ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Izaak Walton Killam (IWK) Health Centre

Halifax, NS

On-site survey dates: May 24, 2015 - May 28, 2015

Report issued: July 28, 2015

ACCREDITATION CANADA
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Driving Quality Health Services
Force motrice de la qualité des services de santé

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About the Accreditation Report

Izaak Walton Killam (IWK) Health Centre (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in May 2015. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only. Accreditation Canada does not release the report to any other parties.

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

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

A Message from Accreditation Canada's President and CEO

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

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

Your Accreditation Specialist is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

Izaak Walton Killam (IWK) Health Centre (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

As part of the Qmentum accreditation program, the organization has undergone a rigorous evaluation process. Following a comprehensive self-assessment, external peer surveyors conducted an on-site survey during which they assessed this organization's leadership, governance, clinical programs and services against Accreditation Canada requirements for quality and safety. These requirements include national standards of excellence; required safety practices to reduce potential harm; and questionnaires to assess the work environment, patient safety culture, governance functioning and client experience. Results from all of these components are included in this report and were considered in the accreditation decision.

This report shows the results to date and is provided to guide the organization as it continues to incorporate the principles of accreditation and quality improvement into its programs, policies, and practices.

The organization is commended on its commitment to using accreditation to improve the quality and safety of the services it offers to its clients and its community.

1.1 Accreditation Decision

Izaak Walton Killam (IWK) Health Centre's accreditation decision is:

Accredited with Exemplary Standing

The organization has attained the highest level of performance, achieving excellence in meeting the requirements of the accreditation program.

1.2 About the On-site Survey

- **On-site survey dates: May 24, 2015 to May 28, 2015**

- **Locations**

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

  1 Charter Place Offices, 1465 Brenton St.
  2 Cobequid Multi-Service Center
  3 Compass, 5940 South Street
  4 Craigmore
  5 Dartmouth General Hospital
  6 Halifax Shopping Centre
  7 IWK Health Centre (Main Campus)
  8 Nova Scotia Youth Facility (Waterville)
  9 Wyse Rd, Dartmouth

- **Standards**

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

  System-Wide Standards

  1 Leadership
  2 Governance
  3 Medication Management Standards
  4 Infection Prevention and Control Standards

  Population-specific Standards

  5 Population Health and Wellness

  Service Excellence Standards

  6 Cancer Care and Oncology Services
  7 Reprocessing and Sterilization of Reusable Medical Devices
  8 Organ and Tissue Donation Standards for Deceased Donors
  9 Organ and Tissue Transplant Standards
  10 Critical Care
  11 Point-of-Care Testing
  12 Ambulatory Care Services
  13 Diagnostic Imaging Services
  14 Hospice, Palliative, and End-of-Life Services

15 Medicine Services
16 Rehabilitation Services
17 Substance Abuse and Problem Gambling Services
18 Telehealth Services
19 Community-Based Mental Health Services and Supports Standards
20 Obstetrics Services
21 Mental Health Services
22 Transfusion Services
23 Biomedical Laboratory Services
24 Perioperative Services and Invasive Procedures Standards
25 Emergency Department

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Canadian Patient Safety Culture Survey Tool
  3 Worklife Pulse
  4 Client Experience Tool

1.3 Overview by Quality Dimensions

Accreditation Canada defines quality in health care using eight dimensions that represent key service elements. Each criterion in the standards is associated with a quality dimension. This table shows the number of criteria related to each dimension that were rated as met, unmet, or not applicable.

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	112	0	0	112
 Accessibility (Give me timely and equitable services)	129	0	4	133
 Safety (Keep me safe)	718	4	36	758
 Worklife (Take care of those who take care of me)	208	0	0	208
 Client-centred Services (Partner with me and my family in our care)	368	0	5	373
 Continuity of Services (Coordinate my care across the continuum)	99	0	0	99
 Appropriateness (Do the right thing to achieve the best results)	1274	12	12	1298
 Efficiency (Make the best use of resources)	93	1	1	95
Total	**3001**	**17**	**58**	**3076**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (100.0%)	0 (0.0%)	0	32 (100.0%)	0 (0.0%)	0	74 (100.0%)	0 (0.0%)	0
Leadership	46 (100.0%)	0 (0.0%)	0	84 (98.8%)	1 (1.2%)	0	130 (99.2%)	1 (0.8%)	0
Infection Prevention and Control Standards	39 (95.1%)	2 (4.9%)	0	30 (96.8%)	1 (3.2%)	0	69 (95.8%)	3 (4.2%)	0
Medication Management Standards	73 (100.0%)	0 (0.0%)	5	63 (100.0%)	0 (0.0%)	1	136 (100.0%)	0 (0.0%)	6
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	35 (100.0%)	0 (0.0%)	7	72 (97.3%)	2 (2.7%)	3	107 (98.2%)	2 (1.8%)	10
Biomedical Laboratory Services	70 (100.0%)	0 (0.0%)	1	102 (99.0%)	1 (1.0%)	0	172 (99.4%)	1 (0.6%)	1
Cancer Care and Oncology Services	33 (100.0%)	0 (0.0%)	0	76 (100.0%)	0 (0.0%)	0	109 (100.0%)	0 (0.0%)	0
Community-Based Mental Health Services and Supports Standards	22 (100.0%)	0 (0.0%)	0	113 (100.0%)	0 (0.0%)	0	135 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Critical Care	32 (97.0%)	1 (3.0%)	1	93 (98.9%)	1 (1.1%)	1	125 (98.4%)	2 (1.6%)	2
Diagnostic Imaging Services	65 (97.0%)	2 (3.0%)	0	68 (100.0%)	0 (0.0%)	0	133 (98.5%)	2 (1.5%)	0
Emergency Department	47 (100.0%)	0 (0.0%)	0	79 (98.8%)	1 (1.3%)	0	126 (99.2%)	1 (0.8%)	0
Hospice, Palliative, and End-of-Life Services	27 (100.0%)	0 (0.0%)	6	102 (100.0%)	0 (0.0%)	5	129 (100.0%)	0 (0.0%)	11
Medicine Services	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0	102 (100.0%)	0 (0.0%)	0
Mental Health Services	36 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	0
Obstetrics Services	62 (100.0%)	0 (0.0%)	2	80 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	2
Organ and Tissue Donation Standards for Deceased Donors	39 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	119 (100.0%)	0 (0.0%)	0
Organ and Tissue Transplant Standards	63 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	143 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures Standards	100 (100.0%)	0 (0.0%)	0	88 (100.0%)	0 (0.0%)	0	188 (100.0%)	0 (0.0%)	0
Point-of-Care Testing	35 (97.2%)	1 (2.8%)	2	44 (95.7%)	2 (4.3%)	2	79 (96.3%)	3 (3.7%)	4
Rehabilitation Services	25 (100.0%)	0 (0.0%)	6	67 (100.0%)	0 (0.0%)	3	92 (100.0%)	0 (0.0%)	9
Reprocessing and Sterilization of Reusable Medical Devices	53 (100.0%)	0 (0.0%)	0	62 (98.4%)	1 (1.6%)	0	115 (99.1%)	1 (0.9%)	0
Substance Abuse and Problem Gambling Services	31 (100.0%)	0 (0.0%)	0	73 (100.0%)	0 (0.0%)	0	104 (100.0%)	0 (0.0%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Telehealth Services	34 (100.0%)	0 (0.0%)	0	38 (97.4%)	1 (2.6%)	1	72 (98.6%)	1 (1.4%)	1
Transfusion Services	75 (100.0%)	0 (0.0%)	0	66 (100.0%)	0 (0.0%)	1	141 (100.0%)	0 (0.0%)	1
Total	**1119 (99.5%)**	6 (0.5%)	30	1786 (99.4%)	11 (0.6%)	17	2905 (99.4%)	17 (0.6%)	47

* Does not includes ROP (Required Organizational Practices)

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Hospice, Palliative, and End-of-Life Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care and Oncology Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Hospice, Palliative, and End-of-Life Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Substance Abuse and Problem Gambling Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Transfusion Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Organ and Tissue Transplant Standards)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Izaak Walton Killam (IWK) Health Centre is commended on preparing for and participating in the Qmentum survey program. The organization has just performed an enterprise risk management process which included a business continuity component. There are good and varied processes for receiving and sharing of information internally and externally. Many of the leaders participate in provincial or regional discussions. This participation allows IWK's leaders to provide input on where the organization sits relative to the other health care organizations in the province.

There is in place an expanded executive leadership team that meets once per month. These meetings provide an opportunity for broader feedback to the executive and board, and it also helps with enhancing communication to physicians and staff.

Numerous members of the executive leadership team have been involved and continue to be involved in the provincial health care restructuring initiatives. This has provided opportunities for the members to be at the forefront of the information sharing and decision making. It also affords members with opportunities to meet on a regular basis with their counterparts in the government and the Nova Scotia Health Authority.

The surveyor team met with a group of 12 different community partners, and the representatives varied from other health care agencies to service clubs, and from the school board to Nova Scotia Health Authority. There were numerous positive comments about the relationship that these partners have with IWK and the sharing of resources that occurs. They find the organization is engaging and receptive of comments from the partners and that information is willingly shared between agencies. There are partnership agreements and/or memorandums of understanding (MOUs) in place that facilitate sharing of information and support the co-leadership model. A recurring comment during the meeting was that IWK is extremely supportive of families and patients requiring additional services and also for the outside agencies, staff members and physicians at IWK will act as mentors for some of the less experienced partner staff members. There is a sense that all involved with IWK are working together to better serve the patients and families.

The organization will help to rally different people together to address issues and will provide space or personnel to facilitate meetings. An example of collaboration is that with the growing demand for mental health and addiction services, they created a 'joint' employee with another agency to help the patients navigate the system. Another example is the nurse that works for IWK and the school board to help transition patients from acute care to the school system.

There is an excellent initiative in collaboration with Dalhousie University School of Nursing that involves the transition of care from acute to the community; and building leadership capacity in the organization. IWK Health Centre offers training to its community partners and provides support for other languages. In fact, it was IWK that was the first agency to identify that Arabic is now the second language in the province and it put supports in place for people that struggle with the English language.

As with all organizations there are challenges to face and opportunities to explore. One improvement opportunity to explore is how best to take advantage of the resources at Dalhousie University's School of Nursing. Keeping the organizational chart updated is challenging as there is frequent movement of staff, and this makes it difficult for outside agencies to know whom to contact.

The survey team met with the chairs of the Family Council and the Youth Council. Positive comments from both groups were made. They find the organization receptive to their comments and suggestions, and that they are interested in what they have to say. They see it as a positive to be closely connected to the executive and the physician group. The only suggestion for improvement is to enhance the education offered to management and staff as it relates to family-centred care and validating the rights of the youth to give consent for their own care.

