ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Izaak Walton Killam (IWK) Health Centre

Halifax, NS

On-site survey dates: May 5, 2019 - May 9, 2019

Report issued: September 9, 2019

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 2019. 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

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

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

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

Table of Contents

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.

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.

About the On-site Survey

- **On-site survey dates: May 5, 2019 to May 9, 2019**

- **Locations**

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

  1. APSEA Building - Children's Intensive Services 5944 South Street
  2. Cobequid Community Health Centre
  3. Halifax Shopping Centre (NS Breast Screening)
  4. Highfield Centre (Midwifery)
  5. IWK Health Centre (Main Campus)
  6. Joseph Howe Drive - AIS
  7. Wyse Road - Dartmouth Community Mental Health & Shared Care

- **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. Governance
  2. Infection Prevention and Control Standards
  3. Leadership
  4. Medication Management Standards

  Service Excellence Standards

  5. Ambulatory Care Services - Service Excellence Standards
  6. Biomedical Laboratory Services - Service Excellence Standards
  7. Cancer Care - Service Excellence Standards
  8. Community-Based Mental Health Services and Supports - Service Excellence Standards
  9. Critical Care Services - Service Excellence Standards
  10. Diagnostic Imaging Services - Service Excellence Standards
  11. Emergency Department - Service Excellence Standards
  12. Hospice, Palliative, End-of-Life Services - Service Excellence Standards

13. Inpatient Services - Service Excellence Standards
14. Mental Health Services - Service Excellence Standards
15. Obstetrics Services - Service Excellence Standards
16. Organ and Tissue Transplant Standards - Service Excellence Standards
17. Perioperative Services and Invasive Procedures - Service Excellence Standards
18. Point-of-Care Testing - Service Excellence Standards
19. Reprocessing of Reusable Medical Devices - Service Excellence Standards
20. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

1. Worklife Pulse
2. Canadian Patient Safety Culture Survey Tool
3. Governance Functioning Tool (2016)
4. Physician Worklife Pulse Tool
5. Client Experience Tool

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	60	2	0	62
 Accessibility (Give me timely and equitable services)	114	0	2	116
 Safety (Keep me safe)	737	1	23	761
 Worklife (Take care of those who take care of me)	160	1	0	161
 Client-centred Services (Partner with me and my family in our care)	510	4	19	533
 Continuity (Coordinate my care across the continuum)	103	0	0	103
 Appropriateness (Do the right thing to achieve the best results)	1177	25	28	1230
 Efficiency (Make the best use of resources)	73	2	0	75
Total	**2934**	**35**	**72**	**3041**

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	49 (98.0%)	1 (2.0%)	0	34 (97.1%)	1 (2.9%)	1	83 (97.6%)	2 (2.4%)	1
Leadership	47 (94.0%)	3 (6.0%)	0	91 (94.8%)	5 (5.2%)	0	138 (94.5%)	8 (5.5%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	30 (96.8%)	1 (3.2%)	0	70 (98.6%)	1 (1.4%)	0
Medication Management Standards	72 (98.6%)	1 (1.4%)	5	56 (100.0%)	0 (0.0%)	8	128 (99.2%)	1 (0.8%)	13
Ambulatory Care Services	46 (100.0%)	0 (0.0%)	1	77 (98.7%)	1 (1.3%)	0	123 (99.2%)	1 (0.8%)	1
Biomedical Laboratory Services	71 (98.6%)	1 (1.4%)	0	103 (98.1%)	2 (1.9%)	0	174 (98.3%)	3 (1.7%)	0
Cancer Care	81 (100.0%)	0 (0.0%)	0	115 (100.0%)	0 (0.0%)	0	196 (100.0%)	0 (0.0%)	0
Community-Based Mental Health Services and Supports	45 (100.0%)	0 (0.0%)	0	94 (100.0%)	0 (0.0%)	0	139 (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 Services	60 (100.0%)	0 (0.0%)	0	104 (99.0%)	1 (1.0%)	0	164 (99.4%)	1 (0.6%)	0
Diagnostic Imaging Services	68 (100.0%)	0 (0.0%)	0	66 (97.1%)	2 (2.9%)	1	134 (98.5%)	2 (1.5%)	1
Emergency Department	69 (95.8%)	3 (4.2%)	0	105 (98.1%)	2 (1.9%)	0	174 (97.2%)	5 (2.8%)	0
Hospice, Palliative, End-of-Life Services	40 (100.0%)	0 (0.0%)	5	93 (97.9%)	2 (2.1%)	13	133 (98.5%)	2 (1.5%)	18
Inpatient Services	58 (100.0%)	0 (0.0%)	2	84 (100.0%)	0 (0.0%)	1	142 (100.0%)	0 (0.0%)	3
Mental Health Services	50 (100.0%)	0 (0.0%)	0	89 (96.7%)	3 (3.3%)	0	139 (97.9%)	3 (2.1%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	88 (100.0%)	0 (0.0%)	0	159 (100.0%)	0 (0.0%)	2
Organ and Tissue Transplant Standards	73 (98.6%)	1 (1.4%)	13	106 (95.5%)	5 (4.5%)	7	179 (96.8%)	6 (3.2%)	20
Perioperative Services and Invasive Procedures	113 (100.0%)	0 (0.0%)	2	109 (100.0%)	0 (0.0%)	0	222 (100.0%)	0 (0.0%)	2
Point-of-Care Testing	38 (100.0%)	0 (0.0%)	0	48 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Reprocessing of Reusable Medical Devices	85 (100.0%)	0 (0.0%)	3	40 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	3
Transfusion Services	76 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Total	**1252 (99.2%)**	10 (0.8%)	33	1601 (98.5%)	25 (1.5%)	31	2853 (98.8%)	35 (1.2%)	64

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	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			
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Organ and Tissue Transplant Standards)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Organ and Tissue Transplant Standards)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	9 of 9	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 (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
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)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
The "Do Not Use" list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
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
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	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Organ and Tissue Transplant Standards)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
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
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Organ and Tissue Transplant Standards)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0

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

Summary of Surveyor Team Observations

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

Board of Directors

The Survey Team had the opportunity to meet with four members of the Board of Directors, review governance activities against the standards and hear directly from members as to the approach adopted by the Board as it relates to accountability and transparency.

A review of the board governance practices and policies reinforced a number of best practices. The focus on quality was noted with approval, including the active involvement of patient partners in the process. A revised approach to quality oversight has resulted in the integration of all quality and risk activities under one umbrella program. This is noted with approval and allows for a streamlined focus on quality and risk mitigation. The Risk Framework had been implemented and the organization had undergone a detailed review of risk across the enterprise, rating the various items relative to importance to address. This is a positive step for the Board from an oversite perspective.

Discussion ensued around the recent audits, 2 separate ones commissioned by the Board - one of CEO expenses, one of fiscal and governance oversight. The Board is commended for undertaking these audits, with the majority of the recommendations addressed. It will be key for the Board to continue to ensure that the recommendations be addressed and that regular reporting to the Board occurs. This process has served as a strong reminder of the role of the Board of Directors in oversight, particularly in ensuring that the processes and procedures in place reinforce accountability and that they are regularly maintained.

The Board's commitment to family presence in the organization is noted. Patient partners are well supported across the enterprise and the Board is encouraged to continue to promote patient partner visibility through active participation on the Board and Medical Advisory Committee. It was also discussed during a meeting of the Family Leadership Committee that the organization should revisit it focus on diversity as there appeared to be opportunities to elevate the importance of this across the Health Centre.

The Board of Directors is committed and involved in all aspects of the work at IWK. They are proud of the organization although shaken by issues of 18 months ago and the turnover of leadership. They appear to have rallied well and are even more passionate now to get things on track.

The survey team had the opportunity to visit 7 distinct IWK Health Centre locations. Furthermore, representatives from 12 Community Partners participated in an open discussion around the relationship of the organization with other partners in the system. Feedback across all fronts was positive with all engaged feeling valued and heard. Ongoing efforts to engage as an organization are noted with approval and the organization is urged to ramp up efforts to reach into various communities across the province and Maritimes.

Asking community partners to describe the organization, the word "complex" was shared on a number of occasions. Clearly, there is a perception of the organization within some sectors of the health care system and the organization must work closely with its partners to understand what is behind this perception and address as necessary.

Numerous examples of reaching out to the community in the mental health program existed, including one sector (community mental health) that has one employee dedicated fully to making links to the community so that they can reach adolescents where they live. This includes getting a memorandum of understanding with some agencies, either businesses or not-for-profit. They also involve their community partners in the planning and implementation of their services.

With 2 main Health Authorities operating in the province, this relationship is key. Strong ties do exist in some areas and maximizing the relationships to the benefit of all served is of fundamental importance.

There has been a significant change in the senior leadership in the past 18 months and many of the positions are still interim. Staff see the CEO as a visible presence and appreciate the walkabouts by senior leadership. The senior and middle leaders in the organization's three main programs are impressive and functioning well in the dyad format. The introduction of a Chief Operating Officer is noted with approval. The focus on elevated accountability is cascading throughout the organization in both clinical and non-clinical areas and is permitting the organization to re-calibrate and re-energize.

The new approach to quality management is enabling the organization to focus efforts around quality improvement, patient safety, engagement, lean processes, patient, family and youth engagement and community health in a more integrated manner. What is also impressive is the engagement of physician leaders in quality management efforts and activities.

Leaders and staff members feel supported and appreciated by the senior leadership. They are well staffed with clinicians and support staff. They also benefit from education leaders, practice leaders and an industrial engineer to facilitate the LEAN initiatives.

The Worklife Pulse survey highlighted concerns around incident reporting, specifically staff being penalized should errors occur. The organization is making significant efforts to address and remedy this perception. The introduction of Safety Coaches - currently 112 across the organization, will help significantly in moving the dial with this perception.

The previously discussed audits have impacted staff throughout the Health Centre.The organization, through transparency and strong communication is making every effort to support staff in moving forward. There is significant pride associated with working at the IWK Health Centre and the public discussion and scrutiny was taken very personally by many and the organizations ongoing efforts to support the team are noted with approval.

There is evidence throughout the organization of family and patient centered care. Programs such as Mental Health have readily adopted the “Partners in Care” practices and they apply this principle in all aspects of

their work. Lean practices are being applied with an increased emphasis on leadership visibility. These efforts are being accepted and endorsed. The organization is urged to continue to spread best practice foci across all aspects of the organization.

There is a great deal of satisfaction with the work that has been done to reduce the wait time to access services. Youth and family members acknowledge that they feel heard by the clinical staff and are involved in making decisions and setting goals about their care. All satisfaction surveys were reviewed by the team and showed very positive feedback from patients and families alike. Very strong systems are in place to secure feedback from patients and there is a clear commitment to ensure that all feedback is respected and informs decisions moving forward.

It was a pleasure for all members of the survey team to visit IWK Health Centre and meet with leadership, staff, volunteers, patients and family members. It was also a pleasure to discuss and review the many exciting ongoing initiatives. All should be proud of where the organization stands, of its resilience and of its commitment to doing right for all of those served. The journey to being a high reliability organization is one that requires commitment and dedication and the entire IWK Health Centre Team demonstrates it is up to the task as care continues to evolve and as accountability and transparency continue to drive the organization.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
7.8	The governing body has a succession plan for the CEO.	
13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!
Surveyor comments on the priority process(es)		

The Survey Team had the opportunity to meet directly with a number of members of the Board of Directors to review the standards as they apply to the governance of the IWK Health Centre. Clearly, with the events of the past couple of years and the increased public scrutiny placed on the Health Centre, it has been a very challenging time being a board member and they are commended for the commitment and dedication that they bring to their role on a daily basis on behalf of those who look to the IWK Health Centre for care and support.

Discussion ensued around the internal operations of the Board - Recruitment, Orientation, Evaluation, On-going Education, and the survey team was impressed with the integrity of the processes: a skills matrix identifying strengths required and a very robust on-boarding program as well as ongoing educational supports for members. As noted in the Governance Functioning Tool, a number of members felt that the evaluation process of individual members could be strengthened and this is an area that could warrant further discussion. Furthermore, accreditation standards speak to Board Chair evaluation something that, other than tangentially through the in-meeting evaluations, is not happening as contemplated. This too should be considered.

The Boards' focus on quality is stellar. This includes the Board Quality Committee and the oversight it provides to the organization's quality initiatives. Through "ASPIRE" and the most recent Strategic Plan, priorities have been clearly articulated vis-a-vie quality expectations and the organization is working through these proactively. The philosophy of combining all areas of quality, safety and risk mitigation for

both patients and staff under one broad philosophy and approach is noted. The role of the Board of Directors in credentialing was discussed and it was felt that a re-fresh on the credentialing process was in order. While the Board itself does not invest itself in the details of the process, they need to be aware of the approach taken so that questions, as appropriate, can be tabled at the meeting. Some organizations are now placing a board member directly on the Medical Advisory/Credentials Committee from a due diligence perspective. This does have advantages for the Board however does disqualify the individuals in question from actively participating in any privileging disagreements should they come before the Directors. Regardless of the approach, the Board is accountable for appointing professional staff to the organization and as such needs confidence in the processes.

Time was spent discussing the recent audits undertaken of internal control processes within the Health Centre. Two specific audits were undertaken, both initiated by the Board of Directors; a CEO Expense Review by Grant Thornton, and a Provincial Auditor General's Audit of Financial Management and Controls and Governance. The Board is commended for the leadership it has demonstrated in these areas and is holding the organization to account as it relates to addressing the various recommendations. Clearly, the organization is stronger as a result of the scrutiny, both from the perspective of internal controls as well as from the overall awareness, enterprise wide, of critically assessing all processes in the organization on an ongoing basis to ensure best-practice protocols and procedures are in place. The process has also been a strong reminder of governance oversight and the importance of having verified confidence in the systems in place throughout the organization. The Board's role is not to delve into the operations of the organization as they hold the President and CEO accountable for this. It most certainly is the role of the Board to question management on systems and processes to ensure that they are in place in the manner expected of a high reliability organization and to establish clear performance expectations including consequences as they relate to operational accountability.

