ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Izaak Walton Killam (IWK) Health Centre

Halifax, NS

On-site survey dates: December 3, 2023 - December 7, 2023

Report issued: January 22, 2024

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 December 2023. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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

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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: December 3, 2023 to December 7, 2023**

- **Locations**

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

  1. 2760 Joseph Howe Drive - AIS
  2. Cobequid Community Health Centre - MHA
  3. Halifax Shopping Centre (NS Breast Screening)
  4. Highfield Centre (Midwifery)
  5. IWK Health (University Ave., main site)
  6. 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

  Service Excellence Standards

  4. Ambulatory Care Services - Service Excellence Standards
  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Cancer Care - Service Excellence Standards
  7. Community-Based Mental Health Services and Supports - Service Excellence Standards
  8. Critical Care Services - Service Excellence Standards
  9. Diagnostic Imaging Services - Service Excellence Standards
  10. Emergency Department - Service Excellence Standards
  11. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
  12. Inpatient Services - Service Excellence Standards
  13. Medication Management (For Surveys in 2021) - 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. 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)	113	2	0	115
 Safety (Keep me safe)	740	8	23	771
 Worklife (Take care of those who take care of me)	151	7	3	161
 Client-centred Services (Partner with me and my family in our care)	524	8	1	533
 Continuity (Coordinate my care across the continuum)	101	0	2	103
 Appropriateness (Do the right thing to achieve the best results)	1179	29	21	1229
 Efficiency (Make the best use of resources)	72	3	0	75
Total	**2940**	**59**	**50**	**3049**

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	50 (100.0%)	0 (0.0%)	0	35 (97.2%)	1 (2.8%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	47 (94.0%)	3 (6.0%)	0	93 (96.9%)	3 (3.1%)	0	140 (95.9%)	6 (4.1%)	0
Infection Prevention and Control Standards	39 (97.5%)	1 (2.5%)	0	29 (100.0%)	0 (0.0%)	2	68 (98.6%)	1 (1.4%)	2
Medication Management (For Surveys in 2021)	96 (100.0%)	0 (0.0%)	4	48 (100.0%)	0 (0.0%)	2	144 (100.0%)	0 (0.0%)	6
Ambulatory Care Services	46 (100.0%)	0 (0.0%)	1	78 (100.0%)	0 (0.0%)	0	124 (100.0%)	0 (0.0%)	1
Biomedical Laboratory Services	69 (97.2%)	2 (2.8%)	1	103 (98.1%)	2 (1.9%)	0	172 (97.7%)	4 (2.3%)	1
Cancer Care	78 (96.3%)	3 (3.7%)	0	109 (94.8%)	6 (5.2%)	0	187 (95.4%)	9 (4.6%)	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	58 (96.7%)	2 (3.3%)	0	104 (99.0%)	1 (1.0%)	0	162 (98.2%)	3 (1.8%)	0
Diagnostic Imaging Services	64 (97.0%)	2 (3.0%)	2	65 (95.6%)	3 (4.4%)	1	129 (96.3%)	5 (3.7%)	3
Emergency Department	67 (93.1%)	5 (6.9%)	0	106 (99.1%)	1 (0.9%)	0	173 (96.6%)	6 (3.4%)	0
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	95 (96.9%)	3 (3.1%)	10	140 (97.9%)	3 (2.1%)	10
Inpatient Services	55 (94.8%)	3 (5.2%)	2	80 (95.2%)	4 (4.8%)	1	135 (95.1%)	7 (4.9%)	3
Mental Health Services	50 (100.0%)	0 (0.0%)	0	91 (98.9%)	1 (1.1%)	0	141 (99.3%)	1 (0.7%)	0
Obstetrics Services	69 (97.2%)	2 (2.8%)	2	85 (96.6%)	3 (3.4%)	0	154 (96.9%)	5 (3.1%)	2
Organ and Tissue Transplant Standards	81 (100.0%)	0 (0.0%)	6	118 (100.0%)	0 (0.0%)	0	199 (100.0%)	0 (0.0%)	6
Perioperative Services and Invasive Procedures	112 (97.4%)	3 (2.6%)	0	109 (100.0%)	0 (0.0%)	0	221 (98.7%)	3 (1.3%)	0
Point-of-Care Testing	38 (100.0%)	0 (0.0%)	0	44 (95.7%)	2 (4.3%)	2	82 (97.6%)	2 (2.4%)	2
Reprocessing of Reusable Medical Devices	85 (98.8%)	1 (1.2%)	2	39 (97.5%)	1 (2.5%)	0	124 (98.4%)	2 (1.6%)	2
Transfusion Services	70 (98.6%)	1 (1.4%)	5	66 (100.0%)	0 (0.0%)	3	136 (99.3%)	1 (0.7%)	8
Total	**1264 (97.8%)**	28 (2.2%)	25	1591 (98.1%)	31 (1.9%)	21	2855 (98.0%)	59 (2.0%)	46

* 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 (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The "Do Not Use" list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health 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
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (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 (Hospice, Palliative, End-of-Life 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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 (Hospice, Palliative, End-of-Life 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
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 (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.

The Izaak Walton Killam (IWK) Health Centre is one of two health authorities in Nova Scotia. IWK is a corporate entity created by the Health Authorities Act of the Province of Nova Scotia. It is a healthcare and research centre dedicated to the well-being of women, children, youth and families. In addition to providing highly specialized and complex care, local primary care, research, knowledge sharing and education, IWK is an advocate for the health of families. IWK services approximately two million people throughout Atlantic Canada with fourteen community clinical and resource sites in Nova Scotia and offers mobile clinics and services, virtual care, and travel clinics throughout the Atlantic provinces as well as tertiary and quaternary care support to Newfoundland and Labrador.

The Community Partners identified the strengths of IWK that include its commitment to student learning; clinical expertise and a commitment to sharing and collaboration; helpfulness in translating clinical practice guidelines into practice; rigor and expertise in research and innovation; and a commitment to equity, diversity, inclusion, anti-racism and reconciliation. Partners also offered opportunities for improvement that include: hiring practices so the workforce is more reflective of communities served, more training in culturally competency and safety, and translation – particularly in Mi'Kmaq.

The organization is commended for its efforts to align its Roads Forward strategy and operational goals with the province's six solutions as contained in its Action for Health strategy. Values and mandate are clearly articulated and can serve as a guide to decisions and actions.

IWK benefits from a significant Research program and collaboration with academic institutions. It is commended for adding a new Quality and Patient Safety Research Chair to the existing cadre of Research Chairs.

IWK aspires to be a world class, high reliability organization. Surveyors noted examples where care and facilities were excellent, however there are also many recommendations and opportunities for improvement identified in the survey report which will help IWK move closer to its aspirations. Since the last accreditation, IWK has encountered significant challenges such as a worldwide pandemic, involvement in response to a mass shooting within the province, and a significant flooding at its main site. During these events IWK staff rose to the occasion and are to be commended for their dedication, expertise and resiliency. Additional ongoing challenges include lack of funding for infrastructure renewal, health human resource recruitment and retention, and antiquated clinical information systems that will require significant attention and investment going forward.

IWK has invested in quality improvement [QI] and safety. There is evidence of a culture of patient safety and reporting errors and near misses. Although there are pockets of quality improvement of which IWK can be activity nor an understanding of basic components of QI. Although organization leaders are highly justifiably proud, surveyors noted that many areas could not demonstrate evidence of quality improvement activity nor an understanding of basic components of QI. Although organization leaders are highly committed to QI, they realize that micro-cultures exist within the organization making hardwiring of QI a significant challenge.

Among areas for improvement is cultural safety and addressing the lack of racial diversity particularly among leaders. An Anti-Racism Action Plan [ARAP] report from 2021 identifies fifty-five areas for action. Several of these are being addressed and the organization is encouraged to pursue this important work.

Another area requiring attention is the large percentage of policies that are overdue for review and possible revision. This poses a significant risk to the organization and will require oversight and commitment.

All Required Organizational Practices [ROPs] were met and this is to be celebrated. The survey team congratulates IWK on such an achievement but would be remiss if it did not also note that sustainability of these achievements will require significant efforts and investments of people and attention to recommendations and suggestions in the following report.

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		
11.3	The governing body works with the CEO to establish, implement, and evaluate a communication plan for the organization.	

Surveyor comments on the priority process(es)

IWK bylaws are established under the Health Authorities Act by the Province of Nova Scotia. A Board of Directors (board) Governance Policy dated 2022 outlines the governance model which involves three key partners: Government of Nova Scotia, directors elected/appointed to the board, the president & CEO. Governors are selected following an open call for interest that identifies specific preferences for applicants. The organization uses a skills/criteria matrix to assist in new member selection. Potential members are interviewed prior to selection. Board members are provided with a comprehensive orientation once appointed. Members interviewed during the survey identified that complexity and the overlay of government on operations was a major insight upon being appointed. Tours of facilities and direct one-on-one time with the CEO were highly valued parts of orientation. It was suggested that a buddy or mentor system be initiated, and a dictionary of acronyms be developed and shared regularly. Policies of the board are reviewed annually. Updated terms of reference for all committees but one newly established committee have been reviewed and approved.