Section 2 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

2.1 Priority Process Results for System-wide Standards

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

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

2.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The board has developed a skills matrix to assess the currently existing membership gaps, and what gaps will present in the near future. It then submits a 'public call' across the Maritime provinces to recruit new members to the board. There is a robust process for reviewing all applications against the requirements, short-listing the applicants and then moving on to the interview process. Throughout the recruitment process existing board members are kept appraised of potential members, and the intent is to ratify the new board members at the annual general meeting (AGM) in October.

The structure and recruitment of the executive and expanded executive leadership team is a topic of discussion at the board, but the members do not involve themselves in the management or operational side of the business and thus remain a strategic board.

The committee structure of the board is an ideal way of getting a broader source to recruit members and to have more diversity in participation. New board members receive an extensive orientation which includes the code of conduct, conflict of interest policy and the ethical framework for decision making. Education is provided at each meeting and yearly, there is the “scrub-in” where board members get to see for themselves the workings of each and every area of board work.

Decisions are made by consensus and the members feel free to ask questions or continue the debate when they have issues with making a decision. The members have extensive participation in the development of the strategic plan, mission and vision.

As there is a relatively new chief executive officer (CEO) at the organization the board has just completed the six-month performance review and it incorporated considerable feedback from multiple sources.

Every board meeting is evaluated for efficiency, comprehensiveness and ease of asking questions and participating in discussions. Each member of the board is asked to do a self-evaluation and the board chair touches base with every member to discuss level of engagement and any issues. An individual performance appraisal is done annually for every board member.

2.1.2 Priority Process: Planning and Service Design

Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.11 The organization's policies and procedures for all key functions, operations, and systems in the organization are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

When the Department of Health and Wellness provides the yearly plan outlining priorities, assumptions and direction, the organization brings it for review by the executive; then the next step is to disseminate to the directors for review, with recommendations on how to meet the challenges and address unmet needs. An attempt is made to allocate resources to each of the strategies and teams are mobilized to validate the statements and assumptions. There are numerous examples of multidisciplinary team functioning such as nurses sitting on the facilities team to provide input on how any projects will impact the clinical work.

The strategic plan is widely communicated using a robust process to ensure that it 'cascades' to the front lines and becomes entrenched in the organization. The same applies for the external dissemination and ensuring that it is incorporated into every stakeholder’s daily work.

Case costing is an initiative currently in process, and several levels of the organization are involved in this initiative including decision support, finance and clinical staff members.

Clinical policies are regularly updated and staff members and unions are involved in reviewing the changes. Review of administrative policies has been delayed due to provincial health system restructuring and the desire to standardize policies across the province. However, given this initiative is not forthcoming, the organization has commenced work on reviewing and updating policies in the interim as this is a potential risk.

There are numerous examples of broad community involvement in providing feedback to the organization. Examples are the Diversity and Inclusion Committee, the Youth Project, and prideHealth. The Youth Project was also invited to present at grand rounds.

In order to plan for any changes in practice or implement new treatment modalities, environmental scans are done and these pull in experts as required. IWK staff members do site visits to best-in-breed centres and bring innovative practices back to the organization.

The communication team is brought in to provide support and guidance to the numerous project teams. The team provides tool kits for communication and also guides the staff members to use different means of communication, including social media.

2.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The process for resource allocation is well defined and familiar to the leadership team. The executive shapes the strategies and then the information is sent to the directors' council for review and implementation. Extensive information is provided to the directors, and directors are encouraged to find the required resources within their own program; if this is not possible, they collaborate as a team to shift resources from one program to another. Financial analysts are assigned to the programs to help provide support and education to the management staff. There are criteria and formats embedded into the process and this is well-known and used by the directors. Decision support consultants are available to provide data or interpretation of data as required. Once initiatives are implemented, they assess for effectiveness such as reduction in wait times or number of patients waiting for access to service.

2.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Medical Staff Office has implemented a rigorous skill-based physician credentialing program to ensure optimal patient care delivery. This is an innovative program.

The implementation of the human resources plan over the years has been successful in having an age-balanced workforce.

There is good evidence of numerous initiatives for staff recognition, including a week-long event for service awards and STARS awards.

The centralization of the Learning Management System (LMS) to keep track of staff qualifications and compulsory training facilitates the management and planning of the work to be done.

Encouragement is offered to continue the work on a performance review program, and to complete the first cycle as planned. Key performance indicators (KPIs) need to be put into place to ensure efforts are sustained.

The documentation of volunteers' orientation and ongoing safety training could be more detailed to reflect that they are up to date with processes.

Risk assessment and training in non-violent crisis intervention is done regularly.

2.1.5 Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

An employee engagement committee is in place to address the concerns that were raised during the organization's previous survey. There is broad representation on the committee from all operational areas. The committee is reviewing the overall results and focusing on staff members expressed need for more education and training, as well as a safer route to provide feedback.

Patient safety consultants and industrial engineers are available to teams that are looking at implementing change initiatives, quality improvement initiatives or efficiency initiatives. Training in LEAN methodology is offered and tools and templates are provided to the teams to help with their initiatives. A manager's toolkit is in development.

There is a well-developed and comprehensive enterprise risk management plan that includes a business continuity plan. A much tighter process for the contracted services is now in place. The process includes standard terms for request for proposals (RFPs), a process for renewal of contract, an evaluation of services provided, and the impact on the patients and an assessment of alternatives.

The adverse event management system (AEMS) is embedded into the practice and extensively used by the staff and physicians. The organization is joining the provincial rating system for severity of events and has agreed on standard definitions of “harm”. The system is available on the intranet for all users.

There is a well-established and comprehensive process to review and analyze sentinel or significant events and disclosure to the patient/family is part and parcel of this process, and there is also mandated reporting to the provincial database. Recommendations following an event are generated and the event is not closed until all recommendations have received action.

2.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a well-developed ethics framework and has established an enthusiastic and knowledgeable ethics committee to guide implementation of the framework. It is evident that the framework reflects the organizational values. The organization utilizes a capacity building model to spread ethics knowledge across the organization.

The ethics committee is supported by an additional team of consultants that respond to requests for both clinical and organizational ethics issues using the 'hot line'. The demand for these consultations is increasing. A tool box for ethics is also available on the organization's intranet. An additional resource titled "Patient and Family Ethics Tool" is shared with patients and families. This tool has previously been identified as a leading practice by Accreditation Canada.

The organization's approach to ethics is frequently requested by other organizations both nationally and internationally. There is also a strong Research Ethics Board that has been in place for many years. The organization follows the practices of the Tri-council.

2.1.7 Priority Process: Communication

Communicating effectively at all levels of the organization and with external stakeholders

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Information Management/Information Technology:
There are centralized and shared services that are not exclusive to IWK, and although there are potential pitfalls to this matrix, it seems to work well. The province is embarking on a project of having one health record that is readily accessible to all providers and IWK is an active participant in this project.

Information technology resources are assessed annually. Every program submits a request and programs are required to rate and prioritize their requests. The team will then review all requests and assess for clinical focus, risk to the organization, urgency and finally for conformity with the strategic plan. If and when funding for a project is provided, the impact on the providers is assessed and a project planning process is put in place.

Policies are in place to meet the needs of privacy legislation, retention of documents and information sharing with other organizations. There are guidelines in place for the use of social media in the workplace and education is provided to staff members and physicians on the use of e-mail and 'texting' for patient information.

There are extensive facilities for research and literature searches, not only for the care providers but also for patients and families requiring more information.

Audits are being conducted, the most recent being the do-not-use abbreviations; more audits are planned by the practice chiefs. There are automated audits in place such as the medication reconciliation initiative.

Communication and Public Affairs:
The communication and public affairs staff ensure that the communication plan is aligned with the corporate plan, and that it incorporates the deliverables and the internal and external stakeholders. They partner with the board and executive to ensure appropriate messaging. They also participate with other public affairs groups from other agencies.

2.1.8 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The physical environment is well maintained, with a five to seven year master plan for renovations developed and in progress. Progress to date includes the Garron Centre for inpatient mental health services and the new molecular laboratory. Functional plans are completed for each of the areas to be renovated, with input from departments directly and indirectly affected. The process includes sign-off by infection prevention and control, occupational health safety and wellness, fire service and others. Of particular interest are the 'mock-up rooms' which are proposed layouts for the upcoming renovations to paediatric and neonatal intensive care units. The mock-ups have been built in the parking garage (the only available space). The rooms are set-up so staff members can see the 'look and feel' of working in the 'new' rooms and at the same time, they can have input to the location of basic essentials such as access to medical gases, code buttons, electrical outlets and so on. The rooms are being designed as single patient rooms, with space for parents to sleep. The family area can be used for 'overflow' if necessary. Once finalized, these mock-up rooms will be converted into much needed storage areas.

Patient and family focus and meeting or exceeding building standards are the goals of all clinical environment renovations in the master plan. It has been noted that the number of code white situations has significantly decreased since the Garron Centre opened. This is attributed to the improved design and layout of the space and improved environment.

Much needed renovations to other areas such as the emergency department, dentistry, women's operating room and the birth unit are all included in the master plan. Time lines for the various projects need to be reviewed and accelerated as quickly as possible, especially for areas such as the emergency department where several safety issues have been identified. Please refer to the emergency department report section for further comment.

In addition to service space renovations, there are also infrastructure improvements such as generator capacity, asbestos abatement, roofing, window replacement and others that have been made or are planned.

Protection Services is responsible for emergency response to all codes, way finding, parking, fire safety, and have overall responsibility for the safety and security of the facility. The service participates in staff orientation and annual training of staff. Protection Services staff members have been trained in non-violent crisis intervention as have the maintenance staff.

2.1.9 Priority Process: Emergency Preparedness

Planning for and managing emergencies, disasters, or other aspects of public safety

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The emergency preparedness group is dynamic and works in a collaborative way to ensure that the organization is ready for all types of disasters. The group has a strong relationship with community partners. There is good coordination with the provincial emergency preparedness system.

The group conducts regular fire drills and regularly training for staff. Encouragement is offered to the organization to increase the proportion of staff members that are trained in vertical evacuation.

The organization has had real incidents allowing it to test the incident management system (IMS) team and set up. The organization is consistently learning from past events. The IMS room is well set up.

There is an all hazards approach to planning that seeks front-line staff involvement.

The work on Ebola preparedness deserves recognition. The organization took a practical approach to Ebola preparedness. The training and procedures can be used for all level 4 pathogens thus, allowing the work done to be used in other clinical scenarios.

It is suggested that the process to manage code brown for chemotherapy agents be tested regularly.

As the organization is moving towards an electronic health record it is depending more and more on electronics, and it needs to consider emergency scenarios in case of an all-computer system failure.

2.1.10 Priority Process: Patient Flow

Assessing the smooth and timely movement of clients and families through service settings

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has well-established systems to manage patient flow effectively, taking a proactive approach to prevent and manage overcrowding in the emergency department (ED).