Throughout the survey, surveyors were remarkably impressed with the passion and commitment brought to bear by all associated with the organization and of the high esteem in which the organization is held in the broader community. This culture stems from the Board and members are commended for setting this tone. Continuing to be visible, internally and externally and advocating on behalf of the IWK Health Centre as a leader in the provision of services to Children, Women and Families and those in need of Mental Health and Addictions Support will be key. Ensuring the right relationships and partnerships exist externally and that the tools and resources are available internally, will be key strategic priorities moving forward.

It has been a pleasure surveying this organization and all can be proud of the great care provided on a day to day basis, the directions currently being pursued and of the current journey towards a truly high reliability organization.

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		
4.10	Goals and objectives at the team, unit, or program level align with the strategic plan.	
4.12	Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	
6.1	Annual operational plans are developed to support the achievement of the strategic plan, goals, and objectives, and to guide day-to-day operations.	!
6.5	Formal strategies or processes are used to manage change.	

Surveyor comments on the priority process(es)

IWK Health Centre has a very strong understanding of its role, not only within the local health care system but also more broadly across the province, Maritimes and country.

The Strategic Action Plan is noted with approval. The current structure and approach to setting performance targets against the 8 goals, identifying key performance indicators and then working through planning, active project and monitoring phases will ensure clear accountability for results. Identifying KPI's for all goals needs to be a priority as one of the keys to advancing the organization will be doing it in a balanced manner with focus on all key areas noted in the plan. While it is appreciated that certain aspects of the organization and operation will take priority focus at certain times, an overall equitable focus will ultimately ensure goal attainment. Within this, ensuring a consistent approach and application of the Plan to the 3 key areas of focus for the organization: Children's Health, Women's and Newborn Health and Mental Health and Addiction,s will also be key.

The inclusion of patient partners in planning is a strength. Whether in defining direction, reinforcing focus or ensuring adaptability, all areas are better supported with the patient and/or family voice. There also appears to be a strong commitment to ensuring the voice of the healthcare team drives strategy and success and the organization is commended for its efforts in this area.The planned engagement that will ensure strong program and service alignment to overall corporate strategies.

One of the real challenges faced by organizations when undergoing change - in the case of the IWK Health

Centre not only the normal change we all experience as our system evolves but also significant change driven by operational factors, giving people the tools they need to flourish is important. It is noted that the organization does not have a formal change management program and while this may not ultimately be an issue, ensuring that the organization and individuals within the organization have the capacity to change, the support to change and a clear understanding as to why the change is necessary will be very important moving forward.

The organization's relationship with its community is strong. It is clear that the IWK Health Centre has much respect by those who use its services and by the organizations that align with it from a service delivery perspective. Continuing to focus on partnerships built on trust will be very important for a successful future, particularly as it relates to the relationships currently in place. The specific relationship with the Nova Scotia Health Authority is key, particularly in light of the fact that there are shared populations across the two Authorities. Continuing to engage and, as appropriate integrate and/or coordinate services and activities will be important.

One of the opportunities faced by IWK Health Centre, which is certainly not unique, is its capacity to generate real-time data and information to support and inform decision making and planning efforts. Significant time and energy is placed on these areas and the Performance Analytics and Strategic Change and Performance Improvement Teams deserve a specific "shout out" for the strong support and direction they provide. Continuing to provide these teams with the tools and resources that can support and drive change across the organization will be fundamentally important, particularly in light of the ongoing change initiatives underway.

Moving forward, continuing to advance the Strategic Action Plan through active front line and community partner engagement will be important. The goals noted are exciting for the organization and when attained will further position the organization as a healthcare leader locally, provincially and nationally. Connecting all of the various activities and initiatives will be important and moving more to a multi-year planning and operational focus will be important.

A continued focus on attaining a high-reliability culture will ultimately define long term success for the organization. People are remarkably proud to work at and be associated with the organization and this commitment is the organization's strongest asset. People want to do what is right, the organization wants to do what is right and the systems and plans now in place will continue to allow this to happen moving forward. All team members in this area are congratulated.

Priority Process: Resource Management

Monitoring, administering, and integrating activities related to the allocation and use of resources.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

IWK Health Centre is to be commended for the exceptional team it has in place to oversee the "resources" aspect of the organization. Within these broader areas, the discussion focused on operating and capital budget planning, data utilization and supports available to the organization, purchasing and acquisition as well as internal and external relationships.

As a Provincial Health Authority there is a strong relationship with the government in numerous areas, including fiscal. The in-year budget process was discussed and the organization is to be commended for the approach it takes in dedicating analysts to specific programs. Based on discussions, these individuals are indispensable for the Managers, Directors and Physician Co-Leads and provide significant insight and support in effectively managing budgets. Monthly reporting is in place and there has been a significant amount of recent effort put towards standardizing and integrating additional information into the process.

Education opportunities exist for new leaders around internal systems and controls and the quality of and speed with which information is now made available - fiscal, utilization, performance, has advanced the organization nicely in this area.

Capital budgeting is facilitated through "CARS," a web-based data base for equipment and infrastructure. A robust priority setting exercise takes place across and within programs where items are ranked by the organization. Revenues for equipment needs are identified through budget process discussions with the Department of Health and Wellness as well as from a Foundation that is remarkably supportive of the organization. Larger facility projects are through government support, with IWK Health Centre having similar infrastructure needs to many aging facilities across the country.

One of the significant challenges with older facilities is aging infrastructure. Add to this a fiscal environment that necessitates choices being made on an ongoing basis around priority areas for investment and it is easy to see why strains exist. It is fundamentally important that investments in "unseen" infrastructure be given the same ongoing priority as immediate patient care needs. Providing day to day high quality care, a hallmark of IWK Health Centre, is only possible with the tools necessary to complete the work: Facilities, equipment, Information Technology etc. so continuing to place priority on this is key.

Over the past 18 months, the organization has been administering a Controlled Environment Project stemming from external audits of the organization that flagged ways internal controls can be strengthened. The team is to be commended with how they have tackled this significant initiative and take comfort knowing that their efforts have been instrumental in the culture of accountability that exists

today. Despite the anxiety of the past couple of years, and the pressures faced by the organization internally and externally as a result, high quality care and service has continued as has the passion staff across the organization bring to their roles. Notably, the scrutiny of the past 18 months has been felt in all corners of the organization and has served as a good reminder that processes need to be continually addressed and refreshed. It has also been a good reminder that it is processes right across the organizationl that always need to be front of mind and challenged regularly to ensure that they can be the best possible. The culture now clearly understands this.

The organization seen today is a much stronger, accountable organization and all should be proud as a result.

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 tremendous amount of work in talent acquisition has produced a stable workforce (staff and physicians) with minimal shortages except in hard to recruit positions. Recruitment and retention strategies within and outside the organization are creative and reach out to all health care professionals e.g., career fairs, STARS program, KUDOS. The celebration of longer term employees through staff recognition is well received. The Pulse survey is a measure of the level of staff engagement. A binder of resources is readily available.

The worklife balance initiatives created by Occupational Health and Safety targeting staff/physician health and safety e.g., monitoring stress and fatigue, attendance, etc., are valuable. Influenza vaccinations continue to be championed by OHS (uptake rate 50-55%). Leaders are supported through professional development e.g., Crucial Conversations course to ensure they are provided the tools to support their staff. There is very good uptake in the Safety Coach Program and interest continues to grow.

Physician credentialing incorporates a 3 year rigourous cycle with a less comprehensive annual renewal. There is a plan to enhance the existing physician evaluation using a 360-degree platform which is aimed for the fall 2019. There is an opportunity to standardize the signing off procedure on charts for visiting specialists.

Volunteers continue to contribute significantly to the care of patients at IWK.

The training, reporting, and debriefing of Code White situations is comprehensive. Human Resource records and volunteer records are complete and stored securely in their respective departments to maintain privacy. Exit interviews are offered to all employees.

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)

IWK Health Centre has, over the past 3 years, made significant strides in advancing its programs supporting quality improvement, safety, risk mitigation and improvement. Fundamental to this change has been a philosophical change that integrates all various aspects under an "Integrated Quality Management" focus. The organization is commended for this as it streamlines the approach and reinforces that safety is safety, whether patient or staff and quality is quality regardless of where in the organization it is a consideration.

The organization appropriately administered the Patient Safety Culture Tool and has a plan to address feedback. The overall perceptions across the organization of the impact on staff of making errors is noted. The introduction of Safety Coaches across the enterprise is a very positive step, with the enthusiasm and focus of these individuals very impactful. By bringing safety to this level, staff will have a much better appreciation of the corporate commitment to safety, notably the blame free culture that aims to identify risk and address areas of concern in a non-punitive manner. These coaches will also remind all across the organization of team members' individual roles and accountabilities in ensuring a safe, quality focused health centre.

The organizations' Quality Improvement Plan was noted with approval. There are an appropriate number of goals identified and in discussions through the organization, programs and services were clear on their areas of focus and had plans in place to meet targets. The corporate support in developing and providing oversite to the Plan is strong and provides all across the organization with resources to support efforts. Key in advancing the Plan and all areas of quality improvement, is ensuring focus and capacity. With the Strategic Plan metrics in place, 9 active Lean Projects, program specific initiatives, safety and risk mitigation projects, having alignment and appropriate support to advance in all areas is key. Many organizations tackle too much at once, resulting in change fatigue and worse, a culture that does not "maintain the gains" of quality initiatives. Maintaining the right balance therefore, to allow the organization to advance in a manner that is sustainable is key.

The area of patient engagement is handled very well by the IWK Health Centre Team. All families are aware of the processes to follow when providing feedback, with tools like the little "Anyone, anytime, anywhere" business cards noted. More importantly than the feedback channels however is the organization's philosophy in addressing feedback proactively and ensuring that appropriate feedback translates to improvement. Disclosure policies and practices have been updated and the management system for collecting and addressing incidents is strong. Groups like the Safety Event Advisory Council ensure ready action on identified risks and readily reinforce with the organization the corporate

commitment in this area.

The organizations' commitment to best practice and standardization was discussed. As an active member of the "Solutions for Patient Safety" Group of Children's Hospitals across North America, IWK Health Centre is committed to sharing data with other centres and learning from the experiences, successes and challenges of others. National groups are also accessed, including Children's Healthcare Canada and the organization's commitment to "TREK," Tracking Emergency Knowledge for Kids", is noted. Continuing to focus on benchmarking, clinically and operationally,y will be important for the organization.

One predominant theme throughout the survey visit was the notion of IWK Health Centre as a high reliability organization. This philosophy is noted with approval as it is a clear and concise way of representing the importance of all areas of quality, risk and safety on a successful patient/family journey. Communicating this consistently across the organization will be key as every action, every day contributes to this. The involvement of patients and families including though the Family Advisory Council is strong. The program is evolving and is well embedded in the organization that brings significant value.

Physician engagement in quality and safety is also strong at the Health Centre. Through advancing visibility, reporting requirements, transparency and accountability, the organization has been able to support the physician team in assuming a leadership role in quality improvement.

Moving to a sustainable culture of quality improvement is a challenge for all organizations and IWK Health Centre is congratulated for its efforts in re-branding the focus internally. Continuing to ensure a manageable program, sharing learnings across the organization, reinforcing the front-line patient safety focus and continuing to reinforce standardization while not losing the "personal touch" that is foundational to the organization, will go a long way in ensuring the vision of a High Reliability organization is not only achieved, but maintained.

There is a strong, committed team in place, passionate about doing what is best. Congratulations on the journey and continued success.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

IWK has for many years supported principle based decision making and has recently updated the document that outlines the strategy and framework for ethics programs and activities. IWK values permeate the document and by the account of those leading, overseeing and supporting organizational, clinical and research ethics these values are reflected in processes and behaviours.

There is a mindset and reality of “every day ethics” as staff readily describe their awareness and use of ethics infrastructures (committees and people), processes (consultation, emerging practice of ethics rounds i.e. PICU) and resources (hotline, education programming and tools).

There is obvious commitment to partnering with external parties. The IWK is part of the Nova Scotia Health Ethics Network (NSHEN) which also includes the NSHA, Dalhousie University, and the Nova Scotia Department of Health and Wellness. The NSHEN builds capacity and creates efficiencies within the province’s health care sector by providing support and sharing resources. The IWK has a Memorandum of Understanding with Dalhousie University with includes purchase of service for consultation and education. The Ethicists are clearly welcomed and embedded in the organization and are part of the clinical care teams as a key resource.

The IWK Research Ethics Board (REB) is distinct and separate from the IWK Clinical and Organizational Ethics Committee and includes representation from the health centre and community. In addition to the standing membership, there is support for engagement of others to bring in content expertise as needed (i.e. First Nations perspective if appropriate). In addition to the conventional structure and processes expected of a REB, the IWK support a full service research office that oversees and manages contracts, grant applications, finance and the processes from pre-grant application to completion.

There is attention given to emerging themes in Clinical Ethics (parental autonomy, truth telling about conditions, uncertainty about goals in care, moral distress, complexity of patients) and Organizational Ethics (conflict of interest, resource allocation, in kind donations), and these influence education programming, policy content. In part because of limitation with resources and administrative support, there is not presently a reliable capture of the number, nature, categorization, location, trends with ethics consultations. The team is currently exploring ways of formally assessing the value and efficacy of ethics consultations and services.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.3 Policies and procedures to support the collection, entry, use, reporting, and retention of information are implemented and reviewed and updated regularly.	!

Surveyor comments on the priority process(es)

The Communication Priority Process involved focused discussion with members of the Communications Department, Information Technology (including representatives from Nova Scotia Health Authority), Decision Support, Strategy & Performance Management) and was supplemented by observations and input from staff, patients and/or families in the clinical and support service areas.

The work of the Communication team is now guided by a refreshed Communications Plan 2018-2020 which serves as a high level framework for the organization as well as being the goals and objectives for the department. It outlines responsibilities and accountabilities for Communications and Public Affairs and includes tactics that support the IWK Strategic priorities.