There are opportunities for the continuing education of board members. Each board meeting has an education component that includes presentations and discussions. The strategic planning process was identified as a highly valued exercise for its education and generative discussions. There are regular opportunities to hear from patients at the board level. These are unfiltered and focus on improvement opportunities.

The board feels it has made significant efforts to successfully implement people-centred care [PCC] throughout the organization, particularly when benchmarked against other organizations. IWK is cautioned in its perceived high assessment, as surveyors experienced diverse levels of people-centred care implementation. It is recommended the organization undertake a more complete assessment of actual levels and the degree to which PCC has been achieved and sustained at its current state.

The board sets annual goals for the CEO and assesses performance on a regular basis. Succession plans for senior executives exist, have been presented to the Governance, Nominating and Human Resource Committees and are updated annually.

Medical staff are afforded seats on the board. There are regular reviews of credentials and privileging of identified staff. The board feels they are well supported in their approval process.

The board receives regular quality and safety reports. Education on safety is made available to board members. It is recommended that board education include a session on the Safety II framework being encouraged within the organization. The board is commended for its efforts to recognize staff who participate in quality improvement. The board is also commended for use of the Governance Functioning Tool and its efforts to enhance evaluation of board performance. It is suggested the board develop a self-assessment component to supplement the annual individual performance reviews undertaken by the board chair.

The board of IWK supports the organization's advocacy efforts in the broader community. The board also expressed its appreciation of the efforts of the IWK Foundation, which at times acts as the voice, eyes and ears of the community to and for the board. Although the board is briefed on communication plans with specific initiatives and issues, it is recommended that the board engage with executive and the communications team to develop a comprehensive corporate communication plan with key performance indicators and targets that are reviewed consistently. Regular review and revision of the plan is also suggested.

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		
4.12	Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

IWK has a good understanding of the populations it serves. Data utilization and patients embedded on many committees help inform on patient needs. There are also special committees such as the Youth Advisory Committee and Transitions in Care Committee. IWK also works with the province on needs-based planning. The organization is encouraged to continue its ongoing assessments and use of analytics. Physician leaders are also well connected with national and international bodies to keep abreast of trends and best practices. The IWK Foundation also provides insight into population needs and expectations. A Tableau dashboard is used to monitor use of services and to forecast needs. Assessments are also undertaken to identify under-served peoples and allow proactive outreach.

There are several appropriate mechanisms to ensure validity and reliability of data used. The Analytic Team shares data with clinicians at team meetings. Quarterly and year-end data audits occur. IWK adheres to MIS standards and CIHI quality checks are embedded for two-way checking and reporting.

Planning could benefit from more robust and electronic information systems. IWK is encouraged to continue its involvement with the provincial electronic medical record initiative.

The organization also works with several partners such as Children's Healthcare Canada. An oral health initiative has been undertaken in partnership with provincial public health and the provincial dental association on prevention methodologies. Other initiatives have included a focus on child safety such as cycling, car seats and ATV safety. IWK also advocates for financial supports for community initiatives.

The organization uses risk assessments and a risk registry to inform the planning processes. Work is underway with its insurer [HIROC] to identify and merge top risks. IWK is encouraged to continue its efforts to refresh its risk framework. The Finance, Audit and Risk Management Committee is encouraged to finalize the infrastructure for units to identify and report their risks up through the structure.

Since the last survey, the organization has implemented a formal process to manage change in line with the provincial initiative. Several staff have been trained and certified in a change management program. In addition, the organization has begun implementation of crucial conversation training which involves a change management component.

IWK is encouraged to ensure all policies have been reviewed and are up to date. A high percentage of policies appear to be older and in need of review. This represents a significant risk to the organization and needs to be addressed.

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 has a fulsome budget building process in place that includes bottom-up and top-down inputs. Financial analysts are assigned to specific areas and work with managers and clinical leaders to identify and understand budget pressures, risks and opportunities. These are summarized and compiled with budget needs of other units and reviewed vis-á-vis government funding letters. There are opportunities for adjustments prior to formal approval by the Board of Directors.

The organization demonstrated strong financial controls, supported by the tone and expectations set by the CEO and executive leaders. An Internal Control Team is active. Controls are reviewed and regularly tested. The board receives regular reports regarding financial performance through the Finance, Audit and Risk Committee of the Board; additional formalized reporting of the financial controls is in the second year of operation. Leaders shared that there has been a considerable improvement in the rigour and robustness of financial control and there is added scrutiny on expense reports. It is noteworthy that at least three members of the board are certified professional accountants [CPAs].

Managers at IWK are well supported by education in budgeting and finances. In-house educational videos have been developed on forecasting and budgeting with step-by-step guidance and supporting documents. Finance provides a one-stop-shop service in financial management and sees itself as client service driven in support of operational and clinical managers. Financial information is shared with units regularly and there is monthly forecasting tied to data and activities to present an integrated view of a unit's operations.

IWK has an enviable record of good financial performance and following government budget directives. IWK accounts are audited by the Provincial Office of the Auditor General. Annual audits have been clean with no significant issues found. While there appears to be a change in the government's appetite for investment in health, the organization is justifiably aware of the need to be prudent and to be able to sustain any increased expenditures.

Business case processes are used to address gaps outside of the approved budget. A government template is used and reviewed by the executive prior to being sent to the government. Resource allocations at IWK are made based on patient care and identified risk. IWK is encouraged to develop a formal set of criteria to guide reallocation decisions.

Capital needs are assessed, and priorities set involving input from stakeholders. IWK feels well supported by its Foundation in securing medically needed capital equipment. Aging infrastructure poses a significant risk. Government policy has resulted in significant deferred maintenance that will eventually come to a negative set of circumstances. IWK is encouraged to continue its advocacy with the government and to seek opportunities from government programs for infrastructure renewal.

Controlled procurement practices at IWK have been strengthened and staff in the unit increased significantly in the last four years. Procurement specialists are increasingly seen as facilitators instead of roadblocks. Work continues to build procurement consistency, and this is encouraged by the survey team. The unit is commended for its efforts to achieve almost one hundred percent electronic purchasing. The organization is encouraged to ensure procurement practices highlight environmental stewardship.

Business continuity for operations is not at the necessary level. The organization is encouraged to address this gap as soon as possible as it represents a significant risk. An area for particular urgency is payroll. The planned move of ERP to a common cloud-based SAP platform [including education and the provincial services] will create challenges and impact current processes. IWK is encouraged to project challenges and develop mitigation plans to minimize disruption from the implementation.

Members of the resource management group convened for the survey described IWK's approach to resource management as conservative, evidence-based, efficient, transparent, rigorous and focused on care.

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)

Advancing equity, diversity, inclusion, and reconciliation are stated as a strategic priority in the current IWK strategic plan, along with enhancing the well-being of IWK's people. There is work underway to refresh the people strategy that was developed in 2017. In 2022 a questionnaire was sent out to staff and physicians to assess the level of engagement with the work of the organization. The results indicated an increased level of engagement amongst physicians and a decreased level of engagement amongst staff.

The tracers conducted during this survey indicate that the organization has been pro-active about receiving this input and creating action plans in pursuit of the strategic priorities respecting well-being of IWK's people. Staff and leaders in every part of the organization provided feedback that IWK is an employer of choice in healthcare but that the organization is not immune to the recruitment and retention challenges that are being experienced globally. The organization's analysis of HR trends demonstrates that the recruitment and retention challenges that have been seen historically in the nursing field have begun to shift to other professions, so recruitment and retention efforts are being shifted accordingly.

The strategic direction related to equity, diversity, inclusion, and reconciliation has been embraced by the People and Organizational Development Department. Work has been done to start the process of taking deliberate steps to ensure that the faces of staff and leadership reflect the faces of the populations served. There are specific initiatives to consult with and improve relationships with Indigenous, African Nova Scotian, and 2LGBTQ+ communities.

The organization prides itself on its partnerships with provincial partners on important processes such as collective bargaining, recruitment and retention strategies, a health equity framework, and health and safety initiatives.

There is evidence that the organization is taking steps to identify and grow emerging leaders and to provide learning opportunities beyond the mandatory and other training available in the Learning Management System.

Processes around recruitment and onboarding are well documented in personnel records. These are currently paper based but the organization plans to launch its new automated HR system within the next year.