Emergency services are available 24 hours daily, seven days a week. Despite having in place procedures to manage deferral of patients the ED team, working with the organization's leadership, has never had to close the ED or defer patients to another hospital. This is because the team identifies and addresses the barriers to care aggressively. One barrier faced by this team that has significant potential to impede access is the constraint on space in the ED. The emergency team has averted this potential impact by way of innovative and efficient use of space, and implementation of standardized processes and procedures to coordinate timely inter-facility client transfers and transfers to other teams in the organization, while maintaining quality of care.

The organization has implemented a protocol to identify and manage overcrowding and surges in the ED, with the code census policy. This policy is an emergent contingency planning response that defines actions in response to sudden increases in demand for inpatient beds at critical access points of care. The policy identifies accountabilities for these actions within this process, assigning physician, nursing and administrative leadership responsibility.

The teams collaborate to actively manage patient flow, collect and analyze patient flow information to identify the barriers to flow, their causes and impact, and to evaluate the effectiveness of the patient flow strategy. The organization has focused on building its relationship with the Emergency Health Services (EHS) team as part of the strategy to improve flow and quality of care for patients. It includes working to promote the standardization of protocols across the continuum of care for the management of high-risk patients. The team has advocated for the establishment of a paediatric provincial EHS advisor dedicated to promoting the improvement of standards of care for paediatric patients.

The organization monitors surgical wait times, prioritizes elective surgical procedures and adopts a flexible block-time-booking strategy that is responsive to patient flow needs.

2.1.11 Priority Process: Medical Devices and Equipment

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

Unmet Criteria	High Priority Criteria
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices	
4.11 The team leaders approve in writing new and updated SOPs.	

Surveyor comments on the priority process(es)

The reprocessing and sterilization department has made huge improvements in both the work environment and culture. Incompatible activities are separated out, and services have been enhanced. There is a strong culture of continuing education and professional development which is well supported by the leadership. It is clearly evident that the staff members are proud of the work they do and feel their contributions have value to patient care at IWK.

Policies are consistently approved; standard operating procedures (SOPs), although well-developed, are not.

2.2 Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

2.2.1 Standards Set: Population Health and Wellness

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness
Recently a strategic plan was developed for women and newborn's health. The top two priorities for the coming years are priority populations and health inequities. Over 1500 people were included in the stakeholder engagement process. The identified goals and objectives align with the corporate quality improvement plan. The team talked about a 'Women's Well-being Expo' that was held to bring education and awareness to women. There are specific educational opportunities for immigrant families and those from lower socio economic status groups. The organization has a Diversity and Inclusion Advisory Council. There is a self-management process for chronic diseases through a self referral process for life style coaching. There is also a self-management program for women with gestational diabetes. Interestingly, IWK holds education sessions in local grocery stores for urogyne and other women's health issues. There is also a collaboration with Dalhousie University to help provide interprofessional education from IWK to community partners. IWK is in the process of obtaining their Baby Friendly Initiative certification. The organization also plays a provincial role in patient safety. A neonatologist and maternal-fetal medicine physician conducts morbidity and mortality rounds at other hospitals as well as look at the transfer process across the province and are able to provide feedback.

2.3 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Organ and Tissue Transplant

- Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients

Point-of-care Testing Services

- Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Clinical Leadership

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

Competency

- Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

- Using interdisciplinary teams to manage the provision of medication to clients

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

- Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Diagnostic Services: Imaging

- Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions

Diagnostic Services: Laboratory

- Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions

Transfusion Services

- Transfusion Services

2.3.1 Standards Set: Ambulatory Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	The team has access to the resources and infrastructure needed to clean and reprocess reusable devices in the ambulatory services area.	
13.6	The team follows organization policies and procedures and manufacturers' guidelines to contain and transport contaminated items to the reprocessing unit or area.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		
The interdisciplinary team works well together. Recent budgetary changes have resulted in staffing changes in the gynecology clinic. The manager has been working with the team to help the members with these changes. Services are coordinated across the continuum both within the organization and in the community. Medical students are included in various clinics throughout the women's and children's ambulatory clinics.		

In the gynecology clinic there were concerns expressed related to soiled reusable equipment being left in public hallways.

Equipment that is brought into the clinics goes through a rigorous process of bio-medical engineering, risk assessment and then education by the clinical leader.

The teams are good at identifying potential risks and mitigating these risks. Effective communication is utilized to help limit risk. Some of the quality indicators include patient satisfaction and access to care. This information is shared with the team members.

Priority Process: Competency

Staff members of the ambulatory clinics attend the: 'beyond entry level competencies' education day to ensure that they are up-to-date and competent to practice. Staff members also receive education on new equipment including infusion pumps. These records are maintained.

Performance reviews are completed by the managers in each of the areas. Staff members are recognized through the use of the 'Kudos' program.

Priority Process: Episode of Care

Privacy and confidentiality is maintained in the clinics. Private examination rooms are available and individual 'numbers' are used to call patients. Referrals are made to other consultants as is necessary. Wait-lists are reviewed and tracked. In the genetics clinic letters are sent out with expected timelines as to when patients will be seen. The clinics monitor no-shows and do follow-up as necessary. A pilot project with an evening clinic in the orthopaedics clinic has occurred with evaluation of impacts.

Health care providers complete comprehensive assessments in all the clinics. A best possible medication history (BPMH) is completed by clinic staff. There is good access to diagnostic services. In the event of a need to see a patient after hours this will be accommodated. Pain assessments are done in different clinics based on the patient populations. Emotional supports are provided to patients during clinic hours and following their appointments. The interdisciplinary teams provide these supports. Service plans are updated following appointments and shared with patients and their families. Medication dispensing does not occur in the clinic setting. Prescriptions are provided and non-prescription medications may be given to patients if required.

During the survey there were areas that the teams identified that brought a good sense of pride. For the gynaecology clinics there is a good sense of ownership by members of the teams, accessibility for patients with disabilities, the role of the nurse coordinator in breast health and the focus on determinants of health as well as a nurse lead bladder clinic. In the orthopaedic clinics there is pride for their teamwork, and for the craniofacial clinic that was developed in 2014 and also for the evening clinic pilot study. The medicine clinics are proud of the care that is provided to patients and their families. These clinics recently hired a clinical leader of development that provides education to clinic staff, and will ensure competencies are maintained.

Priority Process: Decision Support

Staff members talked about the electronic and the paper patient chart. As patients are seen in clinics their charts are then scanned into 'PCI'. There is good access to patient information and previous notes are used to plan care for the patients.

Goals and objectives are discussed and reviewed at care team meetings. Members of the team are included in this process including the physician co-lead, manager and front line staff. The goals and objectives are determined based on the organization's strategic plan, and a review of patient populations and the top priorities that are identified.

Priority Process: Impact on Outcomes

Goals and objectives are identified by the individual teams. Various factors are reviewed to help mitigate risks in the clinics. Falls prevention precautions are reviewed and discussed at various women's and children's clinics.

In the event of a breach of confidentiality staff members and leaders are aware of the processes that are required including notification of manager, notification of privacy officer and then disclosure to patients.

Patient satisfaction feedback is collected across clinics. This feedback is utilized to improve the services that are provided. If a patient complaint is received immediate feedback with the patient occurs as well as follow-up with the involved staff members.

Wait times are collected and acted on. As well, managers review no shows and follow up with patients/families for feedback. In the orthopaedics clinic a trial was done for one clinic where the time was shifted to the evening. This time shift was well received and there were only three no-shows/cancellations noted compared to the usual number. Future trials will be held to determine what impact a shift in time has on service.

2.3.2 Standards Set: Biomedical Laboratory Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	
15.6 The team follows a policy for using expired reagents only under exceptional circumstances that requires validating their continued suitability for use.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Laboratory

The laboratory has undergone significant improvements since the organization's previous survey. Various processes have been streamlined or initiated to improve turn around times. Turn around times indicators are tracked well for most tests. The molecular genetics menu has been expanded resulting in improved turn around times for results previously sent to referral labs. The expanded rapid real-time microbiology menu polymerase chain reaction (PCR) testing reduces the turn around time for results of Clostridium difficile, methicillin resistant staphylococcus aureus (MRSA) and vancomycin resistant enterococci (VRE). This assists in reducing length of stay while awaiting results, and/or reducing patient isolation time when results are negative. The cytogenetics lab has undergone an industrial engineering review resulting in major process improvements, with a reduction of 60% rework to less than 10% rework and reduced turn around times. Now that some turn around times are regularly meeting targets, it is time to work with laboratory users and 'raise the bar' and establish new targets.

The foundation for a document control system (SoftTech) to manage policies, procedures and other documents is now established and much progress has been made to build and utilize the system. There is work in progress to utilize the system to its full potential.

The newborn screening program has been expanded to provide testing for the entire Maritime region. The new molecular genetics lab will provide suitable space and facilities to accommodate program growth. Improvements were also noted in the main lab work space such as the separation of the newborn screening program testing, and windows in transfusion medicine which have resulted in reduced noise levels. There is also improved monitoring and control of environmental conditions such as temperature and humidity in key areas where testing can be affected by changes in these conditions.

The laboratory is overall accountable for clinical practice activities related to the specimen procurement and handling in the clinical areas in much the same way as the point-of-care testing (POCT) program. The quality of results is highly dependent on proper specimen collection and handling. Both parties are encouraged to continue to work together to ensure the information available on the units such as specimen collection manuals are approved, up-to-date, standardized and document controlled, and that clinical staff members are informed. It is noted that more than 50% of laboratory-related errors reported relate to pre-analytical errors alone that is, collecting, handling, ordering.

2.3.3 Standards Set: Cancer Care and Oncology Services

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

The team provides paediatric cancer care and oncology services for the Maritime provinces. The organization belongs to the Atlantic Provinces Paediatric Haematology Oncology Network (APPHON) and Cancer Care Nova Scotia.

The oncology interdisciplinary group collects data on the population it serves and population needs. The team meets quarterly to evaluate the key performance indicators (KPIs) and to identify efficiencies and opportunities for improvement. This group also does strategic planning annually and participates in developing goals and objectives. The team has identified measurable goals and objectives which align closely with the organization's strategic direction.

Priority Process: Competency

The interdisciplinary team meets weekly to discuss patient care. Oncologists, nurses, care coordinators (e.g. bone marrow), dieticians, clinical pharmacists, psychologists, physiotherapists and occupational therapists, social work, and child life specialists make up this team.

The oncology Inpatient unit is a new, well-appointed, cheerful space. Patients and staff members express satisfaction about this clinical environment.

The organization supports the team development training of new staff and ongoing annual skills lab training. New staff members are assigned a buddy for three months, and thereafter as needed for challenging clinical scenarios. Training in new procedures is offered at the time of introduction of the new practice. The new staff members that were interviewed during the survey praised the buddy system and appreciated the welcome they received from the older staff. All health care professionals have an annual process to renew their liscencing

There is a renewed focus on providing staff members across the organization with feedback on their performance in a timely manner. Those staff members interviewed are still waiting their performance evaluation, underscoring the need for the clinical leaders to remain focused on completing this cycle of evaluation and to follow through with the plan for ongoing and predictable performance evaluation in accordance with the annual cycle.