For each project undertaken by the team, a project communication plan is developed. For example, the IWK website is currently recognized as not being particularly user friendly. While it does attempt to support patients and community at large with very useful information about the organization (i.e. Annual report and performance information), the ways and means to navigate the system can be challenging, some information is outdated and some links may be misleading or misunderstood. The communication plan that supports this improvement initiative specifies in appropriate detail the goals and objectives, key milestones with dates, key messages, target audiences, responsibilities for messaging, vehicles to be used with messaging, qualitative and quantitative measures and targets.

Staff have access to information and updates using the IWK Intranet known as “Pulse”. As well, staff have access to web-based tools and resources that are intended to support them in providing care (practice protocols, pre-printed orders etc.) and fulfilling expectations of them by the organizations (policies and procedures). As example, OP3 (One Province, One Process, One Policy), a site shared by the IWK and the Nova Scotia Health Authority (NSHA) supports the vision that in a small province care and patient experience can be enhanced by sharing policies. Staff describe the value placed on all guiding documents and the organization appreciates the need to manage risk by ensure access to current policies and leading practices. For this reason it is essential that the organization continue with its current focus on updating all policies and procedures.

There is evidence of coordination and collaboration of those who support work with Cultural Continuous Improvement, performance analytics and Communications. There is exciting work being launched that will help to ensure that data is translated into information which will be shared and used by teams to advance, monitor and sustain improvements in support of the Strategic Plan. The teams are encouraged to promote as much transparency of information about goals and performance with staff, patients/families and community as possible to enlist interest and active engagement in all improvement efforts.

Through the office of the Privacy Officer, there are processes to identify, proactively address and/or respond to issues with privacy and Freedom of Information requests.

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 Priority process included discussion with representatives from Facility and Plant Services, Infection Prevention and Control, Fire Safety, Environmental Services, Supply Chain Management, and was supplemented by observations during tracers and tours.

It is evident that the physical environment of the IWK is overseen by a team of enthusiastic and skilled individuals who communicate and collaborate well. There is acknowledgement at the senior and board levels that the IWK is challenged with an aging infrastructure. As a result, there has been the start of a Master Program for the IWK, but validation and confirmation of broader plans and prioritization of work is yet to be completed. There have however been a number of areas renovated over recent years (e.g. Inpatient Critical Care Mental Health - Garron Centre, new MRI suite, one NICU); other renovations underway (another NICU and PICU) or soon to be launched; and another in the design phase (Emergency Department). Until such time, it will be critical to be responsive to safety concerns in any clinical area (i.e. secure rooms in Children's Intensive Service). Notably patient partners have been and will continue to be engaged directly with input about and/or co-design of the space.

The team is responsive to risks. A recent incident, believed to be associated with aging electrical infrastructure, resulted in steps being taken immediately (enabled by Emergency Preparedness planning) to support patient care and triggered a critical incident review with an investigation that will generate recommendations.

In order to ensure that legislative, code and building infrastructure requirements are up to date and met, a compliance report has been completed. This assesses and rates compliance to expectations and identifies any gaps or deficiencies. This report is used to inform priorities and resource allocation. Similarly Department of Labour assessments are used to complete or address violations. These assessments are reported to, reviewed and overseen by the Board Building Infrastructure Committee. The organization is encouraged to continue to use these tools, processes and reports to proactively mitigating risks.

While there is evidence of efforts to encourage recycling (recycling containers and a recycling centre), there is opportunity for greater focus and support for environmental sustainability and energy efficiency.

The organization has a Signage Committee that is working to address issues with way finding and fixed signage. Consideration might also be given to exploring options for posting signs/notices in designated locations and in displays that can be easily cleaned. This would reduce the amount of paper taped to doors, cupboards, walls etc. and in doing so ensure better environmental cleaning, infection prevention, and facility upkeep. Inviting patients/families/community members to tour the grounds and facility might

offer new and fresh perspectives about first impressions of the environment and opportunities for improvement.

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Infection Prevention and Control Standards		
13.7	Policies and procedures are regularly reviewed and improvements are made as needed following each outbreak.	
Standards Set: Leadership		
14.9	A business continuity plan is developed and implemented in order to continue critical operations during and following a disaster or emergency.	
14.10	The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!

Surveyor comments on the priority process(es)

The commitment to emergency preparedness is clearly expressed through the major stakeholders presentation of what has been done in the last four years. This includes monthly fire drills, code blue, and code yellow drills for staff. The Codes Green and Yellow are very comprehensive. There are opportunities to review and refresh Code White and Orange which date back to 2005 and 2008 respectively. A refreshed Emergency Preparedness policy was recently launched.

Coordination with external partners at the local, regional, and provincial level has been done.

Various communication strategies have been implemented to ensure that all stakeholders are kept informed during an all hazards event. This includes the use of media, e-mail, and social media to reach patients & families, staff, and the public. A 2-pronged approach to debriefing which includes an immediate and formal component are well received and is used to make improvements to the process.

Currently, there is no single organizational business continuity plan but instead, departmental business continuity plans are embedded into departmental policies. A single organizational plan is in development and will soon be available.

Priority Process: People-Centred Care

Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Mental Health Services		
3.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	

Surveyor comments on the priority process(es)

IWK Health Centre should be immensely proud of the work they have done to passionately pursue a healthy future for women, children, youth and families. Evidence of the practice of authentic patient and family centred care is clearly demonstrated throughout the health centre.

At an organizational level, IWK's Patient and Family Faculty, Family Leadership Council, and Youth Advisory Council all serve to enable patients and families to partner with staff in an effort to improve service design and delivery, along with the quality and safety of care. The focused effort on expanding the patient partner program has led to the recruitment of over 100 patient partners. Recruiting for diversity will help ensure that the program is representative of IWK's diverse patient population. Patient partners now sit on selection committees and are engaged in numerous quality improvement initiatives throughout the organization, especially in Lean work. There is a notable focus on co-creation of solutions with patients and families. A good example of this is the large team of staff, family leaders and external stakeholders that were engaged to find innovative and creative ways to reimagine and redesign the neonatal intensive care unit. Co-creation of solutions with patient and families have also led to improvements in access and flow in community mental health, dentistry, orthopaedic and women's perioperative services.

There are limited areas within the organization where the family voice could be more permanently embedded by pairing family partners with specific units or teams for significant terms Vs episodic consultation. The organization is encouraged to consider including family partners on both their Board of Directors and on their Medical Advisory Committee.

At a direct care level, the organization supports patients and families to be partners in their care and actively encourages and enables their participation. In the rehabilitation clinic, service delivery is planned

around family goal plans that directly reflect the priorities of patients and their families. Rehabilitative services are provided in a multidisciplinary fashion and patients are provided services not only in the IWK clinic, but also in their school and home settings. In the midwifery clinic, patients note a phenomenal client centred approach that is rooted in patient choice and evidence based practise recommendations. In the neonatal intensive care unit, parent involvement in rounding has led to parents feeling more engaged and confident in their ability to be part a meaningful part of the circle of care. In perioperative services, the inclusion of a patient nurse role ensures that a patient feels supported throughout their surgical journey.

IWK's commitment to quality and safety is demonstrated by its focus on becoming a high reliability organization and partnering with 'Solutions for Patient Safety.' The training of over 100 safety coaches is a notable achievement and the desire to cultivate a 'just culture' is evidenced by the solicitation of feedback from patients and families via varied methods. The organization is encouraged to consider training volunteers and family leaders as safety coaches.

A significant number of supports that include bilingual services and interpreters, mental health advocates, social workers and spiritual health support persons are available. A patient and family ethics toolkit can be found on IWK's website and an ethics hotline provides confidential consultation.

Patients and families feel an incredibly strong connection to IWK. The organization is encouraged to sustain its efforts to "make the best decisions with patient and families, our people, and organization through honesty and integrity."

Priority Process: Patient Flow

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
13.5 The effectiveness and impact of the client flow strategy is evaluated.	

Surveyor comments on the priority process(es)

The organizational strategy for pediatric patient flow is well established and is highly collaborative. Flow issues are rapidly escalated and a plan to eliminate or reduce barriers is in place, facilitated through the daily safety call led by the executive on-call.

Goals, purpose, patient care processes, communication, escalation processes and accountabilities are clearly defined. The organization has a remarkable record of preventing diversions and surgical cancellations through collaborative team work and the efficient code census approach. Discharge planning is a focus on the inpatient units. The team is working with the Family Leadership Council to explore optimal ways to approach families about discharge planning early in their admission. A discharge planner on the pediatric medical unit optimizes community supports to ensure timely discharges, and a liaison supports out-of-Province repatriations. Operating room booking is optimized through regular wait list reviews by the peri-operative committee. Efficiency improvements have reduced OR turnaround times. Further resource requirements have been identified and are being escalated.

Mental health services urgent care clinic has been established to optimize timely care for patients requiring mental health services to avoid unwarranted admissions. The ambulatory clinic setting may be used to overcome the shortage of family physicians when this impedes discharge.

There are protocols in place to utilize alternative clinical care areas when overcrowding occurs. This may include off-service patients or reassignment of staff. There is opportunity to improve clarity in these processes by ensuring written procedures are available to staff. Data is available through the unit assessment tool and is shared with managers and leadership. The lack of real-time tracking limits an anticipatory approach and more visibility of data to staff may enhance overall organizational engagement in improving patient flow. Several projects are underway and are showing success. The ability to link these improvements to patient flow data would be beneficial in maintaining the current momentum and help identify opportunities for spread, and monitoring of sustainability.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The planning, acquisition and replacement process is well defined, transparent, accountable and is supported by the organization. Preventative maintenance activities and schedules are appropriately designed, based on manufacturers recommendations and on the condition and age of equipment. All activities are documented and the documentation is easily accessible to users of the equipment. Clinical Engineering collaborates closely with risk management and infection prevention and control.

The Medical Device Reprocessing department has strong, experienced leadership that is well educated in all areas of responsibility. The department is well managed and organized. Staff are committed to quality and patient safety and understand the very important role that they play.

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 and/or tissue transplant service from initial assessment to follow-up.

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

- Partnering with clients and families to provide client-centred services throughout the health care encounter.

Decision Support

- Maintaining efficient, secure information systems to support effective service delivery.

Impact on Outcomes

- Using evidence and quality improvement measures to evaluate and improve safety and quality of services.

Medication Management

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

Organ and Tissue Donation

- Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.

Infection Prevention and Control

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

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

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
15.10 Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The Ambulatory Care Program at IWK is extremely busy providing high quality care for more than 200,000 visits. The paediatric ambulatory clinics visited were Orthopaedics, Rehabilitation Centre and Medical Day Assessment and Treatment Unit (MDATU). These clinics provide outpatient support to patients and families with a variety of underlying clinical conditions from within the province and region. The clinics are welcoming to patients and families. The Women's Gynaecology and Uro-gynaecology clinic and Breast

Health clinic were also visited. Both the women's and pediatric ambulatory services are well designed and focused on meeting the needs of the clinics' patient population.

There was evidence that services are designed based on community needs. Patients and families provided formal and informal feedback into the physical design of newer spaces. The Rehabilitation Clinic was recently renovated (2 years ago) using significant input from patients and families. The space is brightly coloured and child-friendly. A kiosk is positioned in the common space that asks the question: Did we meet your goal today?" An electronic drawing board is mounted on the wall low to the ground for children's' entertainment. Rooms are named according to colours rather than numbers. The renovated Breast Health clinic space is fresh and welcoming.

Clinic staffing is regularly reviewed and the composition of teams (i.e. RN, LPN, PT, etc) are based on patient and family care needs. The Breast Health Coordinating Nurse in the Breast Clinic has provided significant health system navigation support to this patient population.

The clinics have access to appropriate equipment. The Ortho clinic has new exam tables that have side rails to help reduce the incidence of falls for high risk patients. Universal falls precautions are well known by staff and implemented unless a patient is deemed to be high risk and the hospital high risk falls program would be implemented.

Those clinics where IV infusion pumps are used ensure that staff competence is assessed and education is documented.

Priority Process: Competency

Teamwork and team functioning was identified as the major strength for the ambulatory clinics. It was noted that while some clinics were smaller than others (Breast Health Clinic), the staff rely on one another to meet the needs of their patients. Staff are empowered to function to their fullest scope of practice depending on their discipline and role. There was a sense of profound pride in providing patients with care that is based on best practices. In the Rehab clinic, a staff member was successful in obtaining a research grant to implement a new hip surveillance strategy and the project is now in the hands of the IWK Research Ethics Board for their approval.

Staff have access to education through on-line modules and annual skills days. An education fund is available to support continuing education opportunities. Ethical resources are available on the Pulse intranet and staff reported that the Ethics committee meets regularly and will discuss ethical cases and information is shared appropriately. Orientation to the clinics is provided by clinical leaders and preceptors. Annual mandatory education topics include safety reviews, emergency codes, and workplace violence prevention.

Performance appraisals are completed regularly using a 360 degree model. A learning plan that includes goals and strategies is reviewed from the previous discussions and updated to meet current development needs.

Patients and family members were knowledgeable about how to lodge a complaint or concern although almost all stated they couldn't fathom having a need to do so given their high quality experiences with these teams. There was strong evidence of team collaboration with patients and families. The teams are directed by patient and family goals rather than being driven by disease and symptom outcomes.

Priority Process: Episode of Care

Staff in all clinics demonstrate an exceptional pride and passion for the work that they do. Patients and families are their priority. Staff identified teamwork, collaboration and commitment as strengths of their various clinics. The teams are commended for striving to make a difference in the lives of their patients and families.

There is an impressive emphasis on patient and family education in the clinics. Patients are frequently asked if they have questions or concerns and time is allocated to ensure information is provided in a calm and reassuring atmosphere. In the Orthopedics clinic, the surgeon used a laptop to share the radiology image with the patient and her parent, took time to carefully review measurements and details and offered time for their questions. Family members, some paediatric patients and gyne/uro clinic patients reported an extremely high level of satisfaction with their involvement in care planning and decision-making. Comments included: "Options are provided to us and we are encouraged to make informed decisions, the staff and physicians make time for us and we never feel rushed, I couldn't imagine receiving care anywhere else".