Physician recruitment and retention is reported to be in a good place, with IWK described as a workplace of choice. There is a supportive structure in place to engage with physicians via a dyad leadership structure, medical staff bylaws, and a defined credentialing process.

There is a structured approach to workplace health and safety. The organization has achieved excellent results in terms of the rate of time loss due to injury in the workplace. There is a workplace violence prevention policy in place that is well socialized among staff. It is worth noting that awareness of work being done to enhance a culture of safety should continue to be an area of focus for communications because in some cases staff did indicate that they feel that there is an expectation that they should physically engage in workplace violence situations without ready access to protective services, and they do not feel well enough prepared or physically able to do so in all cases. Staff do have access to non-violent crisis intervention training (NVCI).

Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
3.10	The organization's leaders promote and support the consistent use of standardized processes, decision-support tools, or best practice guidelines to reduce variation in and between services, where appropriate.	
12.4	The risk management approach and contingency plans are disseminated throughout the organization.	!
16.3	The organization's leaders require, monitor, and support service, unit, or program areas to monitor their own process and outcome measures that align with the broader organizational strategic goals and objectives.	!
16.7	The organization's leaders verify that the quality improvement plans and related changes are implemented.	!
Surveyor comments on the priority process(es)		

IWK has invested significant resources in its approach to integrated quality management. Its stated goal is to provide safe care every day. The organization has a Quality Improvement Plan (QIP) 2023-2025 that identifies priorities, includes a QIP dashboard that tracks performance against a target and aligns with the provincial government directions. The QIP dashboard should be shared more widely throughout the organization and operationalized on the frontlines by managers.

Surveyors found pockets of excellence in quality improvement yet also visited units where staff could not articulate any quality improvement activities, tools or measures. Some areas had quality boards that were well populated, other units did not have boards, and still other areas visited had boards with information populated by advisors that were not understood and could not be explained. It is recommended quality boards are shared more prominently on the units and are managed and referenced by the staff within the unit, as opposed to being perceived as owned and kept up to date by quality support staff.

The organization executive are strong advocates and supporters of QI. IWK is commended for the consolidation of key portfolios related to quality, safety, informatics into the VP Medicine, Quality and Safety role. This role and the strong support from the CEO, establishes quality improvement at the highest levels within the organization. Leaders are aware that IWK has micro-cultures where quality improvement is not consistent nor standard. It is recommended there be a renewed focus on quality improvement starting with directors and managers.

Training consistent with the current Lean methodologies already adopted at IWK, is recommended. This training should also be afforded to board members who receive regular reports on quality improvement and safety. IWK is commended on its initiative to adopt a Safety II approach. It is recommended that Safety II be a focus of an upcoming Board of Directors education session.

There are approximately twenty-five quality improvement projects at various stages within the organization. Surveyors were advised there is a wait list for QI project intake among the group facilitating quality projects. This highlights the importance of prioritizing QI resources, yet it also indicates the need to expand the organization's capacity to embed IWK's QI approach and use trained and motivated staff. This would increase the profile and expectations for QI as well as reduce reliance on a limited number of facilitators and avoid delays in project initiation. IWK is commended for developing a separate stream for approving QI projects using guidance documents for Research and Ethics Board approvals. The organization is encouraged to amplify recognition and showcasing of successful QI work and QI champions. Team members indicated there is "lots going on with respect to QI but much of it has not been formalized". This should be addressed.

All Required Organizational Practices [ROPs] were met by the organization. Investments in patient safety consultants appear to benefit the organization and in turn, IWK's clients. A culture of patient safety is evident. Executive leadership is engaged. There is a culture of reporting and attention to detail when following up on incidents. A well-subscribed patient safety incident management system [SIMS] was developed in 2015-16. A steering committee meets monthly to review system performance and results are regularly shared with the board. Reported incidents are followed up. A thirty-day target for closing files has been established and the team interviewed indicated the target is reached with fairly high consistency. It is recommended that IWK consider adding their metric for closing incident files to their QIP scorecard.

IWK has a robust risk management approach however the risk registry and/or the risks identified are not shared widely. Many staff interviewed by surveyors were unable to articulate key risks in their area or within the broader organization. IWK is encouraged to develop communications and education on cooperate risks and develop capacity to ensure units identify and assess unit specific risks and mitigation plans.

IWK has a disclosure policy and mechanisms to trigger support for patients, families and staff when there are adverse events. Care teams disclose and document disclosure as close to the event as possible. Training is provided on disclosure to paediatric residents, new physicians and educators. Refresher training on disclosure is suggested for all physicians and staff. There are variations in timing for disclosure. The organization is cautioned about the need to balance delaying disclosure until all facts are determined and being responsive to patient and family needs and rights to be informed as soon as possible and followed-up as new information becomes known. The organization is encouraged to advance actions identified in its Canadian Patient Safety Culture Survey Action Plan, particularly training operational leaders in People Management in a Just Culture. Increased training capacity in this area is encouraged to ensure targets are met.

IWK is commended for its partnership with the Nova Scotia Department of Health and Wellness, Nova Scotia Health and Dalhousie University to create a Quality and Patient Safety Applied Research Chair. The incumbent recruited has a significant track record in implementation science and knowledge synthesis. Work has begun with IWK patient safety consultants on a project involving medication reconciliation. Medication reconciliation requirements are met. Reconciliation on discharge is an area that is not consistent. The organization is encouraged to pursue its stated intention for more training in January 2024.

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)

Ethics - clinical and organizational:

Clinical committee supports clinical care while the organizational committee supports organizational policies. The members are dedicated clinicians and researchers who have high interest in ethics or have some ethics training/experience. They are affiliated with the Nova Scotia Health Ethics Network as well as Dalhousie University Bioethics.

The clinical committee's work is well received and valued by clinical members. They have about one clinical consult per month that is done in a team-based model (ethicist and nurse attend the consult). Most of the clinical consults are for support for clinicians/clinical teams as opposed to direct patient care. The majority of the consults are from the pediatrics group. They are working on awareness with the women's group. They have a good relationship with various teams, especially palliative care.

Both committees are working on increasing awareness of their expertise and role within the organization.

The IWK ethics committee has members who are from the community, and they also consult the Patient and Family Advisory Council as needed. They developed an ethics framework as well as a resource for staff and a separate one for patients and families.

The ethics committee members do not have protected time for their work on this committee. Despite this there is great interest from those with varied backgrounds to join the committee. There is insufficient administrative support leading to clinicians doing administration (checking the phone for consults) as well as program planning analysis. They are working on revamping their feedback form to an online format. Permanent/in-house clinical and organizational ethics roles are suggested as well as increased administrative support. Program support including quality improvement such as how to select and capture outcomes of clinical consultations would be helpful.

Ethics - Research:

The Research Ethics Board (REB) has many successes. They were among the few institutions in Canada that continued research during the pandemic with close safety monitoring. They just found out that they were the best in Canada for processing REB submissions in a timely fashion regarding pediatric cancer trials. They are supporting high quality and varied studies which are increasing in number over time. They are working on efficiencies on processing the submissions as well as recruiting more team members to share the workload. They are also working on succession planning. They are closely linked with Society for

Patient Oriented Research and have representation from the community on their board. They are excited to link and partner with other REBs across Canada to work on national REB approval for multisite studies. IWK team members are very open to new methods of conducting research which has increased the ability to conduct clinical trials. Ongoing support to help the REB with their efficiency and sustainability is suggested.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.1 Information management systems selected for the organization meet the organization's current needs and take into consideration its future needs.	

Surveyor comments on the priority process(es)

Staff and managers from communications and information management met with an Accreditation surveyor and patient surveyor during the on-site survey. They described communication and information management functions to be clear, authentic, trusted, collaborative, two-way, transparent, accountable, evolving and informative.

IWK is commended for its use of analytics to guide communication with internal and external partners. The communications team worked with the patient engagement team to develop a survey of users to also help guide its efforts. In addition, there is a strong relationship between IWK communications staff, Nova Scotia Health and the provincial government. Regular calls occur twice daily. The organization is commended for its invitations extended to caucuses of political parties to share information and seek feedback. Also noted with approval, is an initiative to measure the effects of All Staff emails and recommend remedial efforts to ensure more accurate and useful methods of using email.

Project specific communication plans are developed and shared with the Executive and Board. When asked about a corporate or organization Communication Plan, a series of communication documents was shared following the team meeting. The most current document, which received executive approval in November 2023, outlines key communications priorities, goals and tactics. Assignments of responsibilities for areas of the plan have yet to be finalized. There are no metrics with targets attached to the documents. It is suggested an organization-wide Communication Plan be developed that addresses the results of a communications audit, identifies specific audiences and key messages for those audiences, which channels/medians to be used, specific goals, measures and targets. A crisis communications plan exists that is reasonably well structured and should be part of the corporate communications plan. The Board of Directors should be directly involved in the development and subsequent approval process. Special projects and initiatives at IWK have separate communication plans with focused messages for partners. The organization is commended for its website redesign and commitment to plain language. Efforts are made to control different points of access to information to ensure consistent and accurate messages. Several mediums are used to share and receive information such as quarterly town halls, monthly leadership meetings, weekly staff Pulse Newsletter, and the Pulse intranet sub-site. The research team publishes a weekly newsletter.

Policies related to information management have been recently updated and are estimated by staff to be approximately 75 percent complete. An organization-wide database tracking all policies exists and is maintained by a data analyst. There have been many outdated policies discovered through the survey and the organization is strongly encouraged to commit to updating all policies without delay to overcome this significant risk. Health records are securely stored. Thin chart guidelines have been implemented. Patients have access to their medical records through the Release of Information department and fees are charged based on the nature of the request. Metrics are used to monitor turnaround times for requests.

The organization has yet to move to an electronic record. There is a heavy reliance on paper systems and there were examples of a patient having two files on the unit in specific areas. This results in duplication, extra work and poses a safety concern. Until the new electronic medical record is implemented, it is suggested the organization review its practice of double charting and move to one chart.

IWK has been involved with the province and Nova Scotia Health in the planning and procurement of a new clinical information system. A vendor has been selected and it is hoped this will help standardize processes and lead to safer, seamless care. The new system is designed to ensure updates and comply with industry advances.

IWK has demonstrated its capacity to address breeches in privacy and confidentiality. Protocols for how privacy impacts assessment are available and are used. Protocols and training for disclosure of adverse events exists. Significant and industry-accepted measures have been taken by IWK and its cybersecurity partners [CSDS] to prevent or minimize the impact of a cyber-attack. This includes twenty-four / seven monitoring, cold storage of data, phishing, and sending cautions via email. An architect review board provides oversight.

Team members meeting with surveyors suggested responsiveness to parents and families requesting information be improved, and systems be modernized.

Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
3.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	!
3.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!

Surveyor comments on the priority process(es)

The physical environment at IWK is one of contrasts. There are state of the art facilities and facilities in operation that are deteriorating rapidly and have suffered from use and deferred maintenance. The team responsible for facilities maintenance are commended for their passion and commitment to keep the IWK operational despite numerous challenges that continue to arise. This multidisciplinary team meets weekly and has a good appreciation of the challenges faced. The Building and Infrastructure Committee monitors a Code Compliance Report that include various aspects of operations such as electrical, refrigeration, buildings, fire, boilers, suspended equipment, elevators and aviation. All items in the October report indicated ratings of “compliant “and “mostly compliant”. Actions items are identified.

Knowledge of facility challenges come forward through work order request, safety incident management system, in-house Feedback loop, and OH&S monthly inspections. A cadre of knowledgeable and committed engineers are employed and take pride in keeping facilities operational. Unfortunately, with limited overall funding, maintenance and reinvestments in many critical functions have not made the annual priority lists and have languished. Internal pipe works made of copper and cast-iron show wear from years of carrying harsh chemicals. It was reported that even in recently redeveloped space, septic leaks are occurring. Challenges exist with current plumbing, HVAC, electrical, gas and the building envelope. Recovery from a recent flood continues and this has afforded some opportunities for renewal such as new flooring in impacted areas.

Preventative maintenance was stated to be in a state of transition from an older manual process to the newer Magamation software. All new assets are properly recorded in the electronic system and will generate a maintenance and replacement schedule. At present record keeping is not strong.

It is recommended that a formal facility assessment be undertaken to identify infrastructure capacity and needs. This will be critical in advocating for renewal and assist in the planning for any replacements and/ or redevelopment. A Building and Infrastructure Committee exists to review code compliances and reports to the Board. Construction continues on a new build adjacent to a former entrance that is scheduled to open by 2026.

IWK has made some inroads in environmental sustainability. Lighting has transitioned to energy efficient LED formats and this initiative is estimated to be ninety per cent complete. All new procurements consider environmental impacts. Energy efficiency is hampered by provincial government requirements against incurring debts and energy efficient programs with third parties. There are challenges with environmental stewardship at IWK. There has been a new Sustainability Committee established for facilities and for products. The organization is encouraged to fully support the efforts of this new group with the development of core teams aligning with IWK's strategic directions and the existential needs of the planet. IWK is commended for its implementation of Dial for Dining which has significantly lessened food waste and increased client satisfaction with food services.

Facilities appear to be safe and secure. In-house protection services use closed circuit television. Concern exists that an aging fire alarm system is being phased out in the market and will soon be unsupported by the vendor. This is a significant risk that should be addressed without delay. The organization is also encouraged to implement its new wayfinding initiative that uses visual images that are identifiable in most cultures. The group is commended for its engagement of partners in the design of signage. IWK is further encouraged to renew its MOU with Dalhousie university to ensure that there are clear roles and responsibilities for storage of research supplies to avoid recent OH&S inspection orders. Managers are aware of a pestilence problem and have engaged a third party to help eradicate or manage the identified problems.

While air quality is monitored, there is inadequate capacity to achieve the standards for air exchanges in the operating rooms. The organization is aware of this long-standing gap and hopes to upgrade necessary equipment when funding is available.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Emergency Response Plan for IWK has been updated and is reported to be at the printers. The approach to emergency response is described as having several layers that roll up into a Master Emergency Response Plan. The components are described as basic emergency preparedness, incident command training, and incident management training. There is an expectation that unit managers update the emergency response plans for their individual units on a regular basis and provide their updates to the Emergency Response Team.

The team has seen significant success in terms of the response to the COVID-19 pandemic, a recent flood at the IWK site, and preparation for the impact of previous disaster responses that have occurred in the catchment area.

Fire drills were paused during the pandemic. The emergency response team is working with all units to resume monthly fire drills and to conduct "silent fire drills" as teachable moments.

It is suggested that the organization consider adopting the Incident Command System (ICS) approach, or something similar, to ensure that there is a structured approach to defining the roles of everyone participating in the EOC, the chain of command for decision-making, and a formalized approach to development, approval, and release of communications. The current process is defined as somewhat fragmented but with enough structure and good will that the job gets done in a systematic way. There is certainly opportunity for improvement. While the organization appears to have a formalized system, it may consider adopting the ICS approach to provide a single system method, as opposed to the current hybrid approach.

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.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

IWK is pursuing a healthy future for women, children, youth and families from the Board of Directors down to the frontline staff. The organization is transitioning from a patient and family-centred care approach (PFCC) towards a people-centred care (PCC) philosophy.

The organization's website has content for patients, families and visitors. One notable achievement is the online Patients, Families, and Visitors Guide, which can be customized by visit, some languages, the location a person is visiting from, the facility they are visiting, and the reason for visiting. Despite being able to perform this notable function, the organization can consider implementing additional mechanisms to increase the ease of searching for content.

IWK's main site comprises three connected buildings with distinct colours to identify each one. The walls have signage, information, resources and art moderately spaced throughout the hallways. The organization is commended for having areas where information is available in the population's top five languages and is also encouraged to increase this capacity as needed.

The leadership team is a highly motivated group that has strong ties from past roles outside and current roles within the organization. Senior leadership has aligned The Road Forward strategy with the government's recent broader strategic plan Action for Health. The organization's integration of both strategies is noteworthy since it has the potential for many other positive implications for patients and families going forward.

Patient and Family Partner (PFP) involvement is thriving within the organization. There is a Family Leadership Council (FLC), a Youth Advisory Council (YAC), PFP representation on the Board of Directors, and the Quality Committee of the Board. The organization is urged to consider ways to meaningfully increase the diverse representation in spaces where PFPs are partnering with IWK to ensure additional lived perspectives are captured to inform programs and services.

FLC and YAC actively engage in many of the organization's quality improvement initiatives. They have varying membership categories to permit PFP flexibility in their engagement. Youth Patient Partners (YPP) are also accommodated with the level of engagement. The FLC structure is reminiscent of a hub and spoke model. The FLC is the hub, with the spokes extending to short-term and longer-term subcommittees, ad hoc opportunities, research, and partnering with other communities or the government. There are opportunities for the hospital to explore additional educational opportunities, incentives/recognition, and capacity within the present organizational structure, evaluate and assess the impact of PCC, and embed voices directly into the programs and services offered.

Members of the FLC expressed that they feel valued, appreciated, and heard. They are excited to grow the council and appreciate the circle back after they have been engaged. The group has identified wayfinding as an indicator for the current Quality Improvement Plan (QIP). This team is energized to continue partnering with IWK and looks forward to growing and continuing to have an impact. “A few years ago, I wanted them to know about us – now they know us”.

The ENT and MDU clinics' barriers to accessing and receiving services are identified and removed where possible. Individualized care plans are developed, and the OCEAN eReferral Network has enabled a streamlined process for patients and families to access the hospital.

The Mental Health Program at IWK includes both inpatient and outpatient services. Patients and families have appreciated the team approach” in their child’s/youth’s care. There is FLC, YAC and ad hoc involvement of PFPs in the program. Family experience surveys are sent monthly for feedback on their care experiences.

There are no wait lists for Outpatient Mental Health Services. Referrals are received and managed through a centralized system, and patients are booked within a month or sooner. The team uses the Choice and Partnership Approach (CAPA), patients and families expressed satisfaction with the care received. Family experience surveys are sent out quarterly.

Hematology, Oncology, and Transplant (6L), patients and families have an interprofessional team that individualizes the patient's care plan to meet the expected results or goal of care. Patients (and their parents assist or) self-manage in their care and have reported feeling surprised that “they asked us how we are doing – the parents,” and that “they asked my child permission, even though they're a kid”.

The Pediatric Advanced Care Team (PACT) actively seeks input from patients and families. There are space constraints, and the current clinic allotment for PACT is only one day per week and in a room that does not meet the needs of the patients served (for example, wheelchair, lift system). There is a barrier to accessible washrooms to allow care for patients in wheelchairs and who need a lift. A parent’s letter indicated that the clinic space is not family-centred and trauma-informed.

Patients and families have reported satisfaction with the services they have received in the Emergency Department, Pediatric Medical Unit, Neonatal Intensive Care Unit, and Perioperative Services.

The Obstetrical Service has a dynamic team-based approach to providing services for patients and families. There is access to PFP for input on quality improvement initiatives. The team is commended for creating the couplet care rooms to allow rooming for postpartum parents and their babies in the NICU. Patients and their families felt that “the staff was responsive and supportive”.

IWK is commended for starting its journey toward people-centred care and is strongly urged to continue learning, partnering and engaging with all patients and families.

Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Organizational strategy for patient flow at IWK is well established and collaborative, as IWK manage patients from the three maritime provinces. The patient flow issues are escalated, and changes were made to focus on patients in triage and not only on inpatients needing admission. Daily safety call led by the executive on call helps reducing the barriers for patient flow.

There are minimal barriers for patients to be admitted on the wards or critical care areas (PICU and NICU). Protocols are in place to reduce the barriers in these areas and there is funding in place from the province to increase bed capacity in PICU. This is an improvement from the last Accreditation report.

Strategies for patient flow, goals, purposes, communication escalation, accountability and metrics tracking are now clearly defined. The organization makes significant efforts to prevent diversion and surgical cancellations by running the surge protocol and code census efficiently in a highly collaborative culture.

The team managing the patient flow really appreciates the innovations and creativity to find solutions for the problems they face, the adaptability and the team spirit.

In 2022, in the Emergency Department (ED), the Green Zone strategy was implemented along with the Sick Kids App for triage. These two initiatives have had a positive impact on the triage flow. During the code census and surge periods, additional physicians and nursing staff are reassigned to allow more discharges from the department. Other physical spaces have been created and purposed to manage patients with CTAS 4,5 evaluation in the evenings (orthopedic clinic). In those areas, physicians are supported by the CTA and matched with a nurse. There were no safety incidents recorded in those areas during the expansion.

There are several KPI metrics that ED is monitoring that are mainly related to different time stamps during the ED patient's journey, as suggested in the previous report. Some of the KPIs are the time from triage to physician initial assessment overall, and also for each CTAS, EMS offload, time from decision to admit until the patient left the ED to a ward. A tracking board is available in Tableau. The audits in the Emergency Department have shown improvements in the time taken from the triage to physician initial assessment. The organization may want to ensure that the waiting time in ED is visible and available either on the website or physically at the triage area.

There are well established protocols for surge and code census. The charge nurse in ED manually evaluates the situation in the Emergency Department o determine if a surge or code census should be triggered. As the charting is done on paper, the evaluation of the number of patients in ED is performed manually. The institution may consider having this process in an electronil format if feasible to standardize and ease the evaluation of the situation in ED.

There is a good process in place for patients who are transferred from other Maritime provinces, especially New Brunswick. The bridge call brings all the team members needed for the patient's care in one place to have a clear and accurate communication related to the patient's condition and further management. IWK is looking after all trauma from the Maritime provinces and there were no cases in the last 12-18 months when a patient had to be sent to Sick Kids. Most of the out of province patients, after they are discharged from IWK, are repatriated as further services for rehabilitation are transferred locally, closer to the family.

There were very few surgical case cancellations related to bed occupancy or lack of ICU beds.

With provincial fundings, the PICU expanded the beds from 6 to 10 with the possibility to have 12 beds if needed. Reasons for surgery cancellations are tracked regularly and some improvements may be considered to reduce the cancellation volume on the day of surgery. The surgical waiting lists are reviewed on a regular basis and several initiatives are in place to improve the surgical throughput. The IWK expanded their surgical care to other surgical facilities where surgical cases could be performed for 2 days a week for older and fit patients.

The estimated date of discharge is not documented in Meditech and for audit purposes and further quality improvements, the institution may consider having the date documented electronically rather than manually. This could allow a better tracking and further improvement of discharges from the wards. The nurses in the wards are trained to manage patients with respiratory diseases that require high flow oxygen and CPAP in the ward and not requiring intensive care. These skills proved to be very important during the viral season and released the pressure of bed occupancy in the PICU.

The institution developed a floating nursing team of eight FTE and the early feedback is very positive. A physician is rounding with the managers daily to identify the patients who could be discharged. Further metrics may be considered to have a more measurable impact of the floating team concept. Policies related to patient flow are 100 percent updated.

A nurse practitioner position was created in ED and this had a significant impact on patient flow.

LWBS is tracked in the Tableau and is hovering around 6 percent. There is some research led by physicians looking into reasons and type of populations that leave without being seen by a physician. Further patient flow related research is on the time to triage, virtual checks, and what the flow looks like for patients who require translation versus English speaking.

Physicians expressed their wish to have access to data faster than in current circumstances (3 months).

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices		
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
11.8	Flexible endoscopic devices are appropriately stored following manufacturers' instructions in a manner that minimizes contamination and damage.	!

Surveyor comments on the priority process(es)

The team members and leaders are deeply committed to ensuring safe medical devices and equipment for clients and families. A Quality and Patient Safety Committee meets on a regular basis. There is a strong interdisciplinary team supporting medical devices and equipment including medical device reprocessing, clinical engineering, infection prevention and control and surgical programs. The team was described as, “diligent, dedicated, resilient, collaborative, dedicated, patient-focused, and passionate.” The team members and leaders are acknowledged for their work during a recent flood in the medical device reprocessing department. They worked diligently to redesign this department in keeping with infection prevention and control principles and current and future program needs.

The newly designed medical device reprocessing department is bright and spacious. There is separation between the decontamination and sterilization rooms. There is one-way flow from decontaminated to clean work areas. There are adequate workstations for team members. There is appropriate storage for sterilized medical devices and equipment. The medical device reprocessing department has floors, walls, ceiling, fixtures, and work areas that are easy to clean. Access is provided to hand hygiene supplies including alcohol-based hand rub. Dedicated hand hygiene sinks with knee controls are available for team members. Hand hygiene education is provided. The leaders are encouraged to ensure that hand hygiene audits are completed.

The endoscopy reprocessing unit is located in the operating room. The reprocessing areas for flexible endoscopes does not have adequate space for reprocessing activities. There is one room in which endoscopy reprocessing is completed. The endoscopic reprocessing area does not have separate clean and contaminated work areas. The endoscopes after high-level disinfection are brought back to the contaminated area to dry. The flexible endoscopic devices are stored in a dedicated and closed cabinet. The leaders are encouraged to ensure that endoscopes are stored in a dedicated, closed, ventilated cabinet that is equipped with HEPA filtration, and the storage cabinet is located outside of the decontamination area and procedure room. There are plans to move endoscopy reprocessing to a newly designed room in the medical device reprocessing department. The leaders are encouraged to continue with this important work.

Immediate-use sterilization is used in the operating room for paediatrics, only in an emergency. Complete sets or implantable devices are not flash sterilized. The team members stated that this is rarely used. The leaders are encouraged to review the usage of flash sterilization for paediatrics, identify the costs and benefits, and review staff competency and training.

There is a preventative maintenance program which supports the provision of quality equipment. Infection prevention and control and program staff are engaged in the procurement of equipment. The surgical equipment and medical devices are calibrated in accordance with manufactures instructions. Education and training are provided to team members on new equipment.

The team members are proud of the work that they do in ensuring quality medical devices and equipment. The team members have received education and training in a formal medical device reprocessing training program. Approximately 50 percent of team members are certified medical device reprocessing technicians. The team members stated that their education and training needs are supported. There is an education board located in the corridor of the medical device reprocessing department. They described strong orientation processes that prepared them for their positions. The team members stated that they feel safe at work. They described having personal protective equipment to support workplace safety. The team members and leaders identified the need for an MDR educator to support the education needs of the team. Health human resource recruitment and retention has been challenging. There has been increased workload demand across all program areas such as clinical engineering and medical device reprocessing. The leaders are encouraged to continue to review workload in keeping with current and future demands and to make changes accordingly.

The team members and leaders are committed to quality improvement. There are huddles, SOPs, peer review, infection prevention and control audits, implementation of Canadian Medical and Biological Engineering Society standards, and auditing processes that support quality. A recent quality improvement initiative was the case cart project which resulted in the more effective use of resources both within the operating room and medical device reprocessing department. The leaders are encouraged to continue to support quality initiatives.

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	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

IWK ambulatory care is split into pediatrics and women's. Within pediatrics, there are surgical and medical clinics. For 2023, gastroenterology, ENT, prenatal, fetal assessment, and gynecology/urogynecology/breast clinics were visited.

For Ambulatory - Pediatrics, the leadership is aware of the successes as well as the challenges of the programs. They are working on improving the support of children and youth who do not have primary care and have hired community pediatricians and international medical graduates to fill this gap for the time being. They are also collaborating with their family medicine colleagues.

In the Pediatric GI clinic, patient and family-centered care is practiced and highlighted. There is a GI Patient and Family Council that meets four times a year and provides feedback on improvement initiatives. There are patient and family volunteers in working groups andsurveys are sent to families for feedback. They are also working on improving pain management via Comfort Promise and hope to work on ChildKind certification in the future.

In the Pediatric ENT clinic, there have been challenges with an exponential increase in the number of referrals after the peak of the pandemic. The team has submitted a business case to increase the team members to help with the waitlist. A highlight recently has been the partnership with the Eskasoni Health

Centre to provide community ENT care to improve the rates of ear infections that would lead to affecting many areas of life. The ENT team appreciated a partnership that is trauma informed and “learned the truth” from the Eskasoni First Nations partners. ENT has also partnered with the IWK performance review office and is working on a Lean project for February 2024. They also funded and trained a nurse to be one of the nurse prescribers.

For Ambulatory - Women’s, there have been many challenges that were out of their control. Due to a community clinic building in Dartmouth no longer being usable, the clinics had to move to IWK where the space was already tight. With feedback, they have worked on incremental improvements to support the care. They also have challenges that many other clinics and hospitals have - recruitment and retention of administration staff. They will be hiring three new physicians with new funding. With the new community building, they had a previous patient give feedback on best location. The team will have a strategic planning session in February 2024 to decide which other clinics will move to the community clinic.

For Women’s Gynecology clinic, nurses have created triage tools and live dashboards on waitlists that have been helpful in encouraging team members to continue making improvements. This is shown by a 94 percent clinic attendance rate. Physicians have switched over to an academic salary model which has increased engagement and collaborative changes. The clinic performs reconciliation of lab requisitions as well as referrals to gynecology/oncology. They emphasized that they have a strong team with varied experiences that values providing person-centred care and education.

For the Women’s Fetal Assessment and Treatment clinic, recent renovations have allowed for single patient assessment rooms affording privacy and comfort. They are working with Nova Scotia Health to standardize care across the province. They are a cohesive team that is supported by having all services and team members in one geographic area. The team members enjoy that they are able to create effective rapport with their patients who they see frequently over their care.

Within the Prenatal Clinic, there are many subclinics including high risk, low risk, diabetes, maternal fetal medicine, social determinants and infertility clinic. Despite this they have a strong clinical team that loves caring for patients of all backgrounds. They also give immunizations in clinic. As with other clinics, they have challenges retaining their support aides.

Overall, there are many strengths of the various ambulatory clinics. The key strength is the dedication of the team members. It is clear they enjoy providing care and they themselves have received excellent care at IWK. Some areas for improvement are: 1. Supporting quality improvement projects especially with live dashboard measurements across clinics, and 2. Having formal processes of receiving and incorporating feedback from patient and family members of all backgrounds for any improvement or policy changes. There may need to be a root cause analysis on why it has been challenging to recruit patient/family volunteers for committees.

Details

Having a formal process to receive feedback in multiple different ways from clients and families from various backgrounds rather than the current process of receiving feedback directly from patients and families during care delivery is encouraged.

Input may be from NS Health's efforts to seek feedback from clients and families due to overlap of services by NS Health and IWK. NS Health's Patient, Family & Public Advisory Council currently has seven of 12 seats filled from the whole province. There was no mention about the IWK's Patient and Family Partners Program.

For the prenatal clinic and gynecology clinic, there was enthusiasm to support the families of different cultural backgrounds/languages. IWK could provide support to teams who are engaged to support their families and partner them with families who can give input on how to improve care (e.g., handouts in different languages and/or different format).

For the Prenatal Clinic, there is work to be done on space planning to improve the accessibility and staff safety.

Priority Process: Competency

The Gastroenterology/Medical Day Unit team works on acquiring training that can be helpful in providing individualized care. In the Prenatal clinic, effectiveness is monitored and supported by a multidisciplinary leadership model with an obstetician and family practice MD as leads and a clinical manager. The Pediatric clinics have a comprehensive onboarding document for new nurse hires.

Although teaching is provided, the organization is encouraged to have directions for use included on the client-operated infusion pump forms.

Kudos, which lead to a certificate, are given by colleagues who appreciate the care provided by their team members. There are also awards for nomination.

Priority Process: Episode of Care

There is a nursing led initiative of a nurse triaging all referrals to the women’s gynecology clinic using set criteria.

The ENT clinic is about to launch an updated surgical dashboard that shows metrics such as appointments missed. It is hoped that this can expand to the medical clinics.

There have been significant improvements in the ability to have translation services in person, virtual, and by phone. It was encouraging to have some signs in the hospital using other than the two official languages of Canada. It is hoped that handouts and patient/family feedback requests can also be in other languages.

The ambulatory area is considering having a formal process for how to improve the assessment process with patient and family feedback.

Consideration is encouraged to offer client/family and other care providers the method by which they prefer to receive the list of medications and to update the Medication Reconciliation policy 10.30 with person-first language.

Having formal audit tools in addition to in-time feedback from families and having a process of documenting in-time feedback from families is encouraged.

IWK is working on how to provide care to those who do not have a primary health care provider. It is working on community pediatric support and/or will try to find a primary health care provider.

Priority Process: Decision Support

Records are accessible via release of information (Policy 333). Involving clients and families to give feedback on how to make this more client-centred, such as regarding consideration for adolescents, and caregivers of children/youth with medical complexity, is encouraged.

The adult gynecology clinic has a phone line for patients to call and ask the nurse questions on weekdays which has been very helpful for patients.

The Women's Ambulatory Care Team Committee has been looking for a patient volunteer without success. They would benefit from guidance on how to have effective patient and family feedback and incorporate this into improvements and policy making.

The provincial model for e-referrals for surgery clinics has been helpful to allow for patients to receive timely information on the approximate waiting time. It would be great to expand this beyond surgery clinics.

Priority Process: Impact on Outcomes

A standardized process is developed, and conflicting evidence-informed guidelines are resolved on an individual patient basis. That input from clients and families is formally incorporated into the overall process is encouraged.

In the urogynecology clinic, NP (nurse practitioner) led pathways have been created with input from clients and families. This includes a method to see the RN/NP first while waiting to see an MD which can take a couple of years. Videos have been created to support patient education.

Guidelines and protocols are reviewed with input from clients and families, but not regularly. After feedback from and consultation with families, social work support is provided.

In the prenatal clinic, they engaged families to modify the education documents in different languages and that provided improvements in navigation of care.

QI activities are supported in various capacities for different clinics.

Patients are asked to fill in a provincial pre-op history and physical form as this will help with triaging and anesthesia assessment. This form has been improved with input from clients and families and can continue to be improved. Surgery clinics have developed multiple methods, email, mail, and phone, to have these assessments completed.

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		
7.2	The laboratory has sufficient space to carry out laboratory services.	
8.3	The layout of the laboratory makes it easy to clean and disinfect work areas, equipment, floors and walls.	!
11.3	The team updates its SOPs every two years or more often if required.	
26.4	The safety program includes a safety manual that is available to all team members at all times.	!

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Universal fall precautions are identified and implemented in the Biomedical Laboratory Service. There is strong commitment to ensuring a safe environment that prevents falls and reduces the risk of injuries from falling. This includes implementing strategies following blood collection. The leaders and team members were unable to recall a recent client fall. The leaders are encouraged to continue to implement universal fall precautions.

Priority Process: Diagnostic Services: Laboratory

The team members, physicians and leaders are acknowledged for their dedication to robust pathology and laboratory medicine services. There is a strong commitment to be a national and international leader in laboratory medicine through a dedication to quality, innovation, teaching and research. They provide comprehensive tertiary diagnostic services for women, youth and children of the Maritimes. The objective of the service is to provide the highest quality diagnostic testing tailored to women, youth and children. They are guided by the Department of Pathology and Laboratory Medicine Strategic Plan 2023-2026. This is congruent with the organizational strategic plan. There are strong partnerships with Nova Scotia Health Authority, Canadian Blood Services, and Public Health Services of Nova Scotia, to name just a few.

There is a strong commitment to quality improvement. There is a provincial Quality Manual. The team is acknowledged for their commitment of additional resources to support quality including a laboratory quality coordinator and quality manager. There was exceptional work completed by the team members, physicians and leaders to address the increase in laboratory testing during the COVID-19 pandemic. The

team members and leaders are proud of their work in document control. They are encouraged to continue the progress they have made with SoftTech and to make SOP review and the document control system as part of their ongoing work. Additionally, they are encouraged to continue to ensure that SOPs are reviewed every two years or more frequently if required. Quality processes have been implemented including huddles, quality boards, auditing, and quality assurance programs. The leaders are encouraged to continue the quality improvement journey and to spread the use of quality boards throughout the laboratory service.

The team members and leaders are passionate about providing care to clients and families. This includes a commitment to people-centered care. One such example, was the use of a teaching microscope by a pathologist to support and educate children, youth and families. This has resulted in improved health outcomes. The clients and families described being treated with care, dignity, and respect. They noted that they felt prepared for the hospital visit for blood collection. A family member stated, “The service here is great.” The only suggestion for improvement was the lack of parking.

Human resource recruitment and retention is challenging. The team members stated that they receive education and training to support them in their work. They noted that they felt safe at work. Team members described the value of the orientation process in supporting them in their work. The leaders and team members advised that there is a sufficient number of qualified team members that are able to carry out the laboratory services. However, there is very limited sick leave coverage. Additionally, the leaders and team members noted that there has been an increase in the number of laboratory tests requested and completed. The leaders are encouraged to continue to assess staffing needs in consideration of increased workload and to implement staffing changes as appropriate.

The pathology and laboratory services are located at several locations at IWK Health. The area is welcoming with waiting room spaces and access to accessible washrooms. However, infrastructure is challenging. There is limited space to carry out laboratory services, including lack of storage space and crowding within the laboratory. One such example is the anatomical pathology area which has very limited space. Additionally, in some laboratory areas there are no dedicated hand hygiene sinks. The leaders are encouraged to review the number and location of dedicated hand-hygiene sinks to ensure staff access. There is a commitment to ensuring a clean environment in the laboratory. However, there are areas within the laboratory in which there are wooden countertops and cupboards that are porous and therefore, unable to be cleaned. In some areas there is cracked flooring. Furthermore, because of limited storage space there is clutter and extra equipment located in clinical spaces. The leaders advised that there are plans developed to address the space needs. The leaders are encouraged to ensure that that laboratory space is appropriate for the services provided and to implement plans to address the space required to carry out laboratory services.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
Priority Process: Competency		
17.12	Access to spiritual space and care is provided to meet clients' needs.	
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		
27.5	Quality improvement activities are designed and tested to meet objectives.	!
27.7	There is a process to regularly collect indicator data and track progress.	
27.12	Data about disease control and survival outcomes are collected.	
27.14	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
27.16	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
27.17	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Medication Management		
6.2	Systemic therapy only: Computerized physician order entry (CPOE) or Pre-Printed Orders (PPO) are used when ordering systemic cancer therapy medications.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is evidence of the hematology and oncology program engaging in ongoing data collection and monitoring of some performance indicators and some discreet quality improvement initiatives. However, it is not clear that the program has overarching goals that are guiding these activities in a method to align them toward meeting objectives.

Priority Process: Competency

IWK leads an Atlantic province network that includes organizations and community paediatricians to coordinate care.

Only one infusion pump type is used. It has not only a drug library but has limited protocols built in for each specific clinical area.

Apparently, there is no spiritual care available on site. Families are encouraged to seek spiritual support from their respective groups/communities.

Priority Process: Episode of Care

The team described collaborating with SickKids in Toronto for bone marrow transplants.

Whenever a staff member is handling chemotherapy, they wear a red vest to ensure all other staff, patients and family members do not distract them.

Patients and families interviewed in both inpatient care and ambulatory care in this program are very satisfied with the care received, how they are treated by all members of the team and their level of engagement in developing the treatment plan.

Priority Process: Decision Support

Although the patient records are not yet digital, the charts that were reviewed were very well organized and meet standards.

Priority Process: Impact on Outcomes

There is evidence of the hematology and oncology program engaging in ongoing data collection and monitoring of some performance indicators and some discreet quality improvement initiatives. However, it is not clear that the program has overarching goals that are guiding these activities in a method to align them toward meeting service or program level objectives.

The program is inconsistent in how it collects data and tracks progress and would benefit from organizational support to develop a program plan or roadmap with an accompanying scorecard with strategic indicators based on objectives set to measure outcomes and processes.

The hematology-oncology program has demonstrated evidence of implementing Lean methodologies such as process mapping and redesign to improve both the patient and family experience as well as that of the staff and physicians in the program.

There was no evidence shared or available regarding monitoring of disease control and survival outcomes. It was not apparent that the program is proactively sharing information and garnering input about QI activity, results or lessons learned with the team, or patients and families.

Priority Process: Medication Management

IWK does not have CPOE (computerized provider order entry). Systemic therapy orders are written manually on paper records, reviewed and transcribed by a pharmacist, scanned to the pharmacy, then uploaded into the Pyxis system.

All orders are double checked and prepared systemic therapy is double-checked by a second RN prior to administration/infusion.

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

There is abundant evidence of strong clinical leadership throughout the community based mental health services. The organization has adopted a number of quality improvement initiatives that are designed to optimize client and family ownership of their care plans and to ensure that capacity issues are mitigated by providing the right service, at the right time, and in the right place. For example, the organization has adopted the Choice and Partnership Approach (CAPA) which is structured in such a way that clients choose their goals in care and collaborate with caregivers to develop a plan for access to resources that support the achievement of those goals. In this way pre-established clinical protocols that have not been selected are not undertaken. This eliminates waste from the system and improves patient flow. Although it appears that the organization is early in its journey to use selected data to guide evidence-informed decision making when choosing the key performance indicators and metrics the service is trying to influence, there is engagement in having a structured approach to Continuous Quality Improvement. It was acknowledged during the survey that some of this work was paused during the pandemic response and that efforts are underway to revitalize the work now.

Priority Process: Competency

Because there is a well-defined approach to the care delivery model in community-based mental health, resources have been allocated to support the components of the model. The programs are defined as Community-Based Care, Adolescent Intensive Care, and Children's Intensive Care. There are five tiers of care with 1 being the least and 5 being the most intensive. The teams are multi-disciplinary. Although there are multiple disciplines working in these programs all receive training and are expected to participate in the chosen care delivery model.

It was observed that care planning and service delivery is highly collaborative among physicians, nursing, and allied health providers. There is access to professional development and mechanisms are in place to support peer supervision. The organization is moving toward a system that supports a less administratively heavy approach to performance conversations so that it is manageable for employees and leaders with large numbers of direct reports.

Priority Process: Episode of Care

The team has developed an online system called SHELF that houses valuable data and reference material. Examples include referral management, and the standardized assessment and documentation forms they need. The SHELF system has built in analytics to help them monitor program KPIs. There is a content manager assigned to oversee all the material within SHELF. It is impressive.

Ambulatory Mental Health has implemented the Choice and Partnership Approach (CAPA) to care planning. The model promotes client and family engagement in development of the care plan and a clear pathway in terms of patient flow. One of the added benefits to the approach is that, although there are wait times that need a continuous quality improvement approach, there is no waitlist for access to ambulatory care. For the intensive day and inpatient programs there are significant waitlists, but IWK is adopting some of the work that has been done in ambulatory care to address access and quality issues.

At the Wyse Road site it was noted that there is a team-shared calendar for all patient visits where at the end of each contact the clinician is expected to update the appointment to include three things: confirmation of visit, the length of the appointment, and that they documented a summary in their digital chart in PCI. The clinic administration staff upload this data into an Excel program. The Mental Health program leadership team includes an industrial psychologist who monitors and measures this and other data at the program level to help the teams plan care, assign work, and monitor outcomes. This was noted to demonstrate a remarkable level of sophistication for workload management. There is evidence that similar work is underway or being contemplated in other community-based programs.

The teams have standard expectations for work, meaning four follow up patients daily, fewer if they are doing an initial intake assessment called Choice Appointment, where additional time is allocated. The initial assessment is standardized and at that point the client and family help set goals for treatment in a case formulation method. This assessment includes a HEADS-ED screening tool that is scored on a standardized scale to screen for trauma to inform care and help prioritize urgency. Family take home a visual plan of care.

Clinicians have defined job plans that are set in collaboration with team leaders to manage workload and set objectives for development that are reviewed quarterly, and all of these are visible to the entire team.

Family experience surveys are done in batches quarterly. IWK has hosted two international CAPA conferences in the past few years, where they include families, both attending and as part of panels.

Patients and family members who participated in tracer activities indicated that they were very satisfied with care, and especially appreciative of the integrated approach to include and support family caregivers.

Opportunities:

From staff – They sometimes find it challenging to uphold the mandate when families have chronic issues related to the broader determinants of health such as food security, marginal housing, and income challenges.

There is a Workplace Violence Prevention Policy and NVCI training but staff in the CSI program have been somewhat distressed about feeling that physical engagement with clients is expected, even though it may, and has, lead to physical and emotional trauma to the caregiver.

From clients and families – When they present to the emergency department with a child in severe distress, it would have been helpful to have an immediate intervention to help them, rather than being given an outpatient appointment for follow up.

Service delivery could be augmented with more in-house access to practical resources for things like meal planning when looking after a child recovering from an eating disorder.

The work that has been done around making the community mental health programs more efficient and effective by introducing the CAPA model and structured engagement in quality improvement has been recognized as a leading practice. The Continuous Quality Improvement work was paused to some extent during the pandemic response. It is recommended that the organization continue with this work with an "even better if" approach and spreading good practice to all mental health programs.

Priority Process: Decision Support

Staff and leaders throughout the organization are anxious to move to an electronic medical record. The current paper-based charting system is well maintained along with evidence of an updated way of charting individualized care plans and required assessments to comply with the Accreditation Canada standards for things such as suicide risk, falls,-and medication reconciliation.

Priority Process: Impact on Outcomes

There is abundant evidence of work that has been done to improve the quality of care in community mental health. The CAPA model and other Lean healthcare based initiatives have demonstrated positive results in terms of standardizing care delivery, client as partner and owner of the care plan, and timely access.

It is recommended that the organization continue to develop and build its approach to a structured quality improvement program, including data informed visibility walls and huddles with staff to share information about selected key performance indicators and progress that is made toward achieving strategic and operational objectives. Staff indicated that interest in quality improvement waned during the pandemic response and that work to revitalize it would support staff engagement.

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		
7.15	Clients and families are provided with information about their rights and responsibilities.	!
9.9	The client's level of sedation is evaluated and managed on a regular basis.	!
9.10	The client is regularly screened for delirium and receives interventions to help prevent delirium.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Neonatal Intensive Care Unit (NICU) is divided in two zones, north and south, and it is a state-of-the-art facility in terms of space footprint and facilities for patients and families. The space was designed in partnership and with significant input from families. It was designed to meet family and patient needs. The corridors are not cluttered and there is good light and minimal or no noise. The family information board inside each room allows parents to contribute to the teams' goals and be actively involved in the management of their child if they wish to be. To maintain confidentiality and privacy, the names of the patients are not presents on the doors for each room. In addition to providing all single room patient spaces, supporting parental presence 24/7 as well as sibling presence, initiatives were put in place such as Together Care and Couplet Care in three designated rooms, allowing inpatient care to both mother and baby(ies), which aims to reduce parental separation.

The interdisciplinary team is comprised of nurses, nurse practitioners, neonatologists, residents, RT, social worker, discharge planner, pharmacist, ward clerk, OT/PT when needed and the patient's partner. The unit hired a 0.5 FTE parent partner and in their family leadership council they have around 30 patient partners who are quite engaged.

In terms of long-term strategies, the leadership team in NICU are preparing for another two-day retreat with all staff to identify new goals and visions. In the past, they have brought in a professional facilitator. The themes from the retreat will be posted in an area where the staff can vote on them. The long- and short-term goals are aligned with IWK strategy.

The goals for 2022-2024 were to improve and develop further the culture around respectful workplace and ethical belonging. This initiative rose after feedback from an international medical graduate who spent some time in the unit. The manager developed an educational session on anti-racism which was launched in 2022. The inclusiveness module is now part of the orientation package for new hires.

The second most important goal in NICU was to support the current staff. The manager has had a mandatory exit interview with each nurse who left the unit. The feedback identified that work intensity and trauma were the two main reasons for nurses leaving the NICU. A new initiative called Code Lavender was developed and implemented in 2021. Along with this initiative, a quiet place was designed for the staff members and Schwartz rounds will be introduced in January 2024. A checklist was developed for staff to identify if they are safe to return to their job when they were faced with some trauma in the unit.

The NICU leadership team is to be commended for being so thoughtful and trying to be innovative to attract staff and maintain their current staffing!

A new patient partner was hired in NICU for 0.5 FTE, and this had a tremendous success as it brought parents together. The patient partner is heavily involved in the interview process for new nursing staff and physicians and is part of the quality improvement committee. The Family and Patient Partners committee is meeting in the evening to accommodate their needs.

Strategy development in PICU is driven from the directions of the institution, but also from team feedback. The short-term goals in PICU are to align the values with IWK values, to cultivate a belonging culture, to have a continuum of care and to support the pediatric outreach team. The staffing, the burnout and wellness of the staff are other directions where leadership are looking to act and prioritize. In the long term, PICU leadership is aiming to optimize the interaction with other departments and areas in the hospital as previously it was felt that PICU was working in a silo. New physicians were hired, and the organization has supported new positions of clinical assistant. The clinical assistants are selected from physicians from abroad who will be provided with targeted professional development and evaluation in order to work safely to full scope of practice in the next 12- 18 months. Leadership is very proud of the new model of care developed since the last Accreditation. In PICU there is a bigger space footprint with the new redesign, every room having natural light. Patients and families were involved in the redesign of the space.

Priority Process: Competency

Appraisal of nurse practitioners and clinical assistants is done by the director lines, whereas the appraisal of nurses is done by the manager every two years. The NICU will be one of the sites used for piloting the new evaluation framework that IWK developed.

There is a very well-designed orientation package for the new nurses and there are plenty of educational opportunities in the unit. Nurses and physicians are supported to attend and present to conferences, and to participate in the grand rounds. The evidence-based guidelines are physician driven and physicians are very actively involved in the education of all staff in the unit. There are also weekly pediatric rounds as well as journal clubs every two months and neonates best EBM (expressed breast milk). In the NICU there were 23 new hired nurses and the expertise to manage very complex patients is slightly diluted. A mentorship program was developed for the new hires and more in-room support was in place for them. Training was provided on how to support parents during bereavement.

The site is a training program for neonatology.

In PICU there was an influx of hiring and a new nurse educator was employed to look after the new hires only. Their orientation program includes 12 weeks of mentoring and a buddy system. There is a formal evaluation of new hires at six months. 60 per cent of the staffing have under five years of experience in PICU. Six nurses were certified in pediatric critical care and the goal is for all 30 nurses in PICU to have this certification. There are a lot of educational opportunities not only for nurses but also for respiratory therapists. Some nurses attended the advanced cardiac care training at Sick Kids. There is a monthly educational package developed and nurses are keen to participate in QI and Research.

Priority Process: Episode of Care

Patient and family care provided by the NICU and PICU is excellent and discussions with parents were full of praises for the care their children received. The parents commented on the effectiveness of the team, the way the team respects the families and values their contributions. There is a sense of trust and security in the units when talking to parents. Amazing job for both teams!

Staff paid attention to hand hygiene ad infection prevention. Care planning is performed in partnership with the families. Parents felt very engaged in the treatment of their child in NICU. Everyday ethics is embedded in the units. There is a new lounge for the parents and families which has natural light, clean, large space with adequate secure storage space.

In addition to providing all single room patient spaces, supporting parental presence 24/7 as well as sibling presence, initiatives were put in place such as Together Care and Couplet Care in three designated rooms, allowing inpatient care to both mother and baby(ies), which aims to reduce parental separation. The unit is involved in six clinical trials nationally and internationally. They are soon to launch the Research Centre for Neonates in the maritime provinces. Patients are involved in the local studies.

With regard to bereavement and support, they have close ties with the palliative care team who provide support and are involved with most patients who may have shorter life expectancy. Guidelines were developed regarding when to reach out to the palliative care team. There is a good busy support system for the staff after a bereavement. A social worker follows up with local families.

From a clinical perspective, there were 12 QI teams developed on main morbidities in the NICU. Previously the NICU was an outlier with regard to the rate of bronchopulmonary dysplasia and with several initiatives over the years; now the NICU at IWK reