Scotia provincial government is preparing to launch a Regulated Health Professionals "College" model for imaging technical professionals. All technologists and sonographers are trained and have passed national CAMRT examinations and they are credentialed practitioners. The future College model will introduce CME requirements, at this time the imaging team manages and monitors their own participation in skill maintenance and professional development. The staff have demonstrated a high commitment to continuing education and do their own fundraising to support attendance at seminars and conferences. The radiologists, technical and clerical staff are professional, and demonstrate a teamwork approach within and across departments. Their ability to be gentle with young patients while performing exams and procedures is impressive. Parents interviewed unanimously praised the staff and the hospital for their consideration.

The team has planned and begun a major project to consolidate, update and formalize processes, protocols and policies that are currently used across the sites and modalities. This includes those in use by diagnostic imaging (DI) staff and radiologists as well as those for use by the interdisciplinary team. The work to update existing policies and create a manual is well underway and would benefit from a formal project management charter approach to ensure timely delivery of a successful product. The team is considering the pros and cons of a paper versus electronic format and is trying to envision how they would function in a paperless environment. The team is encouraged to follow through on this important work.

All sonographers reprocess the transvaginal probes and are instructed on the procedure, a process to verify competency is not in place. The drains and air exchange have not been modified by engineering to meet the standards required for the new function in the room designated for the reprocessing function. The reprocessing area must be dedicated to this clean function and housekeeping stores their materials and tools here. The sonographers doing the reprocessing use the same reprocessing classification for each TV probe however they are not familiar with the intent behind the Spaulding classifications system. The staff are instructed on how to clean and disinfect the probe however as previously indicated a training program is not in place. The probes are dried, coiled and placed in storage boxes - inconsistent with the recommendation to hand the probes vertically. A permanent cleaning record of each probe using the serial number is not maintained. The reprocessing data in 7.15 is not recorded or maintained. There is no "technology" in the process used for reprocessing the TV probes- therefore a preventative maintenance schedule is not required. Catheters are one time use so there are no channels to flush.

Not all modalities provide their patients with information about their procedure, there is an opportunity to improve communication with families through the IWK web site or print media.

The ultrasound service mails each patient a letter containing pertinent appointment and safety information. A requisition triage process is in place for all modalities and the radiologists frequently recommend the least invasive method needed to answer the diagnostic question. Great care is taken to radiate the paediatric population only as necessary.

Voice Recognition in concert with Agfa PACS facilitates rapid report turnaround times, routinely less than 24 hours.

The team has a radiation safety officer who has a corporate role. The team does not have a safety committee, or safety officer with a broader mandate or role description. Supervisory and MOM meetings may touch on safety as it applies to current issues however a focused proactive approach to keeping safety and radiation safety issues on an agenda is not in place. The departmental policy and procedure manual is being centralised and is under construction. A "safety" section or separate manual is not currently in place.

Staff did not consistently advise patients of their role in staying safe while in the hospital or department and patients did not indicate they received verbal or written instruction on their role in keeping themselves and their families safe while in the hospital. The majority of patients coming to DI receive a patient safety brochure at the point of entry in the emergency department or clinics and ultrasound patients receive a letter in the mail. The DI team should ensure all other patients have access to the patient safety brochure.

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

Criteria	Location	Priority for Action
The team annually reviews and regularly updates the policies and procedures manual.	6.7	
The team identifies and verifies the education and competency of staff involved in reprocessing of diagnostic imaging equipment and devices.	7.4	
All DI reprocessing areas are equipped with separate clean and decontamination work areas as well as separate storage, dedicated plumbing and drains, and proper air ventilation.	7.6	↑
If disinfection is required, a trained and competent staff member follows detailed procedures for cleaning or disinfecting the DI device or piece of equipment.	7.8	↑
The team stores DI devices and equipment in a manner that minimizes contamination or damage.	7.13	↑
For each DI device or piece of equipment, the team maintains a permanent record of reprocessing.	7.14	

The record of reprocessing includes the identification number and type of device or piece of equipment, the identification of the automated device reprocessor if applicable, date and time of the clinical procedure, the name or unique identifier of the client, and the name of the person responsible for reprocessing.	7.15	
The team appoints a safety officer, a safety committee, or both to lead its safety program.	14.2	↑
The team develops a safety manual.	14.3	↑

Emergency Department

Clinical Leadership

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

Surveyor Comments

TThe IWK has organized its Emergency Department (ED) to meet the unique needs of its paediatric populations. In general, the paediatric upper age is 16 with the exception of 19 for mental health populations. Older patients are triaged and referred to the adult hospital unless life threatening situations that would trigger a 911 call to the Emergency Health Services (EHS).

The triaging process is well defined and immediately 'in your face' on a patient entering the department. Signage is excellent on the outside of the building and clearly directs the patient to the triage desk. There are very large windows and the triage nurse will go to the patient to get a sense of the problem and encourage the families that their child will be triaged quickly.

At triage, there is a detailed process of obtaining history and some objective clinical assessments are done. Once the assessment is completed, the patient is given a coloured card that will identify Canadian Triage Acuity Scale classification and are told the approximate wait in the waiting room. Also the triage nurse reinforces to the patient’s family to contact her if the patient's condition changes.

When a room comes free, the primary ED nurse will come to the waiting room and take the family and the patient to a room for a further assessment and update of vitals. If concerns exist as pertaining to unstable conditions or pain, the nurse will tract down the ED Resident for an urgent assessment. If the patient was stable, the Resident will see the patient in sequence.

After the Resident reviews the patient, the staff man will review the information with the resident and see the patient if needed. Out of this encounter, appropriate diagnostics will be triggered.

When the diagnostics are available, the resident and staff man will return to the patient to give feedback and appropriate therapy to the patient and advise on discharge.

If necessary and especially in the setting of serious illness, magnetic resonance imaging (MRI) and x-ray computed tomography (CT) scan be triggered after verbal consultation with the radiologist. The MRI and CT suite are adjacent to the ED suite. The service is available 24/7 and verbal feedback from the radiologist is very quick.

The physical space in the ED is dated and relatively limited for the volumes of over 30,000 visits per year and the tertiary complexity of many of their patients. Although the space is well utilized and lines of site are generally good, there is little ability to expand if volumes or complexity dictate. Generally the rooms are adequately stocked and equipped, they are often small or in the case of trauma, a fair distance with the EHS bay.

The PACS system allows for very quick access to the diagnostic imaging (DI) images. However the monitor in the ED is small, in a small room that does not easily allow for teaching or consultations or in the case of the cast room, required a different pathway through the computer to see the films.

The staff is well prepared and feel well supported. The academic environment fosters an ongoing learning environment and team work between the staff and the "learners". The group is able to easily access the support of the CHILD LIFE specialist to support family and the patient during periods of stress.

The other population supported in the ED is the mental health Crisis Team that is based within the emergency room. A team member is available 24/7 and can be accessed directly by the patient or family, on the request of the registered nurse (RN), routinely in trauma settings and at the request of the medical staff. They give direction and support as requested, and if needed they can contact the psychiatrist or make follow up visits to the appropriate service.

Overall, a great service!

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

Criteria	Location	Priority for Action
The team has the workspace needed to deliver effective services in the Emergency Department.	2.8	

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

There were no concerns identified in this area.

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

No areas of concern were identified.

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

No areas of concern were identified.

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

No areas of concern were identified.

No Unmet Criteria for this Priority Process.

Organ and Tissue Donation

Donation services provided from identification of a potential donor to donor management and organ recovery.

Surveyor Comments

No areas of concern were identified.

No Unmet Criteria for this Priority Process.

Hospice, Palliative, and End-of-Life Services

Clinical Leadership

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

Surveyor Comments

This service is not an in-patient unit but a consult team that provides end of life consultation, symptom management and bereavement support not only to the IWK but also to the maritime region. The team consists of 1.5 Full-time Equivalent (FTE) of physician support, 1 FTE clinical nurse specialist (CNS) support, 0.6 FTE registered nurse support and 1 FTE of clerical support within the team. The service is largely funded through an endowment except for the CNS and the physician salaries which are flowed from the Department of Health and Wellness and the Department of Paediatrics. The team was also awarded one time funding of $100,000 (Rotman Award of Excellence). They recently lost the third physician and have not filled this position due to a hiring freeze.

The team provides region wide consultation through telemedicine and home visits and when in the community often combine their visits with an educational session to maximize their time. Approximately 30% of their consult requests arise from oncology and the remainder from other parts of the hospital.

They have deliberately built up their profile in other areas of the hospital and requests have gradually grown. They are concerned given the loss of the third physician that they may not be able to meet the demand after they have raised awareness and also be able to meet the on call demands now that two physicians share the load as opposed to three. They work with the core team of interdisciplinary members and do significant teaching on the units and in the Region. Physicians enrolled in the Oncology Fellowship program do a rotation through this Team.

The team also consults on the development of policies/protocols etc such as the Guidelines around Organ Donation. At times the team also provides "curb side" ethics consultation especially in the hours when the ethics consult team is not available. The team is involved in research and does support researchers such as students completing their Master Degrees or Doctoral dissertations.

They cope with the demands and stress of their jobs by sharing the load and partaking in other outlets such as pottery, jogging etc. They are conscious of maintaining their own emotional health.

The team is planning to host a one day conference for Atlantic Canada next year. Members of the team also have a national profile and are involved in committees, such as the Royal College. The team is cross appointed to Dalhousie University.

Quarterly reporting is submitted to the Senior Team including demographic information around the clients they serve. They have a mechanism for documenting phone calls etc so other members of the team are kept in the loop as to what information was communicated to the clients. Evaluation of the service has been overwhelmingly positive. This evaluation was conducted some years ago and they are encouraged to repeat the evaluation.

Referrals to the team are broader than end-of life related and can include support for family members that have experienced a death in the family. They have suggested readings and books that they provide in this situation. Volunteers work with the team to provide support in perinatal loss, for example memory boxes, hats, quilts etc. and they also restock folder holders and take family pictures. The team has at least five inpatients admitted at any one time and they round daily on these patients. They also provide support to inpatient staff and physicians. They informally benchmark themselves against other centres across Canada and the previous CNS conducted a comparison between the centres.

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

This is a relatively stable team from a human resources perspective and there has been limited turn over. The physician lead has been on the consult team for greater than 15 years.

Residents rotate through this service for a one month period and other students desiring a clinical placement or research experience are supported. There is a commitment to self-development and education of other health care providers and support people. One of the physicians is completing graduate studies and all are involved in research and publications. The other physician is a part-time Director of Medical Humanities at Dalhousie University.

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

The team utilizes technology such as telemedicine to provide their consult service and to assess ongoing progress with patients.

The team provides 24/7 service to the region and the IWK.

If there are additional interactions with the patient and family outside of the hospital venue the team member will document the interaction in the shadow health record kept, which is maintained in the service office, so that other team members can be aware of what transpired should they have an interaction with the patient in the future.

The End of Life Service has a regional mandate.

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

Criteria	Location	Priority for Action
Following transition or end of service, the team contacts clients, families, informal caregivers, referral organizations, or bereavement services to evaluate the effectiveness of the transition or end of service, and uses this information to improve the long-term effectiveness of its transition and end of service planning.	12.8	↑

Decision Support

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

Surveyor Comments

The consult team documents on the patient's health record in the department. This documentation is available to any health care provider with access to the medical record.

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

Informal benchmarking with other similar centres across the country occurs.

No Unmet Criteria for this Priority Process.

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

Surgical site infection (SSI) information is collected manually so retrospective audits are done to determine whether antibiotics were administered appropriately prior to surgery to understand the relationship, if any, between prophylactic antibiotics and subsequent infection development. Auditing and analysis of compliance with SSI protocols is not routinely performed; it is only done if there is a problem.

The organization uses its experience with outbreaks, such as an RSV outbreak last March, to improve its processes to deal with future potential outbreaks.

The Infection Prevention and Control (IPC) team is well connected with external organizations and web sites, and it uses information from these sources in revising policies and procedures (P&P). Not all policies have been reviewed on a three year basis, as the team waits for topical or legislative changes to come out first and then revises P&P based on the new standards.

There are three dedicated Infection Control Practitioners (ICP). The most recent hire was due to the Senior Team recognizing that additional education support around infection control was required. There is 24 hour support for infection control issues or questions.

The hand hygiene initiative was launched in 2010, and Hand Hygiene Champions are in place. Hand hygiene audits are conducted, but staff are aware that the audits are being done, thus possibly skewing the results because of the Hawthorne Effect. The hospital collects and trends the audit results and these are available on the Intranet for staff to see but are not publicly reported. Volunteers are also educated around infection control principles and techniques such as hand washing, and revised signage around hand hygiene for the public is under review and about to be rolled out.

Disinfectants at the appropriate concentrations are pre-packaged and provided to Supply Processing Department (SPD) for use in the reprocessing of scopes. The IWK participated in Accreditation Canada’s Reprocessing and Sterilization Services Distinction Pilot and have implemented remedial actions for the deficiencies that were identified. The organization entered into a contract with SterilMed (late 2010) for the reprocessing of selected single use items. This contract is about to be evaluated to determine satisfaction with the arrangement.

A dedicated materials coordinator manages all consignment items.

Screening on admission is done for MRSA and VRE providing the patient has been admitted to a health care organization for a length of stay of greater than 24 hrs within the last year. Testing is also done on all out of province admissions. Ambulatory areas are also being screened. The Children's Services Admission Screening Record is being revised based on Provincial Infectious Diseases Advisory Committee as is the maternal equivalent.

IWK has a good uptake of the influenza vaccine (63%).

Education occurs primarily in a "just in time" approach as there appears to be better understanding and buy in from the staff when it is done in this way. Scheduled in-services are also planned.

Toy cleaning is not part of the environment services contract, so in some situations the Child Life Workers are accountable and on the units it is the staff who are accountable. The policy around the cleaning of toys is currently in the process of being revised.

IPC is very involved in the consultation and oversight of maintenance staff around construction projects in the hospital that have potential IPC implications. Some of the 11 off site locations providing mental health services have built into their rental contract that the landlord must notify the staff in advance of any construction work being initiated so appropriate precautions can be taken.

Eleven areas in the hospital are involved in reprocessing medical equipment. A two staged audit process has been conducted and results are soon to be shared.

Housekeeping services are externally contracted to Compass Group (Crothall Services) and there appears to be some lack of transparency and understanding as to what is within the scope of the contract and what is not, the cleaning standards are not understood, and compliance audits have not been consistently shared with the IWK. This has been identified as a source of misunderstanding. Compass Group is aware that there has been a lack of understanding as accountabilities have not been clear and transparent, and they, as well as the IWK, are striving to correct this. Compass Group engaged an external company to review their practices as a reassurance to the IWK. The distribution of the results of this assessment is still pending. The ICPs have shadowed housekeeping staff to understand their audit processes and how they clean rooms. A Joint Review Committee of Compass Group and the IWK has been formed that brings the users and the providers together for periodic formal review and feedback.

Historically food trays for patients on isolation have been delivered to the nursing station and the nursing staff bring the tray into the room. This has resulted in some delays in tray delivery and cold food. They are exploring other options such as the food services staff person delivering the tray directly to the room but not entering the room. Often family are in the room and can accept the tray.

No Unmet Criteria for this Priority Process.

Laboratory and Blood Services

Diagnostic Services - Laboratory

Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

The laboratory has a strong organizational structure. Some resource issues in various areas have been identified and are being addressed. The laboratory is encouraged to offer younger staff more of the projects and other responsibilities typically reserved for senior staff in an effort to get the junior members more experience and increase their knowledge base. The introduction of resources such as pathology assistants will assist in workload management and in dealing with the shortage of pathologists. Opportunities also exist to review processes using lean tools and with front line input to look for potential time saving and more efficient ways of doing things. The laboratory has made great strides in developing their quality management system, document control system ,inventory control system, safety program and point of care testing (POCT) program just to name a few, but work still needs to be done especially in document control. The infrastructure exists (Soft Tech software) but the writing of all the required standard operating procedures and clean-up of old documents takes a great deal of time and effort. Competing priorities is a challenge for all.

The Diagnostic Planning Committee oversees operations, service needs, and resource issues. It also reviews and makes recommendations on utilization indicators and test menus. The team also has a process for requests from clients for new laboratory procedures and equipment including POCT equipment. Research and clinical trials can have a great impact on a laboratory both in costs, equipment and human resources. Impact analyses are done to some degree and all requests must be approved by the Research Ethics Board before any testing can be started.

A staff training program is in place, and the next step is to develop a competency assessment program with input from the staff member, trainer, and even other co-workers in assessing competencies. This is especially important in a core lab setting with frequent changes in assignments and in situations such as shift work where staff may be required to work independently or with minimal supervision or support.

Space and equipment is state of the art. There is concern however for the significant fluctuations in room temperature, which is not only uncomfortable for staff but frequently results in problems with temperature sensitive equipment such as the main chemistry analyzers and other testing procedures. This can affect patient results. Room temperatures need to be monitored and it should be done at multiple points given this is a large open room. Room temperature is not monitored in some areas where temperature dependant reagents, products or testing occurs. The thermal load of new additional equipment is adding to challenge of maintaining optimal conditions. The noise levels, although considered acceptable, could potentially be a problem over time with constant exposure and should be monitored. The inventory control system is very well designed and maintained.

Currently the laboratory does not have formal contracts with referring labs but is in the process of reviewing opportunities to consolidate the list of reference labs. A draft contract template has been developed and is under review. The laboratory does require reference labs to provide evidence of accreditation, licence or other verification of compliance with applicable standards and operating procedures.

Job descriptions are available for the vast majority of the positions and are in the process of being revised. Completion of performance evaluations on a regular basis is inconsistent. A competency assessment program is under development.

The laboratory provides an excellent training program for lab safety, which includes fun and innovative techniques such as a scavenger hunt for new staff to ‘find' safety equipment around the lab. Up until recently, a newsletter, Lab Quality Times, was published periodically as a tool to help keep staff informed. This tool was well received by staff.

Overall, clients from the various clinical services report that lab staff are collegial, easy to deal with, responsive and knowledgeable.

Opportunities for improvement include reduced turnaround time for electron microscopy, and the availability of the phlebotomist between the hours of 2-7 PM on the paediatric unit. Significant concerns regarding the OP collections area including issues with space, privacy, overcrowding, wait times and potential infection control issues were expressed. Some difficulties with the Meditech system in the ordering of immunology tests were identified as well as other system limitations such as the inability to provide electronic pathology, cytogenetics and molecular genetics reports.

A good working relationship between the laboratory and the Infection Prevention and Control team was noted. The diabetic clinic is satisfied with the fast tracking of A1C specimens. Access to familial genetic reports may be too restricted due to privacy laws which can hamper treatment decisions. The process for collecting tissue specimens when both microbiology and pathology are requested needs to be reviewed with those responsible for collection. Concerns with varying turnaround times for autopsies were identified as causing distress for some families. In summary, the users of lab services were highly complementary and suggested a user forum would assist in resolving any issues.

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

Criteria	Location	Priority for Action
The laboratory establishes a contract with each service provider that clearly outlines the laboratory's requirements. ISO Reference: 15189-07, 4.4.1	2.1	
The laboratory verifies that the service provider can meet the contract requirements. ISO Reference: 15189-07, 4.4.1	2.2	
The laboratory annually reviews its contracts with service providers to confirm requirements are being met. ISO Reference: 15189-07, 4.4.1, 4.4.5	2.3	↑
The laboratory maintains records of all contracts with service providers, including any relevant changes. ISO Reference: 15189-07, 4.4.2	2.4	
The laboratory informs its clients in a timely manner of changes to or significant deviations from the contract. ISO Reference: 15189-07, 4.4.4	2.5	↑
The laboratory has a formal program to assess competence. CSA Reference: Z902-10, 4.3.3.1	7.4	

The laboratory annually evaluates the effectiveness of its education, training, and competency assessment activities and records the results. CSA Reference: Z902-10, 4.3.2.3, 4.3.3.1	7.8
The laboratory has a process for establishing and maintaining SOPs. CSA Reference: Z902-10, 4.2.2.1	10.1
The laboratory reviews and updates the SOPs annually or more often if needed. CSA Reference: Z902-10, 4.6.1.6	10.5
The laboratory tracks changes to SOPs using a document control procedure. CSA Reference: Z902-10, 4.2.2.4, 4.2.3, 4.2.4 ISO Reference: 15189-07, 4.3.1, 4.3.2	10.6
The laboratory monitors and controls utilities and environmental conditions. ISO Reference: 15189-07, 5.2.4, 5.2.5	13.7
The laboratory carries out and records regular checks of temperature, humidity levels, and any other critical factors. CSA Reference: Z902-10, 9.4.4	17.2

Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

The IWK should be commended for a very innovative and effective process of medication management and delivery. It is blessed with a large number of pharmacists and pharmacy technicians spread throughout the organization and not just collected in one detached area. The commitment to engagement with other services and areas within the building has allowed for the relabeling of many pharmacists as clinical pharmacists. The vast majority of staff rotate through clinical sites and the main pharmacy.

The department has successfully implemented a computer generating medication delivery system (Pyxis) on each of the care areas that has allowed for the effective incorporation of the unit dose system. This has been extended to include the use of oral liquid agents and the use of standardized doses to minimize a number of manual steps in the preparation and delivery of medication.

All the ROPs that pertain to the Medication Management Service have been adequately addressed and the organization has often included additional steps to ensure full compliance and strive beyond the requirements. The unique needs for hypertonic saline were recognized in a tertiary paediatric centre and the supply is very controlled and minimized to just two stock IV bags (just enough for one emergent patient).

The need for multiple verifications is clearly recognized and fully implemented to ensure that more than one set of eyes is involved in a number of steps to ensure accuracy in the medication identification, preparation and distribution.

There is a confidence that if concerns were identified with a dosage or drug selection, the ordering physician could be contacted to clarify or modify the order. This sense of advocacy is well established in the culture of the pharmacy.

The needs for security (narcotics), sterility (IV admixtures) and staff safety (cytotoxic meds) are clearly recognized and process and physical spaces have been modified to ensure full compliance within these areas.

Medication Reconciliation is well established and expanding. Ownership is now returning to Pharmacy for this issue to ensure a greater degree of compliance.

Although some pharmacists have dual loyalties (department and programs), it is important to ensure that clear reporting pathways exists to that all pharmacist and pharmacy staff have a relationship with the senior leadership in pharmacy.

No Unmet Criteria for this Priority Process.

Medicine Services

Clinical Leadership

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

Surveyor Comments

Among the acheivements of the medical services team is their success in securing funding for appropriate nursing and therapy services for a baby who is ready to go home.

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

Criteria	Location	Priority for Action
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

Job profiles are generic and are continuing to be developed through the models of care project. The manager is in the process of completing performance reviews.

Staff are responsible for tracking their own education and training,

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

The team includes chaplain services who visit each day to meet with new families and will follow-up with families they have contacted the prior day.

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

The team does have challenges managing patient flow with fewer in-patient beds.

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

All medications are double checked by two nurses.

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

The team has a strong working relationship with its partners. A new strategic plan for mental health is in its early stages; goals, objectives and specifics are not yet written. The 4 South team works within a challenging physical plant, with some staff offices needing to be located off the unit. There are potential concerns about security and access that the staff are addressing within their abilities, for example installing a half/barn door at the nursing station, ensuring the main door to the unit is closed and staff have personal alarms. A benefit of their close proximity to a medical unit is that supplies that are not always required or available in their unit can be readily obtained if needed quickly.

The Compass Centre for Collaborative Child and Family Treatment is available for children who demonstrate significant mental health needs and have not responded to community-based programming or supports. The apartment model includes a clinical apartment lead, along with staff (RNs, Youth Care Workers) to care for children. The physical space provides a number of features including access to playground equipment, a nearby indoor pool, a home-like dining, living room and kitchen areas, with large themed murals.

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 mental health 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

There are space limitations and challenges on the inpatient mental health unit - 4 South. As a result there is crowding in the nursing station and staff offices are located outside of the unit. The interdisciplinary teams on both 4 South and Compass are large and well integrated. There are approximately 16 various disciplines involved in these areas. The teams report performing combined client assessments, as well as having an integrated charting and care planning approach. Following the previous accreditation survey, the teams have worked particularly hard on evaluating their functioning and working on improvements. One example is the implementation of the Collaborative Problem Solving, Relaxation, and Relationship Building Parenting Group. The focus is on family centred care and relationship building between children and families.

Performance appraisals are not consistently completed for staff. Staff are assigned according to clinical competencies and equitable assignments are created. For 4 South there can be significant variation in bed utilization, making workload unpredictable. Staff and physicians report responding to the increased needs and overflow conditions as best as they are able.

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	

Team leaders regularly evaluate and document each team member’s performance in an objective, interactive, and positive way.	4.10

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 team uses strategies such as team meetings, interdisciplinary client assessments and common charting and care planning forms in order to minimize duplication as well as increase communication and collaboration.

While the teams make every effort to increase access, at times there can be waiting lists for admission to both 4 South and Compass. Criteria for admission and processes to assess appropriateness assist in decision making regarding admission. Community partners expressed a desire to have more and faster access to mental health services. The 'emergency department atmosphere' was described as being unsuitable to children and youth with mental health issues and waiting for several hours often exacerbates issues.

Risk and suicide assessments are conducted and recorded. The nursing staff have built in overlap of their shifts in order to provide a complete report from shift to shift.

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

The mental health teams are looking forward to electronic patient records in order to ensure completeness of a single record and to be able to provide more comprehensive care across the continuum of care services (for example emergency and Compass).

The teams described their use of evidence based practice and research. Many physicians have access to the Dalhousie University library services, and the IWK library is available to all staff, along with the many affiliated library support services.

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 mental health teams are evaluating their services, for example patient experience surveys (which achieved very high response rates) and parenting group evaluations. However it is difficult to find comparison data for benchmarking with comparable mental health units and peer groupings.

Family members of mental health patients reported a high level of satisfaction regarding care planning and service delivery. They report feeling their child is receiving safe, compassionate care. Physicians were able to articulate the disclosure process and shared their involvement in case review meetings (at MOMs). Process and outcome measures were not evidenced. At this time, with many changes and a new strategic plan, the teams are encouraged to discern what measures and indicators would be most helpful to track.

Briefings occur at report shift change in order to share information about potential risks or safety concerns.

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 mental health services.	16.1	↑
The team compares its results with other similar interventions, programs, or organizations.	16.3	↑

Obstetrics/Perinatal Care Services

Clinical Leadership

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

Surveyor Comments

The IWK has accesses information about clients and the community from several sources including government reports, school groups, cultural societies, public health and other credible sources. As part of the IWK's collaboration with outside providers, it has successfully set up satellite clinics and became a part of the prenatal education programs presented outside the hospital with significant patient satisfaction.

The IWK offers a large number of training programs with access to teaching in their obstetrics and prenatal areas for students and residents. This includes ultrasound, nursing, medical trainees and genetics, to name a few. In the foetal assessment area, ultrasound is used very efficiently with RN/ultrasonographers providing diagnosis.

Aides clean their own probes on the unit in an appropriate fashion. Specula are washed and then sent down to SPD for gas sterilization. The Biomedical Department maintains their equipment, and tracks repairs and preventative maintenance.

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

Position profiles exist in a generic form for nurses and other positions but are not specific for the prenatal, intra partum and postpartum nursing posts. Physicians are reappointed on an annual basis but their appointment does not ask for continuing medical education (CME) activities, which they do to maintain their licence with the Royal College of Physicians and Surgeons. Nurses are required to show their annual membership and licence from their college.

The hospital is in the process of introducing new infusion pumps and will be training all staff on the use of the new device.

Managers conduct annual performance appraisals for staff. The IWK has an annual week to recognize the positive contributions of staff to the hospital, called STARS. There is also program called KUDOS that recognizes staff at any time of the year for their comments or activities that came to the attention of someone else in the hospital.

It may be helpful to the obstetrical team to join the More Ob program for an excellent educational program geared towards all disciplines on the labour and prenatal floors. The labour unit does have some of the clinical RN leaders attend the ALARM course every two-three years which is very commendable.

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

Units decrease work stress and fatigue by looking to each other for support and accessing the organization's employee assistance program for further support as needed. When adult patients require ICU for care, they are transferred to the QE II hospital, including labour room staff if the patient is in labour. Anaesthesia consults are done prior to a caesarean section or requested and a paper consult note is attached to the file. The Birth Unit may shorten its length of stay in the postpartum unit by having the physician sign a discharge order leaving the nursing staff able to discharge patient if discharge criteria are met without having to call physician again.

The primary prenatal clinic team follows up with patients including the post-partum patient visits. The patient's physician is made aware of the patient's discharge. Patients are given information on how to access resources in the event of questions or concerns that may arise.

The team does not flash sterilise on unit.

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

The foetal assessment area has an excellent process to review guidelines and update them as needed.

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

Safety issues to staff and patients are discussed and modified after discussion at monthly team meetings.There is a multitude of pamphlets available in each unit to help relay information and education to clients and their families.

No Unmet Criteria for this Priority Process.

Organ and Tissue Donation Standards for Deceased Donors

Clinical Leadership

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

Surveyor Comments

The transplantation service is a shared activity with other agencies that support the procurement and recovery of organs and tissue that can be used for further transplantation.

The Emergency Department is often the setting where tissue may be collected after cardiac respiratory death and the physicians and nursing team is encouraged and supported to approach families if there is a potential for tissue collection. If the family is interested, a team assisted by a coordinator will support and inform the family, and if consent is given, the tissue is recovered. The collection team may involve IWK staff but may also involve staff from other facilities.

In the setting where the child makes it to the PICU, the issue of brain death is approached. There is a very well defined process for defining and determining brain death and the engagement of family to consider organ donation. Again, if the family is willing, a coordinator will work with the family and tap into the network of organizations (provincially, nationally or internationally) to determine what organs may be recovered and time the event. These procedures involve the intensivists, the operating room and the organ recovery team.

In the setting where a kidney is recovered and is suitable for one of the children on the renal transplant list, the recipient is contacted and with the support of the IWK nephrologist and IWK staff, a transplant is completed at the IWK and the four to five weeks of recovery occur initially in the PICU and later on the post operative floor

The process is very well supported by the educators and coordinators to ensure appropriate donor selection and appropriate family and community supports are in place.

Obviously this process usually has a sad side with the loss of a child but also a positive side with the child and his or her new kidney. The staff indicated that they feel well supported through this process, and exhibited an impressive degree of knowledge and passion.

Overall, this process is very complex with many steps but has matured with the support provided by many organizations and hospitals.

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 organization met all of the organ and tissue donation standards that are related to competency. No areas of concern were identified.

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

The organization met all of the organ and tissue donation standards that were applicable to the services they provide. No areas of concern were identified.

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

The organization met all of the organ and tissue donation standards that were applicable to the services they provide. No areas of concern were identified.

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 organization met all of the organ and tissue donation standards that were applicable to the services they provide. No areas of concern were identified.

No Unmet Criteria for this Priority Process.

Organ and Tissue Donation

Donation services provided from identification of a potential donor to donor management and organ recovery.

Surveyor Comments

The organization met all of the organ and tissue donation standards that were applicable to the services they provide. No areas of concern were identified.

No Unmet Criteria for this Priority Process.

Organ and Tissue Transplant Standards

Organ and Tissue Transplant

Organ transplant services provided from initial assessment of potential transplant candidates through the provision of follow up recipient care.

Surveyor Comments

The organization met all of the organ and tissue transplant standards that were applicable to the services they provide. No areas of concern were identified.

No Unmet Criteria for this Priority Process.

Clinical Leadership

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

Surveyor Comments

The organization met all of the organ and tissue transplant standards that were applicable to the services they provide. No areas of concern were identified.

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 organization met all of the organ and tissue transplant standards that are related to competency. No areas of concern were identified.

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

The organization met all of the organ and tissue transplant standards that were applicable to the services they provide. No areas of concern were identified.

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 organization met all of the organ and tissue transplant standards that were applicable to the services they provide. No areas of concern were identified.

No Unmet Criteria for this Priority Process.

Point-of-Care Testing

Point-of-Care Testing Services

Provision of testing outside the laboratory, near where care is delivered to the client, in order to provide practitioners with information about the presence of health problems, and the procedures and processes used by these services.

Surveyor Comments

The organization has come a long way in a short time to meet Point of Care Testing (POCT) Standards and implement a comprehensive POCT program. Much has been accomplished or is at least a 'work in progress' with concrete examples of drafted policies and forms. Some policies still need to be established, for example, who is authorized to do POCT and there is ongoing discussion on this with the implementation of 'new' categories of health care workers. It is suggested that the Regional POCT Committee make a recommendation on this so there is consistency across organizations. The final decision would still lie with the individual organization.

The laboratory is responsible for the program and has surveyed clinical areas to determine what POCT was being used (an inventory of existing POC tests being performed). From here the plans to coordinate with the laboratory, educate the users and develop a quality control plan were developed. Requests for new procedures and equipment are now required to be approved by the laboratory. Users are now aware that POC tests must be validated by the laboratory before use and quality control monitoring and staff training completed before implementation of any new procedures. Training programs are in place.

A POCT coordinator has been assigned by the laboratory and users are well aware of the person and her role. Users are also becoming more aware of the requirements and risks associated with POCT and the importance of following procedures.

Some standard operating procedures for POC tests have been developed and available to users (i.e. glucometers), however others such as urine dipstick and occult blood are currently under development.

A policy on self-testing needs to be developed.

A form is currently under development which would incorporate a requisition and report form for POCT tests. Currently there is no requisition form for POCT nor do the patient records clearly identify POCT results. There is opportunity and a need to improve documentation in the patient record.

Consolidation of glucometers to one vendor has greatly reduced the amount of work required to monitor the glucometers and meet training needs. It provides for a more controlled and streamlined effort.

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

Criteria	Location	Priority for Action
The organization has a policy in place to prevent a conflict of interest between POCT suppliers, clients and clinicians.	2.4	
The organization documents performance evaluation results in the personnel files of health care professionals delivering POCT.	3.5	
The organization has SOPs for each point-of-care test it performs.	4.1	
Each SOP contains the title and purpose of the SOP, number of pages, unique identification number, date it was implemented or revised, signature of the authorizing person(s) and date of authorization, steps to be followed in the procedure, and the individual responsible for checking, reviewing, and approving the SOP.	4.2	
Each SOP contains the purpose and limitations of the test; step-by-step instructions on how to properly complete the test and use the corresponding instruments; reference ranges for the results, including critical values; criteria for accepting and rejecting samples; quality control procedures; and literature references.	4.3	
The organization places the SOPs in areas where health care professionals delivering POCT can easily access them.	4.4	
The organization has a policy on POCT client self-testing.	4.8	
The organization periodically verifies that POCT reagents currently being used are working properly, not expired or deteriorated and appropriate for use. CSA Reference: 22870:07, 5.3.2	6.4	↑

When conducting POCT, health care professionals wear personal protective equipment (PPE) consistent with the manufacturer's instructions or the organization's SOPs.	8.7	↑
Health care professionals delivering POCT remove PPE before leaving the testing area.	8.8	
The organization has a standardized written or electronic policy or procedure on how to report and disclose all POCT results. CSA Reference: Z22870:07, 5.8.2	9.1	
When the health care professional verbally reports POCT results to clinicians, the results and methods used to obtain those results must later be documented in a written format and identified as POCT results.	9.5	↑
When completing the POCT report and filing it in the client record, the health care professional delivering POCT clearly labels the results as "POCT".	9.8	
The organization securely retains records of all POCT request forms and their corresponding results for the period consistent with provincial regulations or guidelines.	9.11	

Rehabilitation Services

Clinical Leadership

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

Surveyor Comments

There is approximately one full FTE of student placement hours in a year for physiotherapy and occupational therapy. Currently there are two recreational therapist interns in the department. The team supports students.

The department regularly reviews their utilization information and structures services around the outcomes of the review. In addition, they use this information to determine which care paths to develop next. Regular internal retreats occur as well as participation at other retreats during the calendar year. There is significant collaboration with other providers and system members e.g. school boards, day cares, teachers etc. This collaboration is critical in the coordination of care that is required for these complex situations.

A funding coordinator is focused on raising awareness to potential donors regarding rehab funding needs and for raising awareness with recipients as to sources of funding.The team does not actively build awareness with respect to the services they offer as they may not be able to meet the needs given current capacity issues. They already experience a year over year volume increase of 15-20%.

The team manages to get what they need with respect to supplies and equipment. There is an equipment loan bank that they can access if needed.

It is rare for the manager to get involved in making work assignment decisions. The team juggles to meet the needs.

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

There is regular annual training for such things as CPR. Up to now the department has been fortunate as there has been funding available to support educational needs. In addition, there was a separate fund to access if a staff member was presenting at a conference. The availability of education funding in the future is in question given the financial challenges of the organization.

The team utilizes a variety of tools to assess and evaluate its functioning. The Measure of Processes of Care (MPOC), which is a measurement tool to assess family satisfaction with service and whether the family's goals have been met, is one example. They also utilize goal attainment scaling and the Canadian Occupational Performance Measure (COPM). The charts demonstrated that these tools were in use, as well as goal determination.

The team participates in general orientation and health specific professional specific orientation. Orientation to new equipment can be provided internally, or by a vendor (if the piece of equipment is new to the unit). A train the trainer approach is often utilized and training can be mandatory.

A challenge for the team is the caseload numbers which are growing. The team is beginning to think about new models of service delivery and efficiencies in documentation.

Performance appraisals are underway. This has provided a good learning opportunity for the manager who has identified some patterns.

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

The team works collaboratively to develop care pathways. The team acts with an advocacy voice for the needs of their patients and families. The screening intake process facilitates information gathering and the identification of need for service. This is a standardized approach to intake assessment throughout the service.

The team reviews each request for service and only on an exception basis might services be denied. In those situations every attempt is made to refer the patient to another service.

The team focuses on providing patient centred care and understands that the family unit is critically important when planning care. They also understand that it is not the team, but the patient and family that need to set their goals for service. In the inpatient area goal setting rounds with the team, family and patient occur weekly and are documented in the health record. Individual therapists will document their goals as necessary.

Standardized clinical measures are a strength of the team. They utilize various tools to evaluate progress and outcomes but also understand that the results are directional and need to be taken into consideration with the bigger picture.

A variety of consents are obtained: consent to treatment; consent to speak to other people in the circle of care such as school personnel; consent to gather information from other people etc.

Emotional support and counselling are provided by team therapists, as well as social workers, rehabilitation psychologists and the crisis social worker.

The ethical framework and response at IWK has been tested and utilized on occasions and the team expressed that this is an excellent service.

The team works with solution focused cards to assist them in framing their questions and interactions in a positive frame. It is a scripted approach.

The team utilizes a variety of mechanisms when dealing with transitions - report development that is shared with the receiving agency and the family; telehealth sessions to share information; completed templates of information for school therapists etc. Careful thought is given to transitioning the patient and family effectively.

When a family or patient would like to see their health record this is facilitated and the Improvement Consultant will sit with the family and go through the chart with them. At times a second opinion may be requested and the team will prepare information to be shared for this reason. The family will receive a copy of what was put together.

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

Criteria	Location	Priority for Action
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

Privacy is top of mind but not always realistic in treatment areas such as the gym. Staff are aware of the policy and reinforcement occurs at orientation and at other times as needed.
Clients sign consents allowing staff to share
patient related information.

The development of a clinical practice guideline is an area of focus but at the beginning stages of evolution at IWK.

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 team reviews trends from the AEMS Reporting System and take appropriate actions as indicated. They have focus on prevention and have educated staff about non crisis intervention techniques. Staff in the community maintain first aid kits in their cars.

No Unmet Criteria for this Priority Process.

Substance Abuse and Problem Gambling Services

Clinical Leadership

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

Surveyor Comments

One exceptional collaboration is the First Nations Outreach Workers project.

Staff does have input into role redefinition but a recent redesigned has changed the role functions. There has been a focus on ensuring qualifications are aligned with the scope of practice of a defined role.

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

Criteria	Location	Priority for Action
The team's goals and objectives for its substance abuse and problem gambling 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 space design ensures that the staff and patient's environments are safe, secure, bright and cheery!

There are some non-clinical roles that have specific qualifications but are not licensed, nor belong to a professional association.

There are panic buttons in various locations throughout the site. If there is a violent event, the staff are instructed to call 911.

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

The 'team member' who fills prescriptions and dispenses medication is a community pharmacy.

There is a security officer on duty 24/7.

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

Team is hopeful to obtain a Pyxis medication dispensing system.

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

At the orientation meeting clients must sign an agreement that delineates expected behaviours and requirements to participate in therapy.

No Unmet Criteria for this Priority Process.

Telehealth Services

Clinical Leadership

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

Surveyor Comments

Telehealth at IWK has ten units on site and an additional nine units at off site locations for a total of 19 units. Telehealth has been in place at the IWK since 1996. There is a service level agreement with HITS-NS and a memorandum of understanding is in the draft stages between IWK and the Maritime Partners In Telehealth. Of interest, physicians Nova Scotia are not licensed to conduct a clinical consultation via telemedicine in PEI. A physician in PEI must be present during the consultation with a Nova Scotia MD. This adds to scheduling complexities at times. A group was formed approximately 7-8 months ago to conduct a system review. Recommendations are still pending but one of the recommendations is anticipated to be around the scheduling processes. A number of KPIs are monitored by the group.

Attempts are made to ensure compatibility of equipment across the province and in the maritime provinces.

Redundancy is not built into the system, however if there is a need, such as during a technical malfunction, the team attempts to shift units around to meet the demand or look at rescheduling.

HITS-NS alerts the IWK as to when it is necessary to replace equipment. All equipment is Canadian Standards Association approved.

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 utilizing the technology reported that they had received excellent training on the usage of the equipment and that they receive great support.

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

The priority for usage of the telehealth services is clinical first, education second and administrative usage is the last priority.

Educational material around telehealth and client choices is made available to the patient and family. Informed consent is obtained.

At times there may be many participants at a session. The usual practice is to forward attendees names afterwards to be added to the health record when the telehealth technology is utilized for a clinical reason. Confirmation that this information has reached the health record is not audited or confirmed.

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

Attention to patient confidentiality is taken very seriously.

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

A value stream mapping and a potential failure mode analysis were recently undertaken, as well as the identification of opportunities for improvement. The recommendations from this review are pending.

No Unmet Criteria for this Priority Process.

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 Paediatric Service has benefited from the recent physical plant upgrades that have produced a new, large operative suite to support the paediatric surgical needs of the community. It involves large, bright rooms decorated to create a sense of fun and less anxiety. The pre-operative assessment areas and the recovery rooms are also large, bright and allow for the easy flow of the patient and family.

It was very easy for the patient to track from the entrance, to day surgery, to the waiting room, and then back to day surgery when returning from the recovery room. This is supported by the recovery room staff phoning the family to have them meet the patient at the recovery room doors.

All along the pathway, patient identifiers are clearly used and the staff is very friendly, engaging and share their name.

In the operative suite, the use of 'surgical check lists' and the 'pause' are very well established. Each staff has a very well defined role and can work independently and collaboratively for the benefit of the staff. The operating suites are very large as mentioned but also well equipped with all the appropriate equipment. Once the procedure has been completed, the anaesthetist will wait to move the patient until adequate spontaneous respirations have been established, then the child is returned to the Recovery Room.

At that point the recovery room nurse receives information from the operating room nurse and the anaesthetist. Using an objective scoring system, the child is supported until able to return to the Day Surgery room. The anaesthetist is often in the Recovery Room until the nurse is comfortable with the airway and breathing. Issues such as restraints to protect the IV sites, pain medications and post anaesthetic delirium are addressed at this stage. Finally the child is returned to the Day Surgery suite for further review and to see the family. At that stage issues such as feeding (breast feeding), behaviour and vomiting are addressed.

When ready, the patient is prepared for discharge and final instructions are given.

The process is adapted to accommodate inpatients.

Prior to the surgery, the child is seen by the surgeon and the nursing staff in the pre-operative clinics. A detailed process is started to collect information on the patient and share information with the family about the procedure and the process to be followed on the day of the procedure. A second visit is often necessary to complete the pre-operative package.

At the other end of the spectrum, a patient after surgery may require in-hospital management. The process of assessment, documentation and ongoing support is very well developed to support the inpatient needs of the child including pain management, nausea and vomiting, ambulation, and eventually discharge. The post-operative (post-op) unit is also relatively new and provide for single rooms with appropriate space for a parent.

Unique needs such as schooling, unique feedings and emotional support are identified and addressed

The Adult Surgical Suite (gynaecology and breast health) is contained within the older section of the Women's tower and as such, has been forced to be creative within somewhat limited spaces. However, the site has been adapted to allow for a nursing and anaesthetic review with the patient just prior to surgery. The operating suites, although tight, still have adequate space to allow each of the participants to safely provide service. The surgical check list has been developed to function as a multi staged event prior to the surgery and prior to leaving the operating suite to return to the recovery room. The recovery room allows for immediate support and then space to migrate to an area to support discharge teaching.

At each transition step, there is a clear sharing of verbal information that allows the receiving staff to have an immediate understanding of the events and status of the patient.

The adult surgical floor functions as a 2/3 postpartum and 1/3 post op. The staff is very skilled at recognizing and responding to the needs of the post op patient. There is a clear focus on early ambulation and supporting the patient and family to return home as soon as possible. Obviously, distance from home is recognized and timing of procedures and discharge are taken into consideration.

The Adult Gynaecological team relayed their experiences with a challenge they were having with one piece of surgical equipment. They noticed that they had four complications within a very short period of time. They suspended use of this equipment and quickly commenced a process to understand the reasons behind the incident and determine what needed to be changed. After being reassured that it was not a national problem, they discussed the educational process and felt that it could be strengthened. The team established a mandatory education program for surgeons and nursing staff. After ensuring compliance with the education program, the equipment and process was established and no problems have been detected since this intervention. The team is to be commended for its actions and is encouraged to share their successes.

No Unmet Criteria for this Priority Process.

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	

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
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.	86	0	14	
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.	93	0	7	
21	Working relationships among individual members and committees are positive.	100	0	0	
22	We have a process to set bylaws and corporate policies.	93	0	7	

Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
	Organization	Organization	Organization	
23 Our bylaws and corporate policies cover confidentiality and conflict of interest.	93	0	7	
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.	86	0	14	
26 Contributions of individual members are reviewed regularly.	71	0	29	⚠
27 As a team, we regularly review how we function together and how our governance processes could be improved.	79	0	21	
28 There is a process for improving individual effectiveness when non-performance is an issue.	64	0	36	⚠
29 We regularly identify areas for improvement and engage in our own quality improvement activities.	93	0	7	
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.	100	0	0	
31 As individual members, we receive adequate feedback about our contribution to the governing body.	64	0	36	⚠
32 We have a process to elect or appoint our chair.	93	0	7	
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 = 545 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	8	16	76	
2	Good communication flow exists up the chain of command regarding patient safety issues	15	18	67	⚠
3	Reporting a patient safety problem will result in negative repercussions for the person reporting it	80	11	10	
4	Senior management has a clear picture of the risk associated with patient care	18	22	60	⚠
5	My unit takes the time to identify and assess risks to patients	8	10	82	
6	My unit does a good job managing risks to ensure patient safety	6	10	84	
7	Senior management provides a climate that promotes patient safety	9	20	71	⚠
8	Asking for help is a sign of incompetence	90	5	5	
9	If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	94	3	3	
10	I am sure that if I report an incident to our reporting system, it will not be used against me	17	22	61	⚠
11	I am less effective at work when I am fatigued	8	8	85	
12	Senior management considers patient safety when program changes are discussed	13	32	55	⚠
13	Personal problems can adversely affect my performance	27	21	52	⚠
14	I will suffer negative consequences if I report a patient safety problem	85	10	5	

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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	
15 If I report a patient safety incident, I know that management will act on it	10	24	66	△
16 I am rewarded for taking quick action to identify a serious mistake	31	43	26	✕
17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care	41	26	33	✕
18 I have enough time to complete patient care tasks safely	14	22	64	△
19 I am not sure about the value of completing incident reports	71	13	16	△
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	71	11	18	△
21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	23	26	50	△
22 I have made significant errors in my work that I attribute to my own fatigue	85	9	6	
23 I believe that health care error constitutes a real and significant risk to the patients that we treat	12	18	70	△
24 I believe health care errors often go unreported	19	24	57	✕
25 My organization effectively balances the need for patient safety and the need for productivity	14	28	58	△
26 I work in an environment where patient safety is a high priority	5	11	84	
27 Staff are given feedback about changes put into place based on incident reports	27	23	50	△
28 Individuals involved in patient safety incidents have a quick and easy way to report what happened	15	22	63	△
29 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	27	28	46	✕
30 My supervisor/manager seriously considers staff suggestions for improving patient safety	15	21	64	△

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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	
31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	74	17	10	△
32 My supervisor/manager overlooks patient safety problems that happen over and over	76	14	10	
33 On this unit, when an incident occurs, we think about it carefully	8	13	79	
34 On this unit, when people make mistakes, they ask others about how they could have prevented it	13	20	67	△
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	8	12	80	
36 On this unit, when an incident occurs, we analyze it thoroughly	11	22	67	△
37 On this unit, it is difficult to discuss errors	69	16	14	△
38 On this unit, after an incident has occurred, we think long and hard about how to correct it	11	22	67	△
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	73	23	3	△
40 Please give the organization an overall grade on patient safety	63	32	4	△
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	8	23	69	△
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	10	36	54	△

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	C. These questions are about what happens after a Major Event	% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	11	29	59	
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	19	50	32	
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	20	23	58	
46	Changes are made to reduce re-occurrence of major events	6	19	75	

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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 = 1152 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.	20	24	56	△
2	I am satisfied with communications in my work area.	22	17	61	△
3	I am satisfied with my supervisor.	12	16	72	△
4	I am satisfied with the amount of control I have over my job activities.	14	19	67	△
5	I am clear about what is expected of me to do my job.	9	13	78	
6	I am satisfied with my involvement in decision making processes in this organization.	27	27	46	✕
7	I have enough time to do my job adequately.	31	18	51	△
8	I feel that I can trust this organization.	20	28	52	△
9	This organization supports my learning and development.	19	21	60	△
10	My work environment is safe.	9	12	80	
11	My job allows me to balance my work and family/personal life.	17	16	66	△

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…	20	48	32	
	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is…	62	31	7	
14 In general, would you say your mental health is…	59	30	11	
15 In general, would you say your physical health is…	57	33	10	
	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	88	10	2	
	% < 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)	86	8	6	
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)?	90	7	4	
	% 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?	4	21	75	

		% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
20	Overall, I am satisfied with this organization.	14	23	63	△
21	Working conditions in my area contribute to patient safety.	9	25	66	△

Appendix A – Accreditation Decision Guidelines

The key factor that Accreditation Canada uses to determine an accreditation decision is the degree to which client organizations comply with high-priority criteria and Required Organizational Practices (ROPs). *High-priority criteria* are criteria related to safety, ethics, risk, and quality improvement; *ROPs* are practices that must be in place to enhance client safety and minimize risk.

There are three possible accreditation decisions under Qmentum.

Accreditation	Accreditation with Condition (Report, Focused Visit, or both)	Non-accreditation
Issued when the client organization has:	*Issued when the client organization has:*	*Issued when the client organization has:*
Met 90 to 100% of high-priority criteria in each applicable set of standards AND	Met 71 to 89% of high-priority criteria in each applicable set of standards OR	Met 70% or less of high-priority criteria in one or more sets of applicable standards AND
Complied with all applicable ROPs AND	Failed to comply with one or more applicable ROPs OR	Failed to comply with one or more applicable ROPs AND
Submitted all required performance measure data	Failed to submit required performance measure data	Met 80% or less of the total criteria in all applicable sets of standards
*CSSS only: obtained 66.6% or more on all CQA indicator questionnaires	*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire	*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire

***CSSS (Centre de santé et de services sociaux)** clients in the joint Accreditation Canada/Conseil québécois d'agrément (CQA) program must also administer CQA's Client Satisfaction indicator questionnaire and the Employee Mobilization indicator questionnaire.

NOTES

Accreditation with Condition means the organization must meet conditions specified by Accreditation Canada to maintain its accredited status. The nature of the unmet criteria and ROPs determines the timelines for compliance (six or twelve months) and whether the organization must submit a report, undergo a focused visit, or both. If the conditions are not met within the timelines, Accreditation Canada may grant an extension of six months, based on surveyor input, proof of progress, and a plan to meet the criteria.

Failure to comply within the allotted time may result in accreditation being revoked, at the discretion of Accreditation Canada.

Non-accreditation: A non-accreditation organization may have its status reviewed six months after the on-site survey if it completes a focused visit within five months. The organization maintains its non-accredited status if the focused visit results are unsatisfactory.