The clinics have been responsive to feedback from patients and families. The Orthopedics clinic has begun offering evening appointments in response to concerns that daytime hours are insufficient. Wait times and patient flow is a major strategic initiative for these clinics through Lean work. Engineers have been involved in addressing patient flow and the clinic schedules.

The Medical Day Clinic has implemented interruption free zones to reduce patient safety incidents due to interruptions. The Breast Clinic was renovated and provides a welcoming and healing environment for patients and families. Wait times are measured to ensure patients received efficient care. The time from abnormal radiology to referral to surgeon is tracked and time from surgeon visit to surgery is also tracked.

A handover tool (IDRAW) has been developed to share information for specific patients when unexpected outcomes are identified. Staff consistently identify patients using two sources of patient identifiers such as name and date of birth. Most clinics do not use medications as part of their clinical care but for those that do, medication reconciliation is completed if medications are required to be administered.

Priority Process: Decision Support

There is an excellent focus on patient and family privacy and confidentiality in all ambulatory clinics. Documentation is paper-based and health record flow appears to work for the clinics.

Priority Process: Impact on Outcomes

Safety boards have been implemented by safety coaches in several of the clinics. These boards have helped to highlight safety concerns and effective strategies to reduce incidents. Effective blood specimen collection is an example of a safety issue highlighted on a safety board. Staff were very familiar with how to complete incident reports.

The various ambulatory clinic staff have been engaged in quality improvement activities associated with patient flow beginning with scheduling. They are tracking wait times depending on the clinic. Quality indicators are shared during team meetings however it would benefit all staff, patients and families to post these indicators to increase transparency. Quality improvement activities (such as scheduling and patient flow initiatives) need to be shared with patients and families as they are currently not posted in clinic areas and there was no evidence that this information is shared in other ways. The teams are encouraged to identify outcome oriented indicators that relate to the activities of the various clinics.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Diagnostic Services: Laboratory		
11.3	The team updates its SOPs every two years or more often if required.	
11.6	The team regularly evaluates compliance with its SOPs and makes changes as needed.	
29.1	The team has a comprehensive quality management system.	!

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Precautions are in place.

Priority Process: Diagnostic Services: Laboratory

The biomedical laboratory is working within a new and evolving organizational, provincial and maritime landscape. Laboratory leadership is working collaboratively in many areas both internal and external to the IWK organization on a number of standardization, best practice, quality and other initiatives. The staff are committed to achieving successful change and building effective relationships at every opportunity.

In the biochemistry and hematology laboratories, patient test results are approved manually by a technologist prior to release into Meditech. There are a number of measurable improvements that can be realized from the implementation of auto-validation of analyzer generated patient tests results based on user defined criteria within Meditech. There is a potential to decrease turn around times, increase the quality of test results, standardize result reporting, and create process efficiencies. Auto-validation should be considered as a future enhancement.

Development of the laboratory's quality management system (QMS) is well underway and laboratory leadership is to be congratulated. The Clinical and Laboratory Standard (CLSI) quality system essentials framework has been adopted. Significant work has been completed and the laboratory is urged to continue with the momentum that has occurred to date and to achieve their goal of a comprehensive QMS. Key elements of the QMS have been identified and are being developed through policy and procedure development however gaps currently exist.

The laboratory should assess the roles, responsibilities and accountabilities required for QMS oversight

and leadership and to ensure an appropriate job description is in place. The QMS implementation to date had been ably led and managed by the Laboratory Standards Coordinator (LSC). There may be an opportunity at this point to assess whether the LSC role, responsibility and accountability as currently defined is the best fit to meet the QMS need for oversight and leadership or if the scope of these should be expanded.

Laboratory managers have identified opportunities for improvement that could be explored within the SIM system. As users of the data for quality improvement purposes, the timeliness, sharing and presentation of data could be assessed to determine what best meets the laboratory's needs.

Standards Set: Cancer Care - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Strong leadership is provided through partnerships with internal and external organizations and clinical associations. All health care team members have access to clinical resources and opportunities for professional development. The safe use and labelling of infusion pumps is achieved by limiting the variety of pumps, providing adequate training and re-certification as needed. Collaboration with the pharmacy in both distributive and clinical expertise is paramount to patient safety. Involving patients in the decision making for services has been rewarding e.g., space design and patient information.

Priority Process: Competency

All team members are provided with the education and training e.g. emergency response, IV pump use, information tools, professional development, handling of hazardous medications required to perform their jobs in a safe and effective manner to ensure optimal treatment. Ethical-decision making tools are available for use in complex cases.

The development and function of the interdisciplinary cancer care team includes patients and families to

contribute to the design of services. Occupational Health and Safety provides support and guidance to ensuring staff health and safety including methods to manage risk and to address workplace violence.

Priority Process: Episode of Care

The care provided by the healthcare team is exceptional. The use of evidenced-base medicine from the Children's Oncology Group and use of other reputable resources provides the team with guidance to provide the best care for patient's and families. The team includes nurses, physicians and allied health professionals. The team is resourced with skilled professionals to provide open and transparent information in a friendly and effective manner. This is accomplished either verbally and/or through written information at an appropriate level of comprehension.

Patients are given the necessary tools to advocate for themselves and provided with the correct tools to deal with issues such as consent, ethics and rights. Medication reconciliation, falls risk prevention, two-client identifier, independent double checks, information transfer and pressure ulcer prevention are performed routinely.

Information from the patient is collected and stored securely. Patient rooms are designed with patient and family input. Patients are educated and followed-up by Family Care Coordinators who also advise patients to contact the appropriate health care team member when needed for any situations e.g., venous access device management, homecare and urgent issues.

Priority Process: Decision Support

Policies and procedures for the collection, documentation, access, use, disclosure and security of patient information are comprehended and followed.

Priority Process: Impact on Outcomes

Staff interaction with the patients and families were very professional. The procedure was done privately in a room where personal protective equipment was worn as guided by best practice. The patient was identified using two client identifiers i.e., wrist band, name , and date of birth, and falls risk was assessed and mitigated. A clean procedure was completed followed by a re-assessment without complication in preparation for a lumbar puncture.

Research protocols are used quite often in this population. Various resources are also used to determine the best outcomes e.g., Children's Oncology Group, Association of Pediatric/Hematology Oncology Nurses.

Priority Process: Medication Management

Cancer therapy medications are very hazardous and the care, dosing, use and disposal must adhere to evidence-based information. Standard forms are used throughout the chart to minimize errors and misinterpretation. All guidelines regarding medications are strictly adhered to during the prescribing,

preparation, adjustment, administration and disposal of medications. The independent double check process is used throughout the process to ensure the correct dose is administered. Chemo spill kits are readily available at all points of potential spill and staff are appropriately trained.

Standards Set: Community-Based Mental Health Services and Supports - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The notice that the organization are committed to “Partners in Care” is posted at the entrance of the clinic and it explains to the clients and families what the concept is and what they can expect from the staff members. Clients and families are asked to provide feedback about their visit to the clinic at each visit on a quarterly basis.

A staff member is dedicated to developing partnerships within the community that would benefit youth and children with mental health issues. They are successful in being able to reach youth where they are more comfortable and at the same time provide a richness of intervention by not limiting the visit to just a therapist. They also frequently provide education to the community to build capacity outside of the organization for meeting the needs of the population.

The Children’s Intensive Services is a combination of inpatient (approximately 16-week Monday to Friday overnight program) and outpatient (day hospital) services. It is targeted to support families with children who display barrier behaviours (physical and/or verbal aggression, non-compliance). The service serves only Nova Scotia because of the need for parents to be available and for weekend home passes to be supported as part of the programming. The service adopts a collaborative problem-solving approach and

is dependent upon significant commitment and investment on the part of the parents/families to increase skills with positive parenting. The team is broad in its interprofessional composition and also enlists support from the education system. The team also has access to other clinical teams as needed to support medical issues (diabetes, seizure disorder, etc.). As members of IWK they are actively involved in organizational committees along with strategic and quality improvement initiatives.

To ensure optimal use of limited resources, there are criteria for acceptance to the program through early contact and screening to determine whether other interventions are an option. There is great attention given to supporting patient/family at the points of transitions (on weekends and upon discharge) to enable success with programming and sustainability. Consideration could be given to doing follow-up calls to ascertain if there are issues and to gain an understanding of the short, intermediate and long-term impact of programming on the children and families.

Family feedback was exceptionally positive about the programming. The only suggestion for improvement pertained to the need to upgrade the space or building. The unit does in fact have a very “tired” uncared for appearance but of concern is mainly regarding the two secure rooms which would likely not meet standard for a mental health inpatient setting (inward facing door; breakable glass window (Dec 2018 incident); wooden walls, etc.). Given the duration of patients’ stays in this clinical setting, review for short term and long-term space renovation/planning is encouraged.

As a satellite unit with a population that is known to have aggressive behaviours, the team has tremendous educational support for identifying, mitigating and responding to aggression/violence. There is an internal unit specific Code White response. In event of escalation beyond capacity of the team, the process is to call 911.

Priority Process: Competency

There are different avenues for accessing resources for continuing education and training outside and inside the organization. They also build on the expertise of the team by sharing information and presenting on their expertise. The performance growth sessions are done through the quarterly sessions that the clinical leaders have with all the clinicians and then more formally with goals for development.

When new clinical staff members are hired, the leaders set clear expectations about timelines and productivity.

Priority Process: Episode of Care

The team has had great success in streamlining the intake process and in reducing the timeline for first contact with the clients and families. There is a central intake and referral process where the client is booked for the first visit at the “choice” appointment with a target of less than 25 days for the appointment and then less than 20 days for time between the “choice” visit to the “care partnership” appointment.

The multidisciplinary team includes Psychiatrists, Psychologists, Social Workers, Occupational Therapists, Youth Workers and Clinical Nurse Specialists. They also offer treatment groups and family therapy clinics. They have a process called “Next Step in Care” where family/youth in partnership with the clinician states up front the expectations about the sessions and both are responsible for building on each intervention session.

Priority Process: Decision Support

The patient record is a hybrid of paper and electronic format. Papers are scanned into the electronic record at completion of the visits. Families and clients have access to their record.

Priority Process: Impact on Outcomes

The Community Mental Teams started their work with Choice and Partnership Approach (CAPA) 7 years ago; the focus being partners with the clients and families. They were able to initiate numerous changes, mainly addressing the long wait times for access to the initial appointment. Wait times were reduced from 18 months to 3 to 4 months. Two years ago, LEAN methodology was initiated, focusing on access, quality, morale and productivity. The wait time for initial visit is now less than 28 days. Staff proceeded with value-stream events and looked at measures of improvements throughout the community mental health teams. There are improvement conversations with all the staff members. Clinical huddles are held every Wednesday and administrative huddles weekly.

The 3 sites of community mental health use the same model of practice, the same model of intake and appointments and have embraced the LEAN methodology. Leaders are involved in national and international knowledge exchange opportunities. The Value-Stream Steering Committee reports all findings and results to the Executive Committee. The Quality Leadership Team have been asked to take the lead with other children and adolescent centres in the province.

The value-stream sessions and kaizen sessions have families and youth present for all or most of the sessions to provide input form their perspective. There is also a focus on groups with families and youth. The team must rely on an information system that is not robust and at times will get frustrated because the data retrieval has to be mostly manual.

The program has a full-time dedicated Industrial Engineer and a Behaviour Change Specialist to help with all the quality improvement initiatives.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
12.3 There is a policy on donation after cardiovascular death (DCD).	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The Neonatal Intensive Care Unit (NICU) is currently divided into NICU North with 19 individual rooms and 2 twin rooms totally 23 beds. The current NICU 2 has approximately 19 beds and will soon be moving into their newly renovated space that will be known as NICU South. There is surge capacity in the rooms where they can accommodate an additional patient with medical gas, air and monitor access is located inconspicuously behind a picture. The new space has been designed with patient and family needs in mind. Privacy and confidentiality is built into the design. Privacy glass is on the outside walls of the rooms that can be switched to “open” when needed to visualize patients/families. Milk fridges are located inside patient rooms in NICU North. There are no patient identifiers on the white board at the entrance to NICU North to maintain confidentiality and privacy.

The interdisciplinary team is comprised of the following professions and roles: nurses, nurse practitioners, CNS, neonatologists, residents, fellows, RT, SW, RD, discharge planners, milk technicians, pharmacists, volunteers, ward clerk, parent partner and OT/PT when required. The team is supported by education and frontline leadership roles. Safety coaches are active in the unit and share information and

education about safety strategies such as stop, think, act. The Neonatal Care Committee meets monthly and provides leadership and oversight to ensure the delivery of high quality care and best practices. Morning huddles occur daily that provide an overview of patient and family needs and activities reviewing issues from the previous day/night. Rounds then
occur where individual patient and family progress is discussed. Families can be engaged in these rounds as much as they desire (such as leading the discussion). Parents complete an NICU Parent Rounds Sheet which is similar to a handover report from the infant's nurse..

The Paediatric Intensive Care Unit (PICU) is an 8 bed unit with space for 10 beds. The current space is open and has privacy/confidentiality challenges however the staff work hard to protect the confidentiality/privacy for patients and families. The PICU team will be moving temporarily to a portion of NICU North during re-construction of the current PICU and NICU 2. PICU will then move into its new space.

The interdisciplinary team is comprised of the following professions and roles: nurses, physicians, surgeons, residents, fellows, RT, RD, childlike specialist, SW, ward clerk, pharmacists, and family partner. The team is supported by education and frontline leadership roles. Safety coaches are active in this unit also. Staff in this unit also support the Specialized Paediatric Outreach Team (SPOT) and follow patients up to 48 hours post discharge from PICU and this can be extended if required. There is also an activation arm of this service where inpatient staff can contact SPOT if escalation of care is necessary. Handover rounds are conducted early each morning to review activities over previous shift and to discuss any concerns for the following 24 hours. Following this beside rounds occur in the PICU.

The NICU and PICU teams are dedicated to providing outstanding evidence-based care and their pride and commitment is palpable. Interventions and protocols are regularly implemented based on the latest evidence in the literature. Often times, the teams themselves participate in these studies and experience first hand how changes to practice are making a difference on outcomes.

Child-specific assessments are completed by both teams as appropriate.

Priority Process: Competency

Several courses such as NRP and CPR are mandatory education requirements for staff in addition to training beyond entry level skills. Staff receive cross training in orientation for maternal newborn, women's health and NICU to support floating to other clinical areas. Education is also provided to support leadership training such as charge nurse/team leader skills and preceptor training. PICU offers quarterly education sessions and their Education Committee meets quarterly to plan and organize these sessions.

There are two levels of nurses in the PICU where new nurses (Level 1) must develop a certain level of expertise attending orientation for the requirements to function at this level. Level 2 nurses receive another more advanced orientation and those nurses can become preceptors.

Infusion pump certification is reviewed and completed every two years.

Priority Process: Episode of Care

Patient and family care provided by the NICU and PICU is commendable. Parents commented on the effectiveness of staff teamwork and that it is obvious that team members respect one another and value each other's contributions, which gives them a sense of trust and security. Great job by both teams!

All appropriate (not VTE) ROPs were met in both the NICU and PICU. Ethical decision making is an integral part of discussions during care planning and resources are available to support staff through difficult team and family discussions. Everyday ethics is deeply embedded into both of these units.

Staff are very attentive to infection prevention and control practices. Hand hygiene was witnessed to be stellar.

Care planning is performed in partnership with families. Parents described how their input and preferences (where possible) are considered when making decisions about care options, timing of procedures, and other relevant activities. The NICU has a parent partner group that helps support the needs of families and that can provide feedback into unit activities..

Research is a priority in both NICU and PICU. In NICU, the Chez NICU program is in the process of being implemented based on an NP study of providing access to rounds, via webcam, for parents who do not stay in the unit.

The NICU North has a no interruptions room to reduce distractions as per high reliability organization principles. The NICU is also cognizant of noise levels as has Hortons ears mounted in various locations of the unit (NICU 2) to monitor decibel levels. The monitor changes colour from green to red when the noise level is too high. The NICU North was found to be quiet and peaceful.

Priority Process: Decision Support

Patient and family privacy is a priority for both NICU and PICU. Not only is the physical environment, particularly in the new NICU, been developed to respect confidentiality for patients and families, but health record access is also limited to only those who are within the circle of care. The new PICU is also being designed to support privacy and confidentiality.

The paper-based health record provides a significant amount of information in both of these critical care areas. The team is encouraged to advocate for an electronic health record to enhance communication, quality of care, auditing and research.

Priority Process: Impact on Outcomes

The teams reviews indicators at their committee meetings and staff meetings. Staff can also access unit specific topics posted on Pulse (intranet) that could include information about quality improvement initiatives, new research studies and unit specific activities. Both NICU and PICU are encouraged to

consider how to share meaningful indicators with families (considering content and medium).

The teams are encouraged to review order sets in order to prepare for the eventual implementation of electronic documentation.

Both teams receive meaningful feedback about family satisfaction which is exceedingly high. Families reported that they feel blessed to have their children cared for in these units by such compassionate, expert, kind and supportive staff. The staff are commended for their commitment to patient and family-centred care that is genuine and making a difference in the lives of these families.

Priority Process: Organ and Tissue Donation

Nova Scotia Organ and Tissue Donation program entitled Legacy works with PICU to manage patients who are potential organ donors. IWK has all required policies but they are working on the development of the donation after cardiovascular death policy. Legacy provides an information and an education binder and collaborates with the unit when patients are identified as potential donors. Staff contact the Legacy coordinator who would then approach families and continue to make arrangements if donation is appropriate and consented to by the family.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
4.12	Access to spiritual space and care is provided to meet clients' needs.	
6.7	The team annually reviews and updates the Policy and Procedure Manual.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The Diagnostic Imaging at IWK is well organized and very clean. Patient wait areas are comfortable and quiet. The department's quality initiative to improve directional and location signage has been a success. Overhead and wall signage is colourful, easy to read and well suited to a children's hospital.

Some KPIs are mandated provincially with goals assigned to each measure. The department could assess whether KPIs specific to their site are designed to measure and evaluate the quality of their own service.

A formal, documented, comprehensive training and competence assessment system would assist the department to standardize training and demonstrate staff competence. The department could use the upcoming installation of new MRI equipment to trial a pilot project for formal training and competence evaluation.

The department could also consider the design and implementation of a formal quality management system (QMS). The use of a framework utilizing the generally recognized key elements of quality could be of value in ensuring that the structure, responsibilities and activities of the department are all described through policies and procedures.

The Halifax Shopping Centre site performs screening mammography and is the coordinating centre for the province of Nova Scotia. The environment at this site is welcoming and comfortable.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.10	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
18.11	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency department at Izaak Walton Killam Health Centre provides pediatric emergency services to the local community as well as tertiary services. There are strong partnerships within the organization to ensure effective patient flow through the emergency department.

The emergency department has a clear role in the emergency response plan and actively participates in Code Orange simulations including a recent event which saw widespread involvement from the team.

Mechanisms for escalation of resource requirements are in place and are being utilized in relation to the

physical space and staffing requests. Mitigating strategies have been employed, such as modifications to the triage area and minor changes to the staffing model to enhance triage experience and timeliness. Challenges persist when the department is busy and there is opportunity to enhance the use of data in evaluating the impact of these mitigating strategies.

The department covers a small footprint. Implementation of lean methodology to optimize functioning has resulted in recent positive changes to ensure the best use of space such as redeploying room use. Innovative solutions include the use of the dentistry area for evening Low Acuity Track patients. The aging infrastructure is however evident and given a redevelopment of the department is still in the planning stages, attention should be paid to ensure infection control standards are met. There is a lack of storage resulting in equipment being stored in hallways.

Priority Process: Competency

Comprehensive training is provided through four clinical education days per year, including infusion pump training. On-line modules in the Learning Management System (LMS) provide core organizational education including confidentiality and privacy, Respectful Workplace, hand hygiene and the Safety Information Management System. Organizational orientation as well as unit-based orientation takes place for all new employees. Simulations are carried out on a regular basis, with a focus on the high impact, low frequency events. Learning identified from these events are used to identify and implement changes to enhance patient, family and staff safety.

The team works collaboratively with patients and families who feel included as partners in care. Standardized communication tools are used to share information at transitions of care. There are opportunities to ensure that formalized feedback from families and team members is collected and made available for recognition and further improvements.
The team is highly integrated and works well to ensure appropriate reassignment as census fluctuates. Real time metrics are not available in the ED and may be beneficial in supporting workload assessments and patient flow.

Safety concerns are reported and managed through the on-line safety reporting system (SIMS). All staff receive training in workplace safety and non-violent crisis intervention.

Priority Process: Episode of Care

The entrance to the ED is clearly visible. Parking can be challenging for families and the team have recognized these challenges and put mitigations in place through an improvement initiative. The team provide a welcoming atmosphere. Patients and families appreciate the clear communication and family-centred approach.

The triage area is clearly indicated for patients an families. Patients are rapidly identified as potential infectious risks, however there are limited opportunities in the physical space for isolating patients. Reassessment can be challenging when the department is busy with high acuity patients. Emergency

Health Services have rapid offload and patients are admitted directly from the ambulance bay.

The emergency department is piloting an electronic tool “translator on wheels” for non-English speaking patients. This provides a 24/7 service through visual connection to a translator and has largely replaced the telephone interpretive services.

Patients and families feel safe and included in their care. They felt that the standards of care were excellent and had no concerns. They did not appear to be aware of how they might raise a concern or obtain access to information on rights and responsibilities. There is opportunity to promote this information.

Priority Process: Decision Support

Evidence-based protocols are in place for key pediatric emergency conditions through care directives. These also support the early initiation of emergency care by registered nursing staff, ensuring care provision to full scope of practice. The team have not yet evaluated if this is having a positive impact on care although it is felt it mitigates the time from triage to physician consult.

The team participate in Translating Emergency Knowledge in Kids (TREKK). This ensures that the team are current in providing best practices, for example the current update to diabetic keto-acidosis (DKA) care. There is opportunity to enhance linkages with other areas of children’s health to ensure continuity of care between care areas. The development of standardized care pathways will be an asset as the organization transitions to electronic tools. Currently, the emergency department is paper-based for documentation, ordering and uses printed as well as electronic lab reporting.

Priority Process: Impact on Outcomes

There is a quality, operations and patient safety (QUOPS) committee for the emergency department which includes a patient partner on the membership. Quality indicators have been set and several improvement initiatives have been undertaken. There is a mechanism for review and analysis of the metrics to evaluate the impact of the interventions. This is still in an early phase and is not yet fully in place.

Improvement activities have been focused on the emergency department length of stay and the team has a clear goal. Multiple activities are underway to achieve the goal including the Low Acuity Track (LAT), re-purposing a room to provide an area for patients awaiting results, changes to the triage process, positive and negative deviance feedback at daily huddle and changing the time of the huddle. There are opportunities to increase the visibility of the impact of these initiatives through visual management/quality boards.
Safety risks are identified and managed through simulations and as identified through the Safety Incident Management system.

Priority Process: Organ and Tissue Donation

The standards for organ and tissue donation are met in all areas. There is a current focus on staff education in organ and tissue donation.

Standards Set: Hospice, Palliative, End-of-Life Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
12.4	Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.	
12.5	Information is documented in the client's record in partnership with the client and family.	
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

It is important to stress at the outset that the Paediatric Advance Care Team is a consultation service and, as such not an Episode of Care as is contemplated in the standards. For example, the majority of the patients seen by members of the team are already in other areas of the organization i.e. Cancer Unit, where the specific standards, particularly required organizational practices reside. That said, it was a pleasure to engage with this team of highly motivated, caring and compassionate individuals.

The recent name change is a far better reflection of the role of the team and a much more welcoming name to those accessing the services. With respect to access, the practice of engaging with all cancer patients at the outset of diagnosis, regardless of prognosis is noted with approval. Developing relations early on during a child's care journey allows for a much deeper appreciation of the supports necessary for the patient and family and enables a much higher quality of care and support throughout the entire journey. As one family member contacted noted, "the information I received through the program in an

hour was more applicable to my situation than all information received during the last year." This is not an indictment of other services within the community and Health Centre but rather a great reminder of how this team can bring a very specific skill set to the care journey.

In addition to providing unique, client specific value-added support in palliative care, including end-of-life care, the members of the Paediatric Advanced Care team also provide great support to the organization from an education perspective and from the point of view of grief counselling. These resources are very much valued and are supplemented by extensive literature that is available to staff, patients and families alike. Part of their ability to provide this support is through a network of very supportive volunteers who are versed in the areas noted. These individuals come through the Health Centre Volunteer Program and have provided individuals who have brought joy to many. A special "shout out" to a volunteer, who has sadly passed, for the wonderful garments she knitted for babies who had passed away.

The bereavement services provided through the program are quite simply second to none. Structured to support the unique needs of all individuals over a time period of upwards of a year or more after loss, the service has developed a deserved reputation as being foundational in peoples grieving journey's. It is flexible in nature and allows people to define who their "family" is. There is a data base maintained of grief resources available across the Maritimes to enable access to supports and services within local communities where most grieving takes place. Activities such as the Annual Mail Out and the Afternoon of Remembrance reinforce the culture of caring lived by the team and provide people in need with incredible tools and supports.

Active involvement of patient partners through the Death of Patient Committee and other venues ensures that the voice of the family is fundamental to service provision and planning. Outreach services are provided and the team makes every effort to ensure that there is a strong network of providers connected across the region that are available to support those in need. Educational support is provided to students with good visibility throughout a students education journey.

One specific, external program to highlight is the Special Patient Program supported through the. Nova Scotia EHS. This service ensures that EHS can provide client specific care, defined by their needs, either in the home or through transport to the hospital. It ensures patients wishes are respected, improves quality of life and reduces the stress on patients and families alike. Kudos to the team on this one.

Meeting and speaking with the Paediatric Advanced Care Team was a wonderful reminder of why we go into healthcare in the first place; to help people during their journey and to contribute to the quality of life of everyone touched.

Priority Process: Competency

See Leadership

Priority Process: Episode of Care

See Leadership

Priority Process: Decision Support

See Leadership

Priority Process: Impact on Outcomes

See Leadership

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Infection Prevention and Control

The infection prevention and control (IPAC) program is well established with oversight of activities through the Infection Prevention and Control Committee. The committee reports to the centre wide Patient Safety Committee and more recently has presented to the Board Quality Committee. The IPAC committee has undergone review and restructuring to improve delivery of their mandate and welcomes the opportunity to renew a reporting cycle to the Board. The committee has a strong physician membership and is chaired by the Medical Director of Infection, Prevention and Control. There is widespread stakeholder representation alongside the three infection control practitioners. Antimicrobial stewardship is represented and supports C. Difficile management.

Policies and procedures are in place and compliance is monitored. There is a designated IPAC communications representative to facilitate organization-wide distribution of information. IPAC have a visible presence on the IWK landing page and communicate personally with staff in clinical and non-clinical areas to ensure updates are shared. Communication strategies include volunteer services and contracted services.

There is a protocol and procedures in place for outbreak surveillance and management which are available through the IWK OP3 pages.

As well as province-wide directives of hospital acquired infection rates, current priorities in Children's health include surveillance of shunt infections, spinal manipulation and cardiac surgery infection rates and central line associated blood-stream infections (CLABSI). Significant improvements in CLABSI rates have been in several clinical areas. In Women's Health, targets have also been established for post-operative infection rates in caesarean section, vaginal and abdominal hysterectomies. Opportunities to join the National Surgical Quality Improvement Project (NSQIP) for both pediatric and women's surgery is being explored.

At the unit level, the team has a strong focus on hand hygiene with impressive hand hygiene rates and a robust program. Hand hygiene audits are prominently displayed, and children and families report high compliance by staff. There has been recent engagement with the Family Leadership Council to enhance patient and family involvement in hand hygiene and there is a plan in place to recruit a patient partner to

the Hand Hygiene Committee. An ongoing focus on hand hygiene is to be commended.

Staff training in personal protective equipment (PPE) and N95 fit testing is carried out by several members of the IPAC committee, including Occupational Health and Safety, who also provide significant input through staff immunization and workplace policies. Safety engineered devices in the Emergency Department trauma room were incomplete with missing safety flap and there was no evidence of a process to recognize and replace the incomplete device. This was rectified when notified.

Housekeeping is provided by contracted services and all staff are well trained in IPAC practices, cleaning routines and precautions protocols. Robust audit processes are in place and a collaborative approach is taken to ensure efficient room turnover times, especially during high census. Mechanisms to improve real-time patient tracking may be of benefit to further improve patient flow during peak census, either manually or through electronic capacity management tools. Food is prepared on site according to food safety standards and is available 24/7 for patients and family at request using “dial for dining”.

Infection Prevention and Control meet regularly with Plant Maintenance and Operations and have worked together on several recent projects. The infrastructure is aging and present challenges for the interdisciplinary team in maintaining cleanliness. Areas which provide opportunities to address include: carpeting in high traffic areas (Health Centre Entrance), worn countertops close to water sources (ED) and storage of small objects on the floor. Consideration should be given to a policy and procedure to address non-permanent signage, particularly in clinical care areas, where appropriate cleaning may be impacted.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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

Pediatric inpatient care at Izaak Walton Killam Health Centre is provided on the Pediatric Medical Unit (PMU). This is a 19-bed unit that provides tertiary pediatric services including long-term ventilated patients. Along with individual patient rooms with provision for parents, the unit includes child-friendly spaces for different age groups. The unit has active tracking of patient flow metrics and has seen a steady decline in average length of stay due to active improvement methods.

Strong partnerships exist across Children's Health services and the PMU is supported by a multidisciplinary team to provide family-centered care. There is opportunity to enhance linkages with other areas of children's health to ensure continuity of care between care areas. The multidisciplinary team ensures a full scope of practice and appropriate use of skills.

Quality indicators and target setting is focused on organizational priorities as well as local needs as identified through best evidence and safety events. Resource requirements are actively reviewed through the Pediatric Medical Team (PMT) and Quality, Operations and patient safety committee, both of whom have a patient partner on their membership.
Surge capacity is available to support patient flow through the code census protocol.

Priority Process: Competency

A robust orientation program is provided through on-line modules, classroom teaching, preceptorship and a post-orientation competency checklist. Organizational orientation as well as unit-based orientation takes place for all new employees. On-line modules in the Learning Management System (LMS) provide core organizational education including confidentiality and privacy, Respectful Workplace, hand hygiene and the Safety Information Management system.

Comprehensive ongoing training includes four clinical education days per year, including infusion pump training. New approaches to promote increased engagement are being explored. Opportunities for team members' professional development and training are also supported.

Safety concerns are reported and managed through the on-line safety reporting systems (SIMS). All staff receive training in workplace safety and violence prevention.
eSource is an on-line tool used for team communication to share updates and as a discussion board. A new communication tool (iDRAW) to support verbal and written communication has recently been implemented and an audit process is in place. The tool has been designed with input from staff to reduce repetition and enhance efficiency and effectiveness at change of shift communication.

Priority Process: Episode of Care

There is a strong focus on safety for staff and patients. Falls prevention, pressure ulcer prevention, medication reconciliation and information exchange at transitions of care are audited for improvement, although some are still in the early stages of data collection. Medication reconciliation is supported by a pharmacy technician and clinical pharmacist. The increased availability of the Drug Information System (DIS) will enhance the ability to obtain a Best Possible Medication History (BPMH) on admission.

The PMU team has access to services to support patient care including the dietician, respiratory therapy, the Pediatric Advanced Care team and mental health services. Centralized vital sign monitoring is available throughout the unit. The Children's Early Warning Sign (CHEWS) acuity score has recently been introduced to PMU.
Patients and families are provided with a significant volume of information on admission. The Family Leadership council has been engaged to assist in optimizing this information. There may be an opportunity to consider age-appropriate materials for youth. SIMS, the safety reporting tool, is used to monitor adverse events such as falls.

Priority Process: Decision Support

Evidence based protocols are in place to ensure standardized best practice. All documentation is currently paper-based. Charts are audited for key pieces of information. The data is posted in an area visible to staff and families.

Priority Process: Impact on Outcomes

Oversight for evidence-based practice and guidelines is provided by the Pediatric Medical Team and Quality, Operations and Patient Safety committee.

Safety risks are identified and managed through SIMS, the on-line patient safety reporting tool. Trend data has been used to generate ideas for improvement as well as the use of an ideas board. Processes for promoting reduced variation in care have been utilized and there are order sets in place for key care pathways.

There is a strong focus on staff engagement through education and improvement opportunities. Recent initiatives include the Children's Early Warning Sign (CHEWS) and the new IDRAW handover communication tool. The team are encouraged to minimize the number of projects and continue to focus on the team approach to improvement. Timely access to data should be a priority to support tests of change.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
12.1 Access to medication storage areas is limited to authorized team members.	!
Surveyor comments on the priority process(es)	
Priority Process: Medication Management	

The D&T Committee is an integrated robust committee consisting of doctors, pharmacists, nursing and leadership. It is dedicated to the objectives of supporting the medication management system. The safe and secure utilization of medications from procurement to administration exemplifies the high degree of staff engagement and commitment to excellence. The ongoing strategies of optimizing staff, implementing best practice and using innovation are strengths that will produce optimal safe patient care. There is a well understood and active process for formulary additions and deletions. Antimicrobial stewardship transcends the organization through a variety of activities including optimizing therapy, antibiograms, the use of a dashboard, the development and widespread uptake of the Spectrum phone application and recent presentation at a provincial conference. Pharmacists are involved with monitoring and analyzing SIMS for medication related issues.

Activities in improving quality and process through committing to more Safety Coaches and rotating staff through various job activities works to provide staff satisfaction. Increasing the assistant's roles and responsibilities will increase time for clinical pharmacist activities. The implementation and ongoing upgrades to the Omnicell Carousel, Pyxis, CIVA automation, CATO, Spectrum web application and Pulse website demonstrate the department’s desire to continue to be on the leading edge of pharmacy practice.

The Pharmacy is waiting for some renovation projects in the 6-Link satellite pharmacy and main dispensary front space that will increase space and security and optimize workflow. The creation of more private space for patient and family counselling is a very desirable outcome. The near graduation of the newest pharmacy resident and staff participation through the Safety Coach Program will all result in safer patient care. The future of a single clinical information system may eliminate the current challenges of working with several systems i.e. Omnicell, Pyxis, Meditech and may incorporate computerized physician order entry.

The staff are engaged, professional and well-respected by the health care team. The department actively participates in quality improvement activities and research, for example, decreasing morphine usage and use of higher dose ibuprofen for treatment of PDA in newborns. A significant amount of training for

orientation and professional development continues to be conducted and supported by the organization. After hours, an on-call pharmacist and assistant are always available. Clinical pharmacists are assigned throughout the organization to provide medication expertise.

Excellent and extensive work has been done on meeting all the ROP requirements for high-alert medications, narcotics, heparins, and concentrated electrolytes as demonstrated by audits.

Patient safety is considerably enhanced with Pharmacy participating in the medication reconciliation process at admission, transfer and discharge. The provision of medication procurement, preparation, dispensing, discharge counselling, medication dosing, research, centralized intravenous admixture, drug information, auditing analysis contributes to fulfilling the goals of optimizing safe patient care. Advocacy for the Do Not Use Abbreviations principle has produced positive results as seen in audits. Medications are neatly organized, well labelled and securely stored in the pharmacy and the patient care areas using the Pyxis system. Most of the patient's intravenous doses are prepared by Pharmacy. The issue of alert fatigue has been addressed.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
5.3 Team members are recognized for their contributions.	
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	
15.4 Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

Youth and families are consistently involved in planning for their care and addressing any issues; the team involves the families in planning for recovery and transitioning to home or community services. Every patient has a care plan that is specific to their needs and updated on a regular basis. The patient and the families participate in developing and updating the care plan.

The inpatient critical care mental health unit is staffed with registered nurses and licensed practical nurses; they also have a discharge planner and a patient/family care coordinator that acts as a navigator and resource on discharge from the unit.

The Adolescent Intensive Services has a co-leadership model that supports the front-line leaders of the 3 distinct areas of care, i.e. the 24/7 inpatient treatment unit, the 24/5 treatment unit and the day treatment unit.

Priority Process: Competency

At the Garron Centre the registered nurses are encouraged to pursue the Canadian Nurses Association certification and are financially compensated. There is also continuing education provided provincially

that the registered nurses and the licenced practical nurses are supported to attend. Internally, there are numerous topics that are covered including but not limited to, respect in the workplace, ethics, cultural and gender diversity.

At the Adolescent Intensive Services site and the Children Intensive Services site, the clinical staff members are encouraged to participate in continuous learning based on priorities set by the leadership. Funding is associated with these opportunities.

There is a policy and practice of using a method of least restraint and the staff members are educated on the definition and practices. All staff members on the unit are educated and trained on de-escalation of violent situations.

Performance management discussions with the leaders are completed on a regular basis and the focus of the discussion is on career development. There are standardized communication tools for end-of-shift reporting and for transition to another service or site.

Priority Process: Episode of Care

In developing and renovating the layout of the unit a few years ago, safe provision of care for the patients and staff members was the guiding principle that informed all decisions. Also very important for everyone was that the unit be conducive to recovery in a peaceful, non-threatening environment. Family members are encouraged to stay with the patient if appropriate. There are areas where the patients can gather in a safe place to discuss issues and do therapy. Schooling in available on the unit in a dedicated classroom.

It should be noted that on the Children's Intensive Services site, attention should be paid to the seclusion room. It is in need of improvement. The room should be assessed for what changes are required.

The clients and families have access to a multi-disciplinary team to address the varied needs from acute psychosis to eating disorders. At the intensive services sites, focus includes addiction, violent behaviour and anxiety disorders.

The team functions in a very collaborative and respectful manner towards each other and with clients and families.

Priority Process: Decision Support

There is little to no computerization in the mental health unit; the gaps have been identified and communicated to the senior team. The patient record is all paper-based, including laboratory reports.

There is a Quality and Patient Safety Committee attended by representatives from the different care areas. The staff members participate in the facilitated “Connect” sessions that are held weekly where they can bring issues of conflict and debrief about self care and compassion fatigue.

At the Intensive Services sites, a team for transition support is in place to do a follow-up post discharge for a period of 1 to 3 months to ensure that the youth or child is in a safe place and continuing to progress towards wellness.

Priority Process: Impact on Outcomes

The Garron Centre was renovated just a few years ago and all staff members, physicians, patients and families were encouraged to provide input into the physical layout and flow within the unit; the patients picked the colours for the unit. The layout is conducive to safe provision of care for the patients and staff.

The Adolescent Intensive Services site co-located the 24/7 and the 24/5 programs three to four years ago and the leaders are working on a quality improvement project to enhance collaboration and support between the two teams.

The protocols and procedures are selected and reviewed by the experts, according to research best-practices identified nationally and internationally. They seek input for patients and families on the effects of those practices for their case however the development of the protocols is left to those with expertise.

At the Adolescent Intensive Site, there are 3 full-time Health Promotion Specialists who mine numerous sources for data in order to better plan for education for teens and children.

Standards Set: Obstetrics Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Obstetric Service at Izaak Walton Killam Health Centre includes the Early Labour Assessment Unit, Family Newborn Care Unit, Birth Unit, Perinatal Centre, Fetal Assessment and Treatment Centre and Prenatal Special Care Unit. It provides primary obstetrical services to the local community as well as regional high risk obstetrical and maternal-fetal medicine services with a delivery volume of over 4000 births per year.

There is a collaborative approach across the units to ensure seamless service to patients and families. Women and Newborn Services have a 5-year strategic plan covering 2015 to 2020. Work on the next strategic plan will begin in September 2019. The Child Birth Care Team (CBCT) and Quality committee include a patient partner.

The staffing model includes a resource team of staff who are trained to work in several areas within the program allowing flexibility and permitting many staff to work in more than one area. The environment is generally well-designed to provide privacy. Fetal Assessment and Treatment Centre is challenged to ensure confidentiality and resource requirements have been escalated. The Early Labour Assessment Unit has been renovated and provides a quiet, calm environment for women in early labour despite seeing a high volume of patients.

The Highfield Centre supports the IWK Midwifery Clinic. The IWK introduced Midwifery in 2009 when the profession became regulated in Nova Scotia. It has since become a well integrated component of the Maternal Child Program, and the midwives, who are employees of IWK, are recognized as valued members of the interprofessional team. They are engaged in program operational, quality and professional committee structures.

The Highfield Centre clinic location was selected to enable the midwives to support the care of women identified as being part of under-serviced or priority populations. More than 150 home and hospital deliveries were supported by the midwifery program (2017 data) with almost as many clients being turned away. In spite of creative staffing models with nurses serving as second assistants at some home deliveries, the program is unable to presently address the need for more service and outreach.

Priority Process: Competency

Comprehensive training is provided through education days including infusion pump training. On-line modules in the Learning Management System (LMS) provide core organizational education. Orientation is supported through on-line learning, classroom education and preceptorship. Occasional simulations are held to provide training in obstetrical emergencies including postpartum hemorrhage and prolapsed cord.

Safety reports are entered through the Safety Improvement Monitoring System (SIMS), in which all staff are trained and are reviewed through the quality committee. Staff concerns are also captured in SIMS. Staff have access to training in non-violent crisis intervention.

Staff recognition programs including STARS and kudos are clearly visible in the units. There is opportunity to advance interdisciplinary team-based education and standardized practice and the program may wish to consider a program such as MOREOB to provide structure to ongoing education, with a focus on patient safety using best practice guidelines and a team approach.

Priority Process: Episode of Care

Team-based care is evident throughout the program and families report a high degree of satisfaction with the care they receive. They feel well informed and included in their care planning. The program participates in the WHO Baby Friendly Initiative. This has led to several excellent quality improvement projects being initiated which have transitioned into practice. The focus on skin-to-skin care during laboratory sampling is one such example. The team recently presented on this at the Canadian Association of Perinatal and Women's Health Nurses (CAPWHN) conference.

Universal fall precautions are in place on the birth unit and screening tools are applied across the program. Patients and families are informed through posters, verbal communication and leaflets regarding fall risks to mother and baby. Medication reconciliation and safe surgery checklist is audited and discussed at safety huddles which take place at the change of each shift. ESource is also used to share information with team members.

Protocols are in place for obstetric emergencies including Massive Hemorrhage Protocol and Code Blue. The handover tool ISHARED, is used across all areas and appropriate use is included in the regular audits and safety huddle discussions.

Communication with clients is promoted through white boards in patient rooms. Families were very comfortable with the information they receive and there is continuity of information between the inpatient program and public health. Patients seen at the Highfield Centre midwifery clinic setting describe a high level of engagement in their goal setting and care planning, along with satisfaction with team and options available for home delivery.

Priority Process: Decision Support

The Birth Unit utilizes electronic charting using Meditech for the majority of the patient record. Other program areas are predominantly paper-based and the charts from the Birth Unit are printed prior to transition. Charting is thorough and up to date. Charts are audited for areas of focus, including safe surgical checklist, medication reconciliation, VTE prophylaxis and falls prevention. On-line training modules in confidentiality and privacy are included in the LMS training.

Priority Process: Impact on Outcomes

Oversight for evidence-based practice and guidelines is provided by the child birth care Team, with safety risks identified in SIMS being monitored by the quality committee.
There are many examples of improvement activities including those already identified. A key area of focus has been on length of stay. Numerous improvements have been implemented including a goal-oriented approach and management of substance-exposed infants on the Family Newborn Care Unit.

The provision of postnatal care to provide for unattached patients or those without obstetrical family physicians and a program to promote attachment of newborns to family physicians evolved from the reduced length of stay project. The perinatal care centre has worked with the multidisciplinary care team to promote patient flow throughout the visit by tracking the amount of time spent with each professional.

The Highfield Centre midwifery clinic contributes to the Atlee Perinatal database overseen by the Reproductive Care Program of Nova Scotia. This enables understanding of maternity care and emerging needs with comparative data such as birth rates and clinical outcomes (induction, Cesarean Section, pain support, breastfeeding). There is an excellent opportunity to increase the frequency and transparency of the review of performance metrics within the clinic setting and within the program to support planning, decision making, resource allocation, etc.

While escalation processes are in place, the visibility of this to front-line staff was unclear and there are opportunities to improve communication between front-line staff and executive leadership.

Standards Set: Organ and Tissue Transplant Standards - Direct Service Provision

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		
3.6	The training provided to the team on the SOPs is documented.	
3.7	Compliance with SOPs is monitored regularly.	
3.8	The effectiveness of the SOPs is annually reviewed and evaluated. Based on the results, the SOPs, training activities, or monitoring processes are changed as necessary.	
3.10	All changes to the SOPs are tracked and version numbers are documented.	
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		
18.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
22.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		
Priority Process: Organ and Tissue Transplant		

The collaboration between the IWK Transplant Service and the MOTP is a critical success factor in the services provided. Through a memorandum of understanding, there is clear delineation of the

responsibilities that each partner has and those that are shared. The Standard Operating Procedures are overseen by MOTP with input from IWK as a key stakeholder and partner. Current and standardized assessments, criteria for decision making, pre-printed orders & protocols are essential to the quality of care and service particularly given the small number of transplants. The team is clearly invested and takes pride in providing a quality service and partners with patients/families both in direct patient care planning as well as with quality improvements for the patient population.

Priority Process: Clinical Leadership

The IWK Pediatric Renal Transplant Services team is comprehensive including but not limited to medical, nursing, social work, clinical nutrition, pharmacy, spiritual care, psychology, child life and palliative care professionals. Care planning and delivery reflects the patient care continuum of ambulatory, inpatient, perioperative and critical care settings. The clinical teams of all areas are engaged as appropriate in the planning for any transplant procedure. Importantly, the team works very closely and collaboratively with the Multi-Organ Transplant Team Program (MOTP) which covers all of Atlantic Canada for all living donations and deceased donations through the MOTP as appropriate with the Critical Care Organ Donation Program (CCOD) of the Nova Scotia Health Authority who provide support for organ donation to critical care and emergency departments. Memoranda of Understanding with clear accountabilities and good communication enable all partners to provide services through what might otherwise prove a complex planning and decision making process.

IWK support patient populations in Nova Scotia, New Brunswick, PEI and Newfoundland & Labrador through services provided on site and with providers going to other provinces to support satellite clinics. This enables familiarity with providers and nature of services leading up to transplant and also with follow-up. There is obvious commitment to the corporate goal of exceptional care closest to home. The team has established goals and a two year plan of action.

While the number of transplants is small (4-5/year), leaders have given attention to ways and means of ensuring quality of care by providing support for acquiring and sustaining knowledge, skills and performance improvement (oversight of patient outcome measures).

The MOTP takes accountability for the Standard Operating Procedures (SOP) and these are available by accessing the MOTP website. Given the small number of transplants and the reliance on the SOP's, as well as on IWK policies and preprinted orders to ensure best practices, there is opportunity to ensure all staff and leaders are aware of the means of accessing the MOTP tools. This would include also ensuring all IWK directives that support aspects of transplant services are reviewed and revised regularly, and are made known to all users.

Priority Process: Competency

A nephrologist is the medical director for the transplant team. Given the small number of transplants per year and the challenge of sustaining a surgical service dedicated to the site, the team works closely with the MOTP to ensure that surgeons who are qualified and become duly credentialed at IWK are available

to support the program. Nursing expertise in the perioperative and inpatient settings is supported through a robust education program (yearly education; transplant workshops; preceptorship assignments), access to clinical experts and with access to online resources (SOP's, preprinted orders).

In support of the commitment to quality, there are a number of layers of review with varying degrees of granularity of review, i.e. review of each transplant, morbidity/mortality reviews, Nephrology Interdisciplinary Committee (which includes a parent partner), monthly multidisciplinary rounds, MOTP Quality Committee for Transplants; performance reporting and monitoring at the provincial/national levels.

The team describes awareness of the ethics resources available to them in event of dilemmas with clinical decision making. The team also describes the collaboration that occurs with families at a direct care level and the authenticity of the partnership in care and transition planning was strongly reinforced in discussion with a patient/family who recently had a kidney transplant.

Priority Process: Episode of Care

Discussions with the team, staff in the clinical areas (inpatient unit, pediatric intensive care) and patient/family leave no doubt of the commitment to excellence in patient care and patient/family experience. The extent of engagement of patient/family in understanding condition, treatment options, goal setting, care delivery and transition planning is evident. The involvement of many professions in supporting assessment and care planning is described and reflected in documentation.

Given the uncertainties with the pediatric population in terms of the course of renal disease and the lack of predictability about timing of potential transplant, the team is very sensitive to the need to support transition planning from pediatric to adult care. A Transition Committee now begins this work well in advance of need (i.e. patient age of approx 14 yrs) to create mindset and to put in place ongoing care by family physician and adult team. Of note, this process was in response to feedback from patients/families.

Priority Process: Decision Support

The team, in collaboration with MOTP, monitors performance metrics (numbers, trends, outcomes) as part of centre, provincial, regional and national transplant monitoring and review.

The inpatient record is presently a paper based documentation system. Support for planning the future implementation of an electronic documentation system will enhance communication, minimize risk of errors, optimize work efforts, etc.

Staff have access to resources using the internal web, OP3 (i.e. policies, procedures, protocols etc.) and access to external websites (MOTP for SOP's). Awareness of, access to and use of these resources is particularly important given the low number of transplants. Adherence to processes for routine review and update of all guidelines is encouraged to support best practices.

Priority Process: Impact on Outcomes

There appears to be rigour to the process of reviewing each transplant and monitoring overall numbers and trends. In addition to quality metrics (transplant success, infection rates, wait times), patient satisfaction and experience are captured through patient surveys, formal feedback and 1:1 discussion in follow up encounters.

There are notices displayed in clinical areas to heighten awareness to specific safety practices (e.g.. hand hygiene). There would be tremendous value to displaying a number of select quality, safety and satisfaction measures. It would also be beneficial to make those metrics, performance targets and rates visible to staff and patients/families. This will help to ensure they are informed of and engaged in quality improvement initiatives that are aligned to program goals and the corporate strategy.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Paediatric Perioperative team member are commended for their compassion, patient and family-centred commitment to care, teamwork and emphasis on quality and patient safety. There are 8 (+1) busy operating rooms, a pre-assessment clinic, intake, admission day surgery, PACU and an inpatient surgical unit (28 beds). Four large surgical services (Ortho, neuro, cardio, gen/surg) are very active although there are 12 surgical services in total.

The Women's Health perioperative program includes a care team managing 3 OR's and 10 inpatient beds plus two overflow beds.

Both interdisciplinary teams are comprised of staff roles carefully selected to meet the needs of patients and families. There is an impressive number of medical residents, fellows, and other healthcare professional learners. Nurse Practitioners have become important members of teams and support paediatric orthopaedics, cardiac surgery, and general surgery. As a result of a Lean project in the OR to

improve patient flow and turnaround times, the Women's Health perioperative team clarified role responsibilities and the flow/responsibilities relating to them. A new role entitled Patient Nurse has helped to further imbed patient-centred care into the women's perioperative activities. These role responsibilities are posted on the walls of the various OR. The team presented their work at the ORNAC conference this year "Using Lean Principles to Improve OR Efficiencies". This scholarly endeavour is noted with approval. The team is very proud of their achievements and outcomes related to this QI project. The Nurse Liaison role is highly valued by patients and families.

The inpatient surgical paediatric unit (8 + 2 overflow beds) is well designed to meet the needs of children and families. The private rooms (almost all of the rooms) have a parent bed that support family presence. Equipment, sinks, toilets, etc. are appropriate for children. A large playroom is shared with the medical paediatric unit.

The paediatric perioperative team has implemented significant person-centred care practices such as identifying children with autism who might require a different approach (a sign is posted on the door). A child life worker provides support to children throughout their perioperative journey.

Partnerships with referring agencies throughout the region are strong and effective.

Safety huddles and rounds are conducted in these clinical areas. Rounds are also conducted daily by the interprofessional team. Interdisciplinary safety meetings are conducted quarterly by the children's health team. Program operational activities are managed at their respective Quality and Patient Safety Committees. There are also unit specific committees that address quality and safety issues such as the OR Committee (Women's Health).

Priority Process: Competency

Team building exercises are conducted quarterly by several of the teams to optimize team functioning. Education is available to staff members annually during skills days where mandatory training is provided and skills updates include IV pump training, safety skills, and other related professional development topics. Orientation programs are provided to new staff and preceptors are effective at sharing knowledge and skills.

Several units have boards where education, audits and new information is posted along with staff being recognized. The organization is commended for safety boards posted in clinical areas by safety champions.

Priority Process: Episode of Care

Pre-assessment clinic visits are scheduled depending on the type of surgery and specific patient clinical needs. Education is a priority during these visits in addition to identifying risks associated with anaesthesia. The Women's program pre-assessment clinic was renovated two years ago using feedback from patients and families along with best practices. The space is private and allows for confidential

conversations. The paediatric pre-assessment clinic is welcoming, child-friendly and private. Improvements were also made to the paediatric intake area to reduce confusion about where patients and families should go when they arrive on the day of their procedure (this is directly related to feedback the team received from parents and staff).

Operative practices and processes in both the women's health program and paediatrics are impressive. Not only are staff extremely patient and family-centred but their attention is focused on safety and risk practices. The surgical safety checklists by both teams are extremely well implemented. Two client identifiers are checked both when staff change or transition in the care journey by the patient. Key information is reviewed carefully and verbally repeated to ensure the right patient is in the right location. Patients and family as partners is imbedded into all care processes. The staff and physicians are commended for their genuine approach to respecting patients and families as partners. The paediatric perioperative team has implemented the Balance Program for children on the autism spectrum. Parental presence has also been encouraged and supported during the induction process. In one care, the patients' mother looked extremely engaged and relaxed during the experience.

The Women's Program implemented a research study: Enhancing Recovery After Surgery (ERAS) program and congratulations is offered to recognize their outstanding results. Length of stay has been reduced significantly as a result of implementing the evidence-based bundle of interventions. The patient education passport contains good information. The 7A adult inpatient surgery unit has a central monitor for oxygen saturation monitoring for patients with sleep apnea. This is a very good practice. It is also noted that they don't provide gender services but rather are inclusive regardless of gender identity.

The paediatric inpatient program has implemented "high dependency beds" or rooms within the unit that offer more intensive nurse monitoring and are strictly nursing driven (i.e. nurses determine when a patient's care needs require more intensive nursing care). A SPOT team (nurses from PICU) will follow a patient who has been transferred to the inpatient unit from PICU for up to 48 hours to facilitate the transition from high intensive nursing care to less monitoring.

All relevant required organizational practices were met by these teams. Transfer of information deserves special mention for all teams. In particular, the information transfers between the pre-op area, OR, and PACU are particularly effective.

Access to DI services for women's health patients should be reviewed.

Priority Process: Decision Support

Health record documentation is manual using paper records for nursing and allied staff (and then scanned into the health record) whereas physician progress notes and discharge summaries are dictated and available in the Meditech system. The organization is encouraged to continue to advocate for a comprehensive electronic solution to enhance the quality and safety of patient care through improvements in electronic documentation and order sets. Health records are complete and organized. Staff were readily able to locate forms and information they require when reviewing patient data.

Priority Process: Impact on Outcomes

There is a overwhelming sense of pride and satisfaction by the staff and physicians in all perioperative areas and inpatient units. Many staff reported that they feel privileged to work in their clinical areas with their supportive teams. Staff appeared happy and engaged. They acknowledge that there have been many quality improvements using LEAN principles and activities and while it has been a lot of work, the outcomes have been excellent.

Patient satisfaction is extremely high in all patient care areas. Patients and families are offered several ways to provide feedback on their experiences.

Several indicators are posted in the various clinical areas on both paediatrics and women's health. In the paediatric inpatient nursing unit, it was noted that a sign stating 419 days infection free was posted. Hand hygiene rates are also posted. Many audits are conducted that relate to quality improvement activities and LEAN events in addition to ROP related initiatives. These are also reported at staff meetings and quality meetings. The teams are encouraged to consider ways to share relevant indicators (such as patient satisfaction, hand hygiene) with patients and families. Some of these might be found on the website however patient advisors might be in a good position to identify ways to share indicators and outcomes with patients and families. Some indicators might be shared with patient partners who are members of Quality Committees. The women's surgical team reported that they have brought issues to the Family Leadership Council to obtain advice. An example of this would be how to empower patients to ask "have you checked my armband" in support of the related poster.

The Women's Health perioperative team encourages peer rotating audits within the OR/PACU area for activities such as surgical safety checklist, interruptions and use of unapproved abbreviations.

Staff were knowledgeable about how to complete incident reports and described the importance of reporting near misses/good catches.

Priority Process: Medication Management

Medication processes are safe and consistently managed in both the paediatric and women's health ORs. Medications are stored in the central core in a Pyxis dispenser. Medications and solutions were noted to be labelled appropriately when placed on the sterile field. Emergency equipment is readily available in both OR areas. Syringe pumps were noted to be used during OR procedures.

Standards Set: Point-of-Care Testing - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Point-of-care Testing Services

The Point of Care Testing (POCT) Program is developing well under good leadership. POCT problems and quality concerns that may arise are followed up with documentation in a timely manner Performance of internal quality control and external proficiency testing is at a high level and data well monitored by the POCT technologist coordinator. The benefits of interfacing POCT devices with additional middleware for quality control and inventory management could be explored as a quality and efficiency improvement initiative.

KPI development is ongoing and the organization is encouraged to implement a comprehensive set of indicators for monitoring purposes.

The POCT Committee could consider the value of adding utilization management to their scope of oversight responsibilities. There is a good working relationship exist between the laboratory and POCT users which enables the success of the program. POCT users comment on the high level of support that they receive from the laboratory.

Policies and procedures continue to be reviewed and developed as is the case with all laboratory documents.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Transfusion Services	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Precautions are in place.

Priority Process: Transfusion Services

Transfusion medicine staff are well educated and experienced in the knowledge and skills required to perform their duties.

Maintenance of temperature and humidity within acceptable limits can be a challenge at times. A large portable air cooling machine is located within the department to maintain an acceptable temperature. The air discharge hose from the equipment is placed through a window leading into an internal hallway. The hose extends out into the hallway approximately 8 to 10 inches at a height of approximately 4 feet. A risk assessment should be performed due to the potential risk for harm to any passersby and to the equipment hose. Humidity should be monitored and the impact of out of limit values assessed in discussion with product manufacturers.

Transfusion medicine's allocated space is problematic. The department is a walkway for persons moving from one area of the lab to another. Ideas for clearly defining and segregating transfusion medicine-only space should be discussed and barriers created to prevent persons not performing transfusion related activities from accessing the space.

In consideration of the patient population served, the possible purchase of a blood irradiator has generated discussion within the department. A formal assessment could be performed to inform future discussion and decision on this issue.

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.

Governance Functioning Tool (2016)

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: September 10, 2018 to October 26, 2018**
- **Number of responses: 11**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	9	91	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	N/A
3. Subcommittees need better defined roles and responsibilities.	82	0	18	N/A
4. As a governing body, we do not become directly involved in management issues.	9	0	91	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	55	18	27	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	9	91	N/A
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	N/A
12. Our ongoing education and professional development is encouraged.	9	9	82	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	9	91	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	10	30	60	N/A
17. Contributions of individual members are reviewed regularly.	20	20	60	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	18	18	64	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	10	60	30	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	9	18	73	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	36	18	45	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	18	82	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	9	0	91	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	9	0	91	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	9	0	91	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	N/A
27. We lack explicit criteria to recruit and select new members.	55	27	18	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	N/A
31. We review our own structure, including size and subcommittee structure.	0	10	90	N/A
32. We have a process to elect or appoint our chair.	0	18	82	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadia Average
	Organization	Organization	Organization	
33. Patient safety	0	9	91	N/A
34. Quality of care	0	9	91	N/A

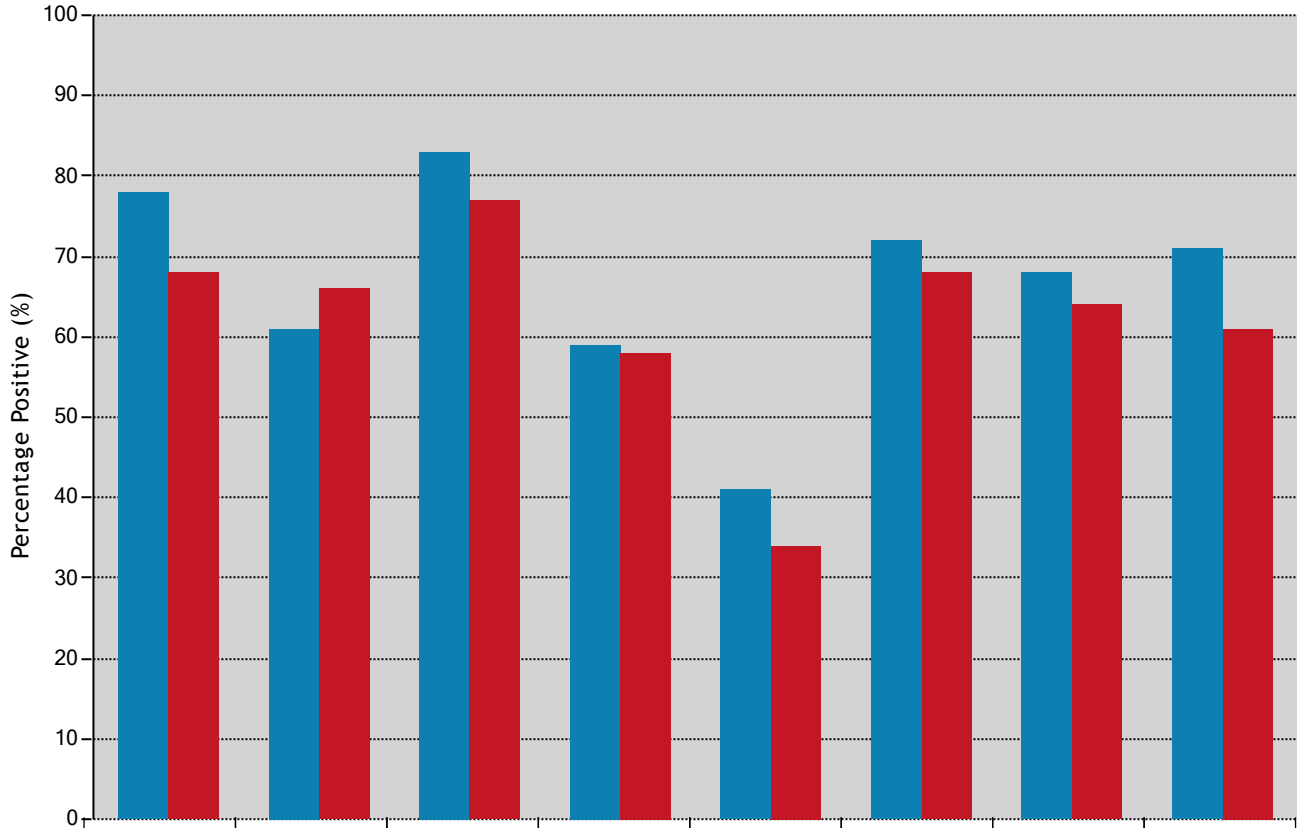
Canadian Patient Safety Culture Survey Tool

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: October 27, 2017 to January 1, 2018**
- **Minimum responses rate (based on the number of eligible employees): 327**
- **Number of responses: 933**

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
	78%	61%	83%	59%	41%	72%	68%	71%
	68%	66%	77%	58%	34%	68%	64%	61%

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, 2018 and agreed with the instrument items.

Worklife Pulse

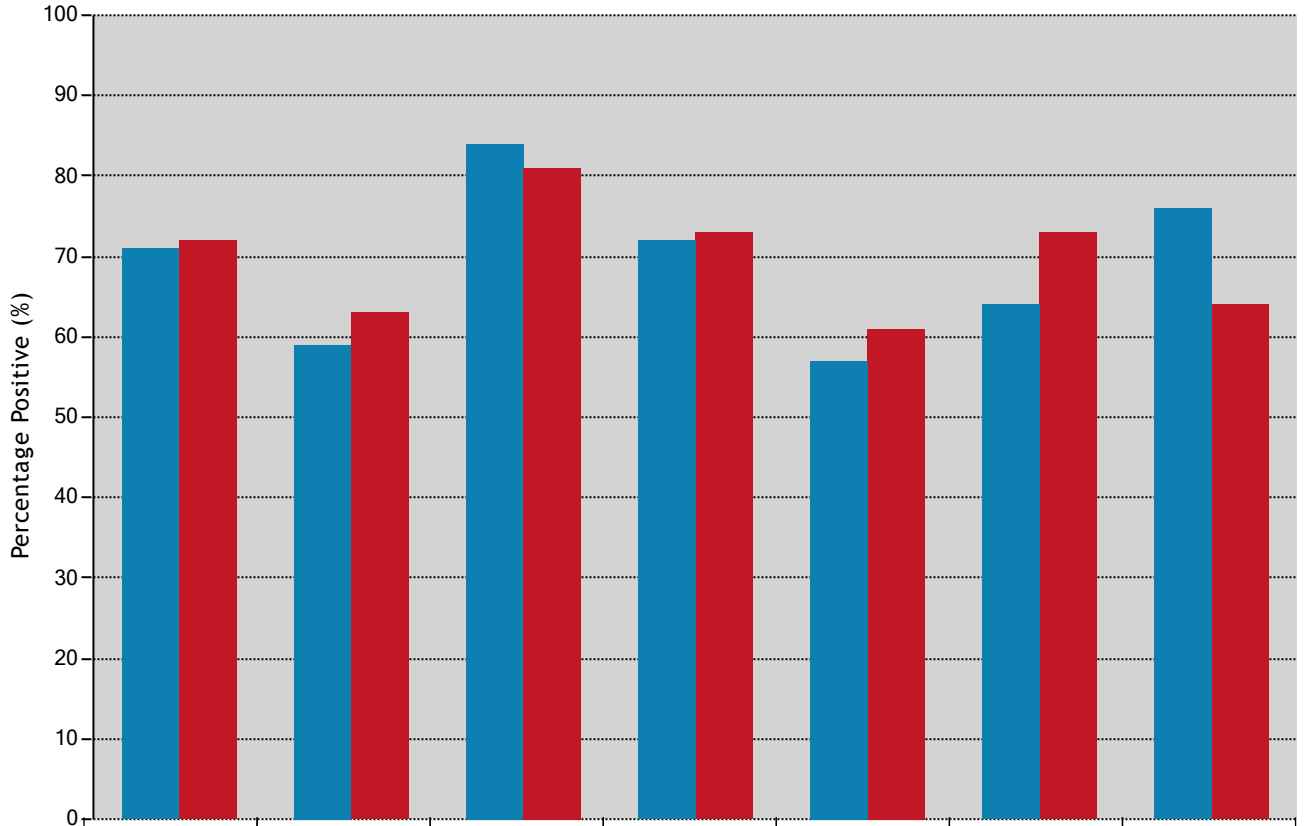
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse 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: November 1, 2018 to December 3, 2018**
- **Minimum responses rate (based on the number of eligible employees): 332**
- **Number of responses: 1007**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	71%	59%	84%	72%	57%	64%	76%
	72%	63%	81%	73%	61%	73%	64%

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, 2018 and agreed with the instrument items.

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

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 successfully completed its 2019 Accreditation Canada survey. The success in this endeavor, like so many others undertaken at the Health Centre is made possible through the outstanding work of staff, physicians and volunteers as well as their dedication to providing the best possible care to children, women, youth and families every day.

Accreditation provides us with the opportunity to be evaluated using nationally accepted standards of excellence. The 2019 on-site survey was undertaken by eight reviewers from Accreditation Canada, including for the first time a patient/family reviewer. The team met with many of our teams and services as well as management and the Board to assess over 3000 standards. At the end of the visit we were provided with a high level review of areas where we excel and those where there is opportunity to improve. Embracing the philosophy of high reliability we can now leverage the findings from the survey to inform our continuous improvement journey as we strive to further improve the care we provide to our patients, families and community.

We were pleased to see that our strategic priority on becoming a high reliability organization focused on safety, visible leadership and robust continuous improvement was seen by the reviewers to be embedded throughout the organization and aligned with the philosophy of the goals of Accreditation Canada. Similarly our commitment to patient/family co-creation and integration was noted as commendable, as was our renewed emphasis on responsible stewardship and the development of a strong control environment. Consistently through the review, clinical care delivery was noted to be collaborative, patient-focused and dedicated to quality and safety. The reviewers also noted that the pride and commitment of the people at the IWK from the Board, leadership and management to the front lines are the organization’s strongest asset.

We welcome the observations which provide insight into areas of opportunity for improvement and are pleased that these complement the existing and future focus areas identified internally. We will continue to drive momentum and results around this important work, including improved use of real-time data to plan and audit services, a continued focus on development of local level improvement activities and reporting of outcomes/ progress and a communication strategy to disseminate findings more widely. Identified areas for improvement requiring IM/IT solutions continue to be addressed as we work with our provincial partners to advance Nova Scotia’s goal in the creation of a single integrated health record for every Nova Scotian.

We wish to acknowledge the tremendous work of the Accreditation Canada Survey Team and thank them for the valuable insights they have provided in this report which will enable us to continue our commitment to “passionately pursue a healthy future for women, children, youth and families”.

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.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
People-Centred Care	Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.