Priority Process: Episode of Care

Clinical teams assigned to new patients inform them of who is responsible for coordinating their service, and how to reach their care coordinator. The teams provide the patients with information about their diagnosis and about their integrated and comprehensive plan of care. They offer continuity of care by way of the care coordinator role.

The teams have implemented medication reconciliation completely across all points of transition of care.

The teams evaluate the emotional state and needs of patients, and support is available from chaplaincy, social workers and clinical psychologists. Terminally ill patients have the support of a palliative team.

The teams offer their clients/patients strategies to manage pain, and to protect them against accidental falls and from developing pressure ulcers.

Priority Process: Decision Support

The team maintains an accurate client record across the continuum of clinical settings in which the client receives care.

The team utilizes evidence-based guidelines and research based protocols to guide therapy. The team has a well-established process to select and maintain up-to-date guidelines and protocols, with clear accountability for this task.

The team is active in research protocols, and protocols must be approved by the Research Ethics Board (REB) to ensure that they meet approved research and ethics standards.

Priority Process: Impact on Outcomes

The team demonstrate a strong commitment to patient and staff safety. Staff members were observed using two client identifiers when approaching patients to give them their medication and to conduct procedures. These identifiers are name and date of birth, and unit number was also used where applicable.

Families admitted to the in-patient unit receive the patient safety bookmark which contains educational material for families.

Staff members receive education on managing their personal risk during orientations and annual reviews are conducted thereafter.

The team monitors data on their performance, benchmarking against like organizations such as the British Columbia Children's Hospital and the Children's Hospital of Eastern Ontario, and Stollery, and other paediatric oncology centres across Canada known as the C17 Group. KPIs have been identified and these are monitored and benchmarked against other like organizations. These are also applied to quality improvement initiatives and to baseline annual team goals and objectives.

The team identifies, reports, records and monitors sentinel events, near misses and adverse events. Physicians have educational dialogue on disclosure techniques, lead by leadership with expertise in this area.

2.3.4 Standards Set: Community-Based Mental Health Services and Supports Standards

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

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
The overall mental health and addictions program has a well-articulated strategy until 2016. Each area of the program has articulated goals and objectives. The program staff members are engaged in developing goals and objectives. The program also has a program report card that is distributed yearly. The program has made a conscious decision to focus on the development of indicators that reflect the program's progress. The staff members are familiar with the appropriate policies and are able to find them. The mental health program has a diversity of out-patient programs and services at several locations. These serve a wide population of children and youth from five years to 19 years. These programs are available at the main site as well as at a variety of locations in the community and beyond.
Priority Process: Competency
The community-based teams have a strong culture of providing evidence-based services to their clients. They have developed methods of managing their caseload and methods that ensure that each client/patient receives the best possible care. Clients have the opportunity to be cared for by staff members that have specialized training. They regularly meet with one another to ensure that their practice is strong. Performance appraisals have started to occur and staff members indicate they would like to see this happen on an annual basis.

Priority Process: Episode of Care

The clinic in Dartmouth was visited during this survey, and it is one of three community mental health clinics that provide services to children and youth. The clinic staff members were highly engaged and responsive to client need. They had recently invested in the Choice and Partnership Approach (CAPA) and have received training in this regard. This is a model that emphasizes choices and partnerships. This methodology has reduced wait times and facilitated highly sub-specialized services. These staff members are rightfully proud of what they have accomplished by focusing their services in this way.

The out-patient clinic is patient focused and works hard to accommodate patient need. There is on-call support available after hours. Clients commented that the staff members were responsive and always called back when assistance was needed. Clients/patients and their families are much involved in the care. They receive a personalized letter following their initial assessment that outlines the discussion and agreed upon plan for follow up.

Priority Process: Decision Support

The teams are well-versed in issues related to confidentiality and privacy. Policies and procedures are easily available to support this work.

The mental health program has prioritized the development of clinical outcome indicators and is supporting this work by having dedicated staff members that provide the infrastructure and support. There is also considerable opportunity for research. The organization provides front-line staff members with the opportunity to develop their research interests. There is a process whereby staff members can apply to have time specifically allotted for research. This is widely known and they must submit applications at specific times of the year.

There were comments during the survey about a desire to have greater access to an electronic health record. However, staff members have found methods of making their current system work. They are pleased that they can find past records via the Meditech computer system.

Priority Process: Impact on Outcomes

The out-patient teams are focused on outcome measures and as such work collaboratively to develop indicators that are reviewed and monitored. The outpatient teams share information and meet quarterly to review results. The support that the program receives for this initiative is appreciated and the staff members indicate that they value the opportunity to review and improve their work. They are highly focused on outcome indicators and this work continues to evolve and become more sophisticated. The team is highly focused on safety and patients also express a feeling of safety in coming to their locations.

There are a host of outcome related projects underway at this time. These include indicators related to patient acuity, discharge tracking and monitoring, wait time dashboard and strategic key indicators. The teams are encouraged to continue to make the development of outcome indicators and action plans a priority. It is apparent that the teams have strongly benefited from the development of a program strategic plan as well as from a well-coordinated approach to indicators.

The team has clearly defined mechanisms for the transition of patients internally and externally. They use various forms of communication including review of chart, teleconference calls and face to face meetings. The team has developed ways to seek information and advice from family members about the care received.

The patients/families involved in the survey were very positive about the care received from IWK programs.

2.3.5 Standards Set: Critical Care

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
3.2	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.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.4	The team implements the Safer Healthcare Now Ventilator-Associated Pneumonia (VAP) bundle for all clients on ventilators.	!
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The teams are aware of their major sources of referrals. Collaboratively the teams work on measurable goals and objectives for the coming year and beyond. The teams work on surge capacity and have a 'unit of the month' identified to complete daily huddles and update the rest of the teams. There are major redevelopment plans in place with completion expected in four years. The teams are excited about this and continue to provide care that promotes the well-being of patients and their families.

Each of the critical care units discussed areas that they were proud of and the neonatal intensive care unit (NICU) team indicated it provides a high technical environment, and a 'low tech and high touch' approach. Survival rates for the patient population as well as the overwhelming 'acceptance' and inclusion of families into the NICU bring a sense of pride. Research is also a large area of focus for the interdisciplinary team.

The paediatric intensive care unit (PICU) has worked on a variety of initiatives during the last few years. The PICU will be introducing chronic renal replacement therapy shortly, as well as a rapid response team that will start up in September.

Priority Process: Competency

Each of the units has interdisciplinary teams providing patient care. The team morale in the PICU has improved in the last three years and retention strategies have proven effective. Morale in the NICU is good. There are clear roles and responsibilities in both these areas, with scope of practice articulated.

Debrief sessions are available following critical incidents. There is ongoing training and education and this occurs routinely. Daily interdisciplinary rounds occur and include the families.

Priority Process: Episode of Care

The teams are excited about the redesign of their areas, which will be more patient and family centred. Both the NICU and PICU conduct interdisciplinary rounds with the family present. Both units utilize evidence-based practices to ensure safe delivery of care. Research projects are conducted in both areas and follow Research Ethics Board (REB) guidelines.

Staff supports are in place and include 'Care Givers Voices' sessions in the PICU that are held on a monthly basis. On annual basis the 'beyond entry level competencies' education days are held for all staff members to upgrade their skills and to maintain competencies in their respective areas.

There is to be a change in the maximum age for patients in the PICU. With this change the key priority for the team is implementation of venous thrombosis prevention education.

Each of the critical care units is locked to ensure patient/family privacy and confidentiality. However, due to the 'open' space units confidentiality is a key priority for the interdisciplinary team. In the NICU, neonates that are born at less than 1000 grams with skin integrity concerns have their identification band attached to the isolette. This is assessed regularly and once appropriate, the identification bracelet is applied to the babies arm or leg.

During the survey a physician indicated there is a great sense of pride amongst staff members for the care that is provided. There is an honest approach to 'bad' situations, which is much appreciated by families.

There are usually one or two organ retrievals done per year. The PICU has a binder that contains all of the necessary information that is to be followed. A team from Queen Elizabeth II Health Sciences Centre is contacted to assist the team at IWK and they will lead the overall process and notification and approval from the donor families.

Priority Process: Decision Support

Critical care specialists are available daily in both the units. Accurate records are kept for all patients. Best practice guidelines based on research are followed.

Priority Process: Impact on Outcomes

The teams identify potential risks while they deliver patient care. The PICU benchmarks provincially and nationally. The ventilator associated pneumonia (VAP) bundle is not implemented at this time due to low infection rates. The blood stream infections (BSI) bundle has been implemented. Infection rates are posted in the paediatric and neonatal ICUs as well as on PULSE.

Sentinel events are reported with full disclosure to the families. Patient/family surveys are distributed and results are collected and shared with the staff. Both teams collect indicator data to track their progress.

Priority Process: Organ and Tissue Donation

There are approximately one or two donors per year. The team has an organ donation binder filled with information that it follows. The team will connect with the Queen Elizabeth II Health Sciences Centre team and then collaborate throughout the process. The organization's team follows the lead of the Queen Elizabeth II Health Sciences Centre team as determination of neurological death is confirmed and consent is obtained. The actual organ retrieval process occurs at IWK Health Centre.

2.3.6 Standards Set: Diagnostic Imaging Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
1.5	The organization sets clear lines of accountability for diagnostic imaging services delivered across the organization.	!
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

Diagnostic imaging (DI) is organized with good attention to patient and staff safety. Staff members are knowledgeable and passionate about their work. They are commended for their unique initiatives to raise funds to help off-set costs for continuing education.

Wait times for ultrasound and magnetic resonance imaging (MRI) continue to be a challenge, and this is common for most organizations. As the demand and utilization of these modalities continues to rise, the wait times will continue to increase. Some of these procedures are becoming more complex, requiring longer scan times. The recruitment of qualified professionals has been problematic in this region and in others for some time now, however, there are signs of improvement. The team has had some success in reducing wait times and monitoring is ongoing.

The breast screening/diagnostics program is impressive with a strong quality management system in place. A great deal of work has gone into the centralization of this program and it is functioning well.

There has been a great deal of work to date in reviewing and updating technical polices and procedures and working towards an electronic system to manage these documents is encouraged. Documents in the majority of areas have been reviewed and document control with the remainder such as general X-ray procedures is work in progress.

The organization is encouraged to determine overall accountability for the use of portable ultrasound or other imaging equipment and develop guidelines/policies on the appropriate use, training requirements and maintenance of this equipment.

2.3.7 Standards Set: Emergency Department

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team has the workspace it needs to deliver effective services in the emergency department.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This is a highly motivated and effective clinical team. The team has documented and measurable goals and objectives. The data are collected manually and transcribed by ward clerks into electronic format. There is no current plan to adopt the use of an electronic tracking system. This data can be retrieved retrospectively by the team, but is not available in real time to inform patient flow in the department. The data supports a steady increase in volumes of patients seen annually in the department, with an increase in the need for treatment of mental health patients that remain in the department for longer periods. The quality and operations group meets monthly to reflect on the data, to review key performance indicators (KPIs) and to define scope of service and set clinical priorities.

The team continues to review and improve service delivery. Evidence- based guidelines are updated on a regular basis. Examples of recently updated clinical guidelines include those for asthma and for neutropenic patients presenting with fever.

Patient flow strategies are implemented in the emergency department (ED). Although recently refreshed, the work space in the department is constrained. The team has implemented innovative solutions for space

utilization in order to improve patient flow. The Code Census policy, an emergent contingency planning response, defines actions and accountabilities for these actions that respond to sudden increases in demand for inpatient beds at critical access points to care. Within this process, physician, nursing and administrative roles responsibility is clearly assigned.

Staff members interviewed during the survey stated that space constraints in this clinical area, especially during high volume periods, affect their ability to deliver excellent quality of care. The challenges of space constraint include: physicians, nurses and trainees all share a small central counter space to complete their documentation, while consult service physicians and Emergency Health Services (EHS) personnel must share a few work stations adjacent to the hub. In the resuscitation area, space for charting is restricted to a small sink-side countertop.

Other examples of space constraint given by staff interviewed include: the need to store some resuscitation equipment required for the resuscitation area outside the designated room because of lack of space; rooms identified for specialized activities are more often used to provide routine patient care; and lack of appropriate interview space in the triage area is creating an ongoing challenge for the team to ensure patient privacy. Staff members have also raised the concern that the public have unrestricted access to the triage area and clinical care areas because of the open design of the space, which affects staff and patient safety. Although the reconfiguration of the ED space has been recognized by the organization as a priority, there is an opportunity to develop a plan to proceed with renovations of the area as a priority to address the issues identified.

The ED, as it is currently configured, does not meet the infection control standards required for a level 4 pathogens pandemic centre, and this is a designation that this organization has been given for the Maritime provinces.

Priority Process: Competency

There is a renewed organization-wide focus to provide feedback on performance in a timely manner to all staff. The staff members interviewed during the survey still await their performance evaluation, underscoring the need for the clinical leaders to remain focused on completing this cycle of evaluations and to develop a predictable cycle for ongoing evaluation.

The team members receive training in equipment use and its storage. As part of their orientation new team members are told how to access supplies and how to access preventive maintenance.

Priority Process: Episode of Care

The emergency department is clearly marked and accessible, and signage is both visible and understandable.

Medication reconciliation is completed and a best possible medication history (BPMH) is generated for those patients where a decision to admit has been made.

The team is presented with an ongoing challenge to ensure client privacy. This is because of the restricted space in the triage area of the emergency department.

The team has well-established processes for the transfer of information when transferring a patient at the time of admission or at discharge home.

Priority Process: Decision Support

The team uses evidence-based protocols to provide emergency care. The team has a process to select, develop and to update evidence-based guidelines. The existing clinical guidelines recently included protocols for the management of asthma and of neutropenia with fever.

The team maintains accurate and consistently complete patient records.

Priority Process: Impact on Outcomes

Providers were observed checking two patient identifiers when providing therapy and administering medications. The team has a falls prevention program and staff members receive training in this regard. Patients receive a falls assessment risk and it is evaluated. The team tracks frequency, causes and type of injury.

Priority Process: Organ and Tissue Donation

The emergency department supports the process of organ and tissue donation in its role of contacting the coroner and the organ and tissue retrieval service, and by discussing donation with families.

2.3.8 Standards Set: Hospice, Palliative, and End-of-Life Services

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

As the mandate of IWK Health Centre is multi-provincial, the team collects information from the different provinces, regions and sites. The team is a "virtual" team, i.e. there is not any specific unit or site where the care is provided. Patients are not co-located in one area but kept in the most appropriate and familiar setting, the team works with the health care providers and the families to assess and meet the needs of the children and youth.

It is in the mandate of the team to provide education on end-of-life care to other health care providers and other agencies. A comprehensive bereavement service is offered to the families. Resources are also available for the health care providers. The team will make arrangements to meet with the family when it is convenient for them and they also make home visits, especially with the child that is near end-of-life.

The team meets regularly to discuss clinical and administrative issues, and once per year the team has a retreat. The team regularly surveys the families and the health care providers to assess if the team is meeting their needs. One initiative that the team is presently looking at is to address the increase in the number of referrals/consults for end-of-life of newborns and anticipated antenatal death.

Priority Process: Competency

The team is cohesive and high-functioning. Team members support each other and work with one goal in mind: that the patients and families have the best quality of life when they are nearing end of life. They have access to significant continuing education because of funding that is available in a trust account.

Priority Process: Episode of Care

Access to the service is by way of a consult to the physician on the team. At the time of survey there was only one full-time equivalent (FTE) physician, and attempts are being made to recruit another 0.5 FTE physician. There is no wait time to access the service. When a consult is made, one or two members of the team will make contact with the family and arrange for assessment, intervention and follow-up.

The palliative care team sees it as in its mandate to advocate for the needs of patient and family and to remove barriers to good quality of life. There are many times that multiple agencies are involved in the care of the child, and coordinating care is considered key in ensuring that the family has a good experience.

Pain management is part of the service provided by the palliative care team. All interactions and interventions are documented, including telephone contacts. The team will work with the primary care provider to address and record advance directives. The communication of advance directives is also communicated to paramedicine.

Priority Process: Decision Support

The team, by way of the physician, participates in research at the national level.

Priority Process: Impact on Outcomes

The team is connected to other organizations nationally and internationally to look at best practices and compare outcomes. The team regularly collects feedback from families and from health care providers about the quality of their service and quality initiatives.

2.3.9 Standards Set: Infection Prevention and Control Standards

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
4.7	The organization monitors compliance with IPC policies and procedures and makes improvements to the policies and procedures based on the results.	
4.8	The organization regularly updates IPC policies and procedures based on changes to the applicable regulations, evidence, and best practices.	!
7.6	The organization has policies and procedures for disposing of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Overall, the infection prevention and control program is robust. There are clear processes in place to enable the infection prevention and control (IPAC) program to help engage staff. During the survey a few different campaigns were described where this led to a 'laugh and learn' approach that resulted in a positive learning environment, rather than a punitive environment.

The support teams spoke about the preparations for Ebola and the specific focus for that. There are policies in place but some of these are outdated and have not been reviewed due to provincial health system restructuring and efforts to standardize policies across the province. It has been identified by the organization that this has resulted in a risk so these policies are currently in the process of being updated.

Food service has processes and audits in place to ensure that they meet the necessary requirements. There is a clear process in place in the event of any external recalls.

The staff group present discussed the pride in the changing culture related to IPAC and the overall engagement of the front-line staff. The partnerships between the various groups in the organization and the strong linkages were also mentioned. Some challenges that were identified include trying to meet all the demands that various stakeholders have relative to IPAC, and understanding the specific roles that housekeeping, IPAC and occupational health play in ensuring patient safety. It was identified that social media also plays a role and the importance of ensuring that public relations is involved when mock procedures are being carried out.

2.3.10 Standards Set: Medication Management Standards

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Medication Management
The organization benefits from a modern pharmacy system in line with current best practice. The drugs and therapeutics committee is effective in keeping up with all practice changes. The pharmacy and nursing staff members have strong working relationship, and this allows for an integrated approach to safe medication management. The antimicrobial stewardship program has strong on-site expertise. The antibiotic evaluations should graduate from cost savings to clinical outcomes. Except for first doses, the pharmacy should strive to prepare all intravenous (IV) products within the first 24 hours of admission. The pharmacy could optimize the talent pool in making better use of pharmacists' time. The organization is urged to explore using the expertise of pharmacy technicians and time saving technology such as a camera system in oncology satellites to better use pharmacist time. The pharmacy uses unlicensed pharmacy attendants to take care of technical pharmacy duties. Medication preparation is a high-risk activity and needs to be restricted to licensed providers. The next step in medication management automation should be for bar-coding and 24-hour pharmacy services.

2.3.11 Standards Set: Medicine Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The paediatric medicine team is a multidisciplinary team that consists of physicians, nurses, nurse practitioners, pharmacists, dieticians, social workers, child life specialists, physiotherapists and occupational therapists.

The team collects information about the population that it serves, using it to align scope of service to population need. The team has identified annual goals and objectives which are specific and measurable, and tracks performance against key performance indicators (KPIs).

The team has a formal process to renew appointments for all health care providers. Team members receive ongoing training to enhance their skills via annual skill-lab activities. Staff development is supported by donations for education and provincial funding. Staff members are well-supported in times of traumatic events with peer group debriefs and the employment assistance program.

Priority Process: Competency

There is a renewed organization-wide focus on providing staff members with feedback on their performance in a timely way. The staff members interviewed during the survey still await their performance evaluation, underscoring the need for the clinical leaders to remain focused on completing this cycle of evaluations and to develop a predictable cycle for ongoing evaluation.

Priority Process: Episode of Care

The teams use standardized processes and policies to improve interdisciplinary care. Team members have an opportunity to debrief with the support of members of the palliative care team after traumatic incidents. The clinical leaders organize sessions to facilitate debriefing on a regular basis as needed. Evidence-based guidelines have been developed and are refreshed at regular intervals.

There is evidence of compliance for all required organizational practices. Documentation to support infusion pump training was provided. The teams use two client identifiers before providing any service or procedure, and checks were observed. The medication reconciliation process is fully implemented in paediatric medical services. Routine thrombo-prophylaxis to prevent deep vein thrombosis and thrombo-embolism is not required as a routine for the paediatric population less than 18 years of age. The risk for developing a pressure ulcer is assessed using the Braden scale tool. Pain is routinely evaluated for all admitted patients, and assessments are documented on daily flow sheets.

Parents interviewed during the survey described the physical environment as welcoming, easy to navigate, and clean. The staff members were described as caring and friendly. Staff members self-identify and wash their hands. Patients were informed about safety. Parents feel well-informed about their children's condition and about the plan of care.

Priority Process: Decision Support

The teams maintain the client records and keep them up to date. They have a process to select and maintain evidence-based guidelines, and are currently using guidelines for asthma, bronchiolitis and diabetic ketoacidosis (DKA). Additionally, staff members have opportunity to acquire specialized learning using self-learning advanced learning modules in the areas of asthma and DKA.

Research protocols must receive approval from the REB prior to staring activities in the clinical setting.

Priority Process: Impact on Outcomes

There is evidence that the required organizational practices have been met by medicine services. The teams use two client identifiers before providing any service or procedure, and checks were observed during the survey.

Fall risk assessments are performed routinely and preventative strategies are employed when indicated. Patients receive written information and education on their own role in promoting safety.

The teams report on adverse events, near misses and sentinel events and have a policy to disclose these. Patient feedback is actively sought and is used to guide quality improvement initiatives. Quality improvement initiatives are evaluated over time.

2.3.12 Standards Set: Mental Health Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This team has identified clear directions until 2016 and has developed a mental health report card with clearly articulated indicators. The in-patient unit at all three sites have clearly defined goals and objectives. The teams meet regularly to review their progress and to review scorecard indicators that are applicable to their program.

There is a clearly articulated leadership structure that is supported by advanced practice and other specialty positions. There is a strong sense of teamwork in all the inpatient units, and the youth forensic system in particular also works with the justice system in a unique environment. The justice system staff members appreciate the growing collaboration.

Priority Process: Competency

The in-patient teams are multidisciplinary in their composition. They are well supported by advance practice nurses. The Garron Centre has a new clinical resource nurse role. A staff member is on duty most of the time to provide support and mentoring to the newer staff. This role has been recently extended to include an eating disorder resource nurse, which has enabled new staff members to quickly develop clinical skills in the sub-specialty of treating eating disorders.

There is a clear management structure in the program that supports clinical and non-clinical staff.

Priority Process: Episode of Care

The 16 bed in-patient unit at IWK main site has been open for one year. This is a state-of-the-art facility that provides for the delivery of a high standard of care. The design of the unit along with staff training has resulted in a significant reduction of code white incidents during the past year. The staff members utilize the space and configuration to provide recovery-based care in a comfortable environment. The furnishings provide a feeling of warmth but also consider safety.

The specialized in-patient units also provide care in spacious and safe environments. There is a recently created room in the ED to facilitate the provision of emergency care. This room, while away from the main emergency corridor, is small in size and somewhat institutional.

The staff members on all three units appear engaged in patient care and are knowledgeable. Processes are in place to ensure that care is delivered in an organized manner. Daily team meetings in the Garron Centre provide an opportunity for the inter-professional team to organize care on a daily basis. More thorough patient reviews are held weekly. There is an opportunity to review care and share information around care planning.

The COMPASS team and Youth Justice team are knowledgeable and committed to their unique patient populations.

Priority Process: Decision Support

The team has well-organized documentation that is initiated via the centralized intake process and/or emergency department. The staff members are educated on key policies and procedures including confidentiality and the specific laws that relate to mental health legislation. They can also readily access information from the well-organized intranet. Staff members have access to internal and external education.

At this time there is a paper chart utilized. Staff members look forward to the introduction of an electronic health record (EHR). As previously noted the youth forensic system operates in collaboration with the justice system. Staff members are well-versed in clinical and legal issues related to the patient population.

Priority Process: Impact on Outcomes

There is a culture of quality and safety on the in-patient units. Staff members are aware of protocols around patient safety. There is a patient safety consultant assigned to the program that works on various initiatives related to patient safety with the staff. Although there are no cameras in the Garron Centre, the staff members are comfortable with safety practices including the use of a safety alert system.

2.3.13 Standards Set: Obstetrics Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team has recently completed a strategic plan for the next five years including all areas of the program. There are a variety of out-patient clinics and in-patient areas that provide a seamless approach to pregnant women. There is an ethics booklet available to patients and staff members if the need arises. The antenatal unit and post partum units both have multiple private rooms conducive to privacy for parents. New epidural pumps were recently purchased, and staff members were educated on the use of these pumps.

The overwhelming theme noted across all areas of the women's and newborn program is the sense of great teamwork. In all the areas including antenatal clinics, birthing suites and post partum the staff members indicated that their greatest sense of pride is the interdisciplinary teams and the collaboration. Goals and objectives were recently developed by the different managers across the program.

Priority Process: Competency

There are interdisciplinary teams in place across the program. There are physician lead and manager co-lead care team meetings to establish priorities and evaluate outcomes. Orientation for the women's and newborn program covers four different areas to ensure that coverage is available based on the demands of the various units.

Work life stress is reviewed. There are times that the units are very busy and workload is assessed. Attempts are made to shift the workload to different areas.

During the survey the clinical educator spoke about 'E-Source' as a tool to document staff education, as well as the provincial documentation tool for education called LMS. There is also a 'Kudos' program that encourages staff members to recognize each other for a job well done.

Priority Process: Episode of Care

Each of the areas, whether out-patient clinics or in-patient services, has interdisciplinary teams providing care across the continuum. Assessments are done across the continuum throughout the pregnancy to determine if there are any high risk issues or problems. Information is shared across the continuum of care for all patients. Even though high-risk patients are well-served the teams have access to other consultants if required. Access to diagnostic services is readily available. If diagnostic services are required after hours on-call physicians are available to provide services.

Note is made of the 'unit of the month' which is a practice that identifies a unit to participate in daily huddles to determine what processes need to be put in to place if a surge were to occur. Staff members are trained in different areas so that they can be transferred between units if the need arises.

There are clear processes in place to monitor foetal health during all stages of labour. There are three operating rooms (ORs) available in the birthing suites to ensure that all booked and urgent cases can be performed as needed. Pain is assessed and managed in the birthing suites and post-partum areas. Consent is obtained by the physician prior to c-sections and any other procedures.

A best possible medication history (BPMH) is completed on admission to Birthing Suites, transfer points and discharge from post partum. Two client identifiers are used in all of the areas including inpatient and clinics.

Every patient is provided with a booklet titled: "Loving Care" which is provided by Public Health. Bereavement services are available when required and are offered across the various areas of the program. The interdisciplinary team is used to help provide these services. Skin to skin contact is done routinely and the practice around the 'golden hour' has been implemented. The program is in the process of seeking 'Baby Friendly' certification and is well on its way, and the team is proud of the accomplishments thus far.

Priority Process: Decision Support

There is good coordination of patient information across the continuum, from out-patient antenatal to in-patient post partum care. Evidence-based guidelines are reviewed at care team meetings and then it is determined which ones to implement. Faxed reports are used to transfer information between units. Shift to shift report occurs but varies between the units. Research projects do occur and all REB guidelines are followed.

Priority Process: Impact on Outcomes

New epidural pumps were recently introduced to the units. Thorough education and training was completed. Appropriate client identifiers are utilized in out-patient areas as well as the in-patient areas. The falls prevention strategy has been implemented in the birthing suites as well as at post partum. There is an information pamphlet that is shared with patients.

The units utilize a patient safety pamphlet that is given to all patients and then reinforced verbally by staff. The antenatal unit will be conducting a trial of a new induction process beginning next week and the team is excited about this trial.

2.3.14 Standards Set: Organ and Tissue Donation Standards for Deceased Donors

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team strongly supports the organ and tissue donation program at IWK Health Centre. This strong culture of support also affects the attitudes and support that front-line staff members have for the program, and is evidenced by the potential donors that are identified in a compassionate manner. The organization has a robust integration with other organ procurement and transplant services in the city, the province and nationally.

Priority Process: Competency

The multidisciplinary team is well-integrated with other hospitals, services, programs and the province. Team members have a great deal of experience and are well trained and educated. There is effective communication across the team.

Priority Process: Episode of Care

There is a standardized questionnaire and intake form in place and which are used for possible donations.

Priority Process: Decision Support

The team follows the current standards and evidence at a local, provincial and national level.

Priority Process: Impact on Outcomes

All team members are comfortable with and encouraged to report improvement opportunities and disclosure of sentinel events. Quality indicators are monitored.

Priority Process: Organ and Tissue Donation

The team delivers compassionate care to the donor and the donor family. Many bereavement support processes are offered including an annual memorial service. One particularly moving memorial tool that has been implemented is the pewter "dual heart" necklace, where the infant or child wears the small heart and the parents retain the large heart in memory of their child and their selfless act of donation.

2.3.15 Standards Set: Organ and Tissue Transplant Standards

Unmet Criteria	High Priority Criteria
Priority Process: Organ and Tissue Transplant	
The organization has met all criteria for this priority process.	
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Organ and Tissue Transplant	
Two mothers of children that had received kidney transplants were interviewed during the survey. They described the service and support at IWK before, during and after transplant as stellar. They always felt that no question or concern was thought of as "stupid" and felt staff supports were available at any time.	
Priority Process: Clinical Leadership	
The transplant and organ procurement time are given priority for the operating rooms (ORs), OR teams and the related services required. There are contingency plans as well. This program is well supported and valued across the organization.	
Priority Process: Competency	
Staff members are invested in the program and receive training and ongoing education. There are contingencies built in to alleviate the issue of working too many hours.	
Priority Process: Decision Support	
The transplant team sets the standards and "leads the pack" with setting successful transplant outcomes and best practices.	

Priority Process: Impact on Outcomes

The team sets and monitors quality indicators well. Investigation of quality improvement opportunities and implementing continuous improvement initiatives are part of IWK and its related partners' culture.

2.3.16 Standards Set: Point-of-Care Testing

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
4.4	The organization places the SOPs in areas where health care professionals delivering POCT can easily access them.	
4.8	The organization has a policy on POCT client self-testing.	
9.5	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.	!
Surveyor comments on the priority process(es)		
Priority Process: Point-of-care Testing Services		

The point-of-care testing (POCT) staff members have made huge progress in the training and monitoring of POCT. They are responsive to clinical concerns and do not hesitate to perform extensive investigations to get to the root of a problem. For example, when there were concerns expressed by the clinical area that perhaps the current glucose monitors were not the best choice for PICU patients, the laboratory performed a large re-validation study to determine the best monitor choice for their patients. The results were shared with the POCT committee and the clinical partners.

IWK has a robust validation protocol. When problems occurred, they did not hesitate to implement a PDSA study to revalidate their finding and search for possible root causes of testing result discrepancies between the POCT instrument and the confirmatory laboratory test

2.3.17 Standards Set: Rehabilitation Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization does not have a formal in-patient rehabilitation program. The rehabilitation program consists of a set of primary and tertiary care services. The on-site visit focused on three elements of the program namely the outreach high school program, the in house pre-school program and the seating clinics. The programs visited were ambulatory in nature. The overall program has a variety of out-patient teams. The different teams have metrics to assess the level of care provided. The different teams have strong links to community partners and clinical teams to support the care.

Priority Process: Competency

The team uses a standardized process to assess and document patient outcomes.

The equipment, such as the lift that is used in the school program that was visited during the survey, should meet the same standard of maintenance and cleanliness as if it is in use in the hospital. During the visit it was noted that the equipment would not meet hospital standards.

Priority Process: Episode of Care

The school program has a strict and well-structured consent to treatment, allowing for open communication between the school and the parent.

As already noted, the lift at the school visited did not meet hospital standards, as there is shared used between clients. The responsibility for cleaning and maintenance of this type of equipment should be clearly delineated between the school program and the hospital program.

Priority Process: Decision Support

The teams make significant effort to ensure there is coordination of care both in the school and the hospital. The school team has outcome-based treatment plans that are obtained in consensus between parents, educator, health care providers and the child if possible. The team use standardized tools to assess and to establish treatment outcomes.

Priority Process: Impact on Outcomes

The teams use evidence-based guidelines and tools to assess patient outcome. The patient and family interviewed during the survey were satisfied with the care received. They felt listened to and part of the decision-making as far as treatment outcome.

2.3.18 Standards Set: Substance Abuse and Problem Gambling Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The CHOICES team provides a range of outpatient, day treatment and inpatient services to youth. The program has established a harm reduction model. The CHOICES team contributes to the well-developed mental health strategic plan that provides a roadmap for current and future services.

The substance abuse staff members are familiar with the strategic plan. They are currently in the process of changing their model so that their services are better aligned with others to achieve optimal access to their services. The treatment team is engaged in program planning on a regular basis.

Priority Process: Competency

The CHOICES team members enjoy excellent space with ample meeting rooms, interview space and quiet rooms. The team has access to training opportunities that allow for use of evidence based practice. There is a comprehensive orientation for new staff members both by way of general orientation and at the program level.

The interdisciplinary team has an appropriate method of transferring information from shift to shift. There is clear transfer of accountability documentation on patients that are attending substance abuse programming during the day and remaining for the 24/7 program.

Priority Process: Episode of Care

The teams have well-established processes for development of care plans that cover the continuum of service. The team has clearly identified roles that ensure this planning occurs in an effective manner. There are early discussions about discharge. Community partners are involved in the discharge planning process as required.

There are clear and ongoing assessment processes at every stage of the patients' structured time in the program. Family involvement occurs at every stage of the process, with patient consent. The team has written materials that it provides to patients and families regarding their role in patient safety. These materials clearly spell out the responsibilities of all parties.

Priority Process: Decision Support

The teams utilize appropriate consent forms that are clear and engage the client and family. There is general hospital consent as well as one that clearly articulates the requirements of the program. Team members are educated on appropriate legislation as well as new treatment modalities.

The program uses information to modify its offerings. It reviews resource allocation to ensure that services that are most needed are provided to the community.

Priority Process: Impact on Outcomes

The mental health and addictions program has developed a strategy along with clearly articulated actions to move the program forward. The teams have also developed an overall mental health and addictions program report card that is published quarterly. This report card has clear indicators that are reported and teams review the indicator results and develop action plans as required. The approach to outcome measurement is structured and has become part of the clinicians' day-to-day way of thinking.

2.3.19 Standards Set: Telehealth Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
9.9 The team follows up with clients and service providers to determine whether the telehealth services provided contributed to the achievement of the client's service goals and expected results, and uses this information to identify and address barriers that are preventing clients from achieving their goals.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization submitted a briefing note to the deputy minister about the need to reassess the model of delivery. The report highlights the fact that 60% of telehealth technology is used to support administrative or educational sessions. The report suggests to change the provincial governance structure to support more effective health care deliveries. This initiative reflects the excellent work done on assessing the quality of the telehealth services provided.

The organization has a policy on telehealth. Encouragement is offered to continue the work on the draft policy governing tele-practice and addressing all forms of electronic communications to meet the needs of the ever changing practice environment.

Priority Process: Competency

The organization has a qualified telehealth team available.

Priority Process: Episode of Care

The care provided using telehealth is structured and meets patients' expectations. Access to telehealth services could be improved to optimize the coordination of appointments with remote locations. Once the appointment process is simplified the clinical team should be encouraged to promote this service to their patients.

Priority Process: Decision Support

The organization has requested a review of the current state of telehealth services for the last year. This review was to identify area of improvements and has assisted in planning future improvements to the system based on best practices and access to current technology.

Priority Process: Impact on Outcomes

The organization has done an excellent review of optimal use of telehealth services. The team keep track of practical indicators and is taking steps to improve the system to allow better access for clinical use. Encouragement is offered to the organization and team to better promote the use of telehealth directly to patients and families. There is room for more use of telelehalth by the clinical team.

2.3.20 Standards Set: Transfusion Services

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services

The transfusion medicine team effectively engages its clinical partners. The laboratory staff members are comfortable consulting clinical staff members about further patient history information or patient needs. The clinical staff members are comfortable consulting with transfusion medicine for their expertise as well. Kudos to the organization and laboratory leadership team to continue to value the importance of staff development. There are many educational opportunities available to transfusion staff and laboratory staff in general.

2.3.21 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Surgical services at IWK Health Centre are provided by two distinct teams namely, the children's surgical team and the women's surgical team. Both teams were evaluated during this survey. Both teams collect information about clients and population needs, aligning their scope of practice to meet these needs. The teams have identified their annual goals and objectives. They monitor key performance indicators (KPIs), benchmarking against external comparator programs. Both teams engage in provincial and national activity to define clinical standards.

Teams evaluate patient flow, putting in place strategies such as flexible block operating room (OR) booking scheduling to be responsive to increasing wait times.

There is evidence of compliance for all required organizational practices. Documentation to support infusion pump training was provided. The team uses two client identifiers before providing any service or procedure, and checks were observed. The medication reconciliation process is fully implemented in all areas providing surgical services. The organization provides thrombo-prophylaxis to prevent deep vein thrombosis and thrombo-embolism to the appropriate age group. Routine prophylaxis is not required for the paediatric population, less than 18 years of age. The risk for developing pressure ulcers is assessed using the Braden tool. The use of a safe surgery checklist to confirm safety steps is a well-established part of both the children's and women's programs' pre-operative routine. Falls risk assessment and strategies for prevention are implemented and practiced. There is an excellent risk assessment tool applied to the PM of medical devices and equipment to assist in prioritization of work.

The organization has made available interpretive services for the French, Arabic, Chinese and Inuit languages.

Both programs are engaged in their first cycle of completing the new performance appraisal tool. High performing staff members are recognized in multiple ways including public postings on notice board or e-postings, and local and organization-wide celebrations.

Both the women's and children's' surgical teams have a dress code. The children's OR dress code varies from the women's OR dress code in that it recognizes the presence of family members in the OR and defines the required dress code for this group. Dress code is strictly adhered to by both groups.

Parents and clients interviewed during the survey describe the physical environment of the hospital as warm and welcoming, easy to navigate, organized and clean. The staff members were described as competent, caring and friendly. They indicate that food services are satisfactory. A surgical patient was effusive about her surgeon's attentiveness and care. Staff self-identify and wash their hands. Patients were informed about safety. Parents indicated that they were well taken care of by staff members, making them better able to care for their sick child. Parents and patients felt that they had received: "the exactly right amount of clearly understood information" about their medical condition.

Section 3 Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

3.1 Governance Functioning Tool

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

- Board composition and membership
- Scope of authority (roles and responsibilities)
- Meeting processes
- Evaluation of performance

Accreditation Canada provided the organization with detailed results from its Governance Functioning Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: June 1, 2014 to July 13, 2014**
- **Number of responses: 12**

Governance Functioning Tool Results

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	17	83	93
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	17	83	93
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	8	92	97

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	8	92	97
4	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.	0	8	92	95
4	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.	0	8	92	95
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	8	0	92	92
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	8	0	92	92
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	8	92	95
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	8	92	95
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	96
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	96
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	8	0	92	94

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	8	0	92	94
10	Our governance processes make sure that everyone participates in decision-making.	0	0	100	94
10	Our governance processes make sure that everyone participates in decision-making.	0	0	100	94
11	Individual members are actively involved in policy-making and strategic planning.	8	8	83	89
11	Individual members are actively involved in policy-making and strategic planning.	8	8	83	89
12	The composition of our governing body contributes to high governance and leadership performance.	0	8	92	93
12	The composition of our governing body contributes to high governance and leadership performance.	0	8	92	93
13	Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
13	Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
14	Our ongoing education and professional development is encouraged.	0	17	83	88
14	Our ongoing education and professional development is encouraged.	0	17	83	88
15	Working relationships among individual members and committees are positive.	0	0	100	97
15	Working relationships among individual members and committees are positive.	0	0	100	97
16	We have a process to set bylaws and corporate policies.	0	0	100	95
16	We have a process to set bylaws and corporate policies.	0	0	100	95

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18	We formally evaluate our own performance on a regular basis.	0	8	92	82
18	We formally evaluate our own performance on a regular basis.	0	8	92	82
19	We benchmark our performance against other similar organizations and/or national standards.	0	8	92	72
19	We benchmark our performance against other similar organizations and/or national standards.	0	8	92	72
20	Contributions of individual members are reviewed regularly.	0	25	75	64
20	Contributions of individual members are reviewed regularly.	0	25	75	64
21	As a team, we regularly review how we function together and how our governance processes could be improved.	8	17	75	81
21	As a team, we regularly review how we function together and how our governance processes could be improved.	8	17	75	81
22	There is a process for improving individual effectiveness when non-performance is an issue.	0	27	73	64
22	There is a process for improving individual effectiveness when non-performance is an issue.	0	27	73	64
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	0	17	83	80
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	0	17	83	80
24	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.	0	8	92	84

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
24	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.	0	8	92	84
25	As individual members, we receive adequate feedback about our contribution to the governing body.	0	17	83	69
25	As individual members, we receive adequate feedback about our contribution to the governing body.	0	17	83	69
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	0	8	92	84
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	0	8	92	84
28	As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
28	As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
29	As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	85
29	As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	85
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	0	8	92	92
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	0	8	92	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	8	92	87
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	8	92	87
32 We have explicit criteria to recruit and select new members.	0	0	100	84
32 We have explicit criteria to recruit and select new members.	0	0	100	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	8	92	90
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	8	92	90
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
34 The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
36 We review our own structure, including size and subcommittee structure.	0	0	100	89
36 We review our own structure, including size and subcommittee structure.	0	0	100	89
37 We have a process to elect or appoint our chair.	0	9	91	95
37 We have a process to elect or appoint our chair.	0	9	91	95

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

3.2 Canadian Patient Safety Culture Survey Tool

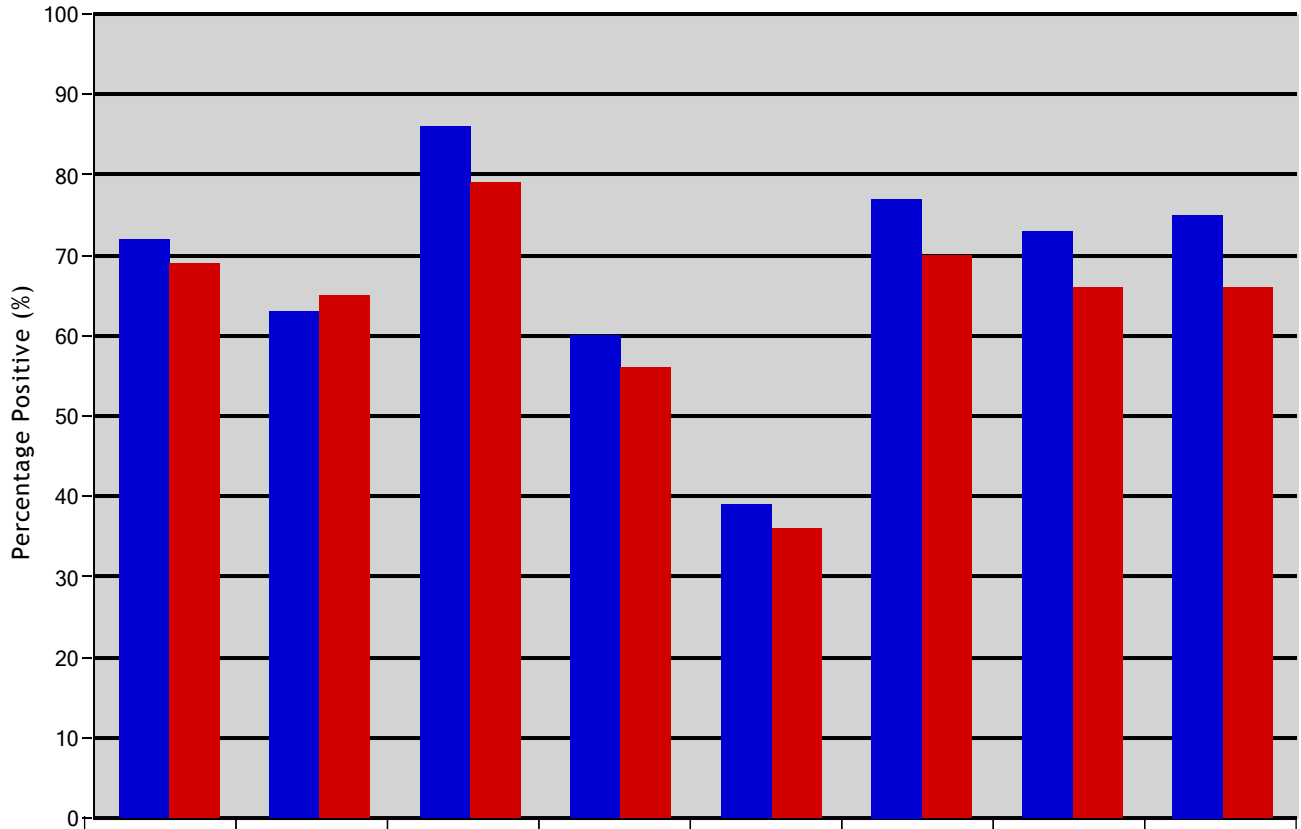
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations with the Patient Safety Culture Tool, an evidence-informed questionnaire that provides insight into staff perceptions of patient safety. This tool gives organizations an overall patient safety grade and measures a number of dimensions of patient safety culture.

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: April 14, 2014 to May 31, 2014**
- **Minimum responses rate (based on the number of eligible employees): 286**
- **Number of responses: 810**

Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	72%	63%	86%	60%	39%	77%	73%	75%
	69%	65%	79%	56%	36%	70%	66%	66%

Legend

Izaak Walton Killam (IWK) Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2014 and agreed with the instrument items.

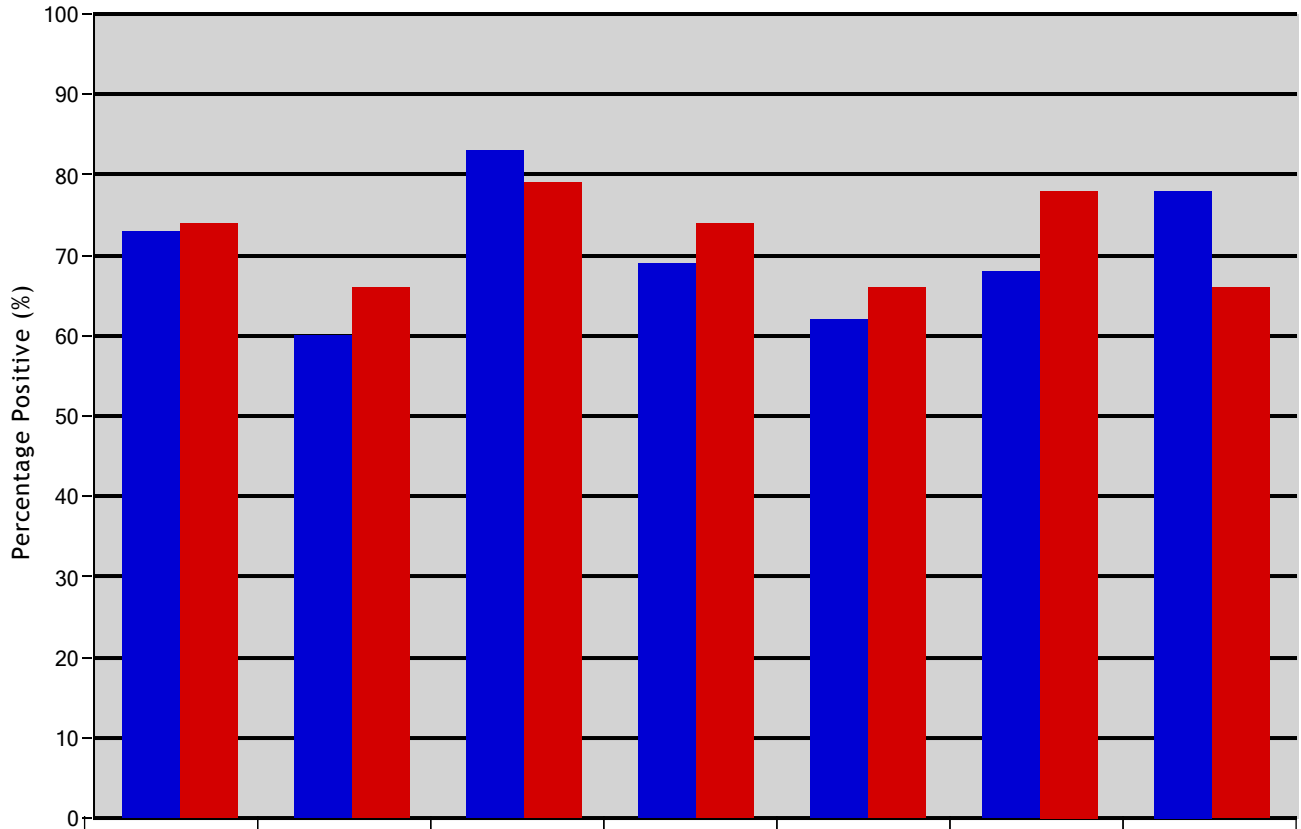
3.3 Worklife Pulse

Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

Organizations can use results from the Worklife Pulse Tool to identify strengths and gaps in the quality of worklife, engage stakeholders in discussions of opportunities for improvement, plan interventions to improve the quality of worklife and develop a clearer understanding of how quality of worklife influences the organization's capacity to meet its strategic goals. By taking action to improve the determinants of worklife measured in the Worklife Pulse tool, organizations can improve outcomes.

The organization used an approved substitute tool for measuring the quality of worklife but did not provide Accreditation Canada with results.

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	73%	60%	83%	69%	62%	68%	78%
	74%	66%	79%	74%	66%	78%	66%

Legend

Izaak Walton Killam (IWK) Health Centre

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

3.4 Client Experience Tool

Measuring client experience in a consistent, formal way provides organizations with information they can use to enhance client-centred services, increase client engagement, and inform quality improvement initiatives.

Prior to the on-site survey, the organization conducted a client experience survey that addressed the following dimensions:

Respecting client values, expressed needs and preferences,including respecting client rights, cultural values, and preferences; ensuring informed consent and shared decision-making; and encouraging active participation in care planning and service delivery.

Sharing information, communication, and education,including providing the information that people want, ensuring open and transparent communication, and educating clients and their families about the health issues.

Coordinating and integrating services across boundaries,including accessing services, providing continuous service across the continuum, and preparing clients for discharge or transition.

Enhancing quality of life in the care environment and in activities of daily living,including providing physical comfort, pain management, and emotional and spiritual support and counselling.

The organization then had the chance to address opportunities for improvement and discuss related initiatives with surveyors during the on-site survey.

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	Met
Provided a client experience survey report(s) to Accreditation Canada	Met

Section 4 Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

The IWK Health Centre has just completed another successful Accreditation Canada Survey. 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 improve the quality of care and services we deliver to the patients and families we serve. A huge thank you is extended to each of you for your participation and support during the accreditation process.

The accreditation process enables us to evaluate our programs and care against national standards of excellence through a continuous quality improvement cycle, culminating with a multi-day visit by Accreditation Canada surveyors every four years. The scope of our 2015 on-site survey by Accreditation Canada was extensive, as seven surveyors visited with many teams and services across the IWK, including several community sites where IWK provides services. The surveyors followed a comprehensive schedule as they 'traced' both clinical and administrative priority processes through their course, meeting with the Board of Directors, staff, physicians, volunteers, patients, families and community partners in order to assess the IWK's compliance with 25 sets of Qmentum standards and approximately 3000 criteria.

Overall, the accreditation survey has provided an opportunity to acknowledge our many successes as well as identify and validate opportunities for improvement. Setting priorities for addressing these areas for improvement will be a key factor as we move forward on our quality improvement journey. The IWK has also recently embarked upon our journey to define our strategy over the next five years. This accreditation report helps inform our strategy as we chart the course to achieve a balanced structure for excellence and results.

We wish to acknowledge the tremendous work of the Accreditation Survey Team for their leadership in helping to ensure a successful visit. 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 quality and safety at all levels and quality improvement is embedded in all we do. The Accreditation Canada Qmentum Program provides us with the best practice standards and measures to evaluate our work and will enable us to remain committed to helping families be healthy and get the best care.

Appendix A Qmentum

Health care accreditation contributes to quality improvement and patient safety by enabling a health organization to regularly and consistently assess and improve its services. Accreditation Canada's Qmentum accreditation program offers a customized process aligned with each client organization's needs and priorities.

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 10 business days.

An important adjunct to the Accreditation Report is the online Quality Performance Roadmap, available to client organizations through their portal. The organization uses the information in the Roadmap in conjunction with the Accreditation Report to ensure that it develops comprehensive action plans.

Throughout the four-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, develop action plans, and monitor progress.

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

Appendix B Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
Communication	Communicating effectively at all levels of the organization and with external stakeholders
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served
Principle-based Care and Decision Making	Identifying and decision making regarding ethical dilemmas and problems.
Resource Management	Monitoring, administration, and integration of activities involved with the appropriate allocation and use of resources.

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served, through leadership, partnership, innovation, and action.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and overall goals and direction to the team of people providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	Using information, research, data, and technology to support management and clinical decision making
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
Organ and Tissue Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
Organ Donation (Living)	Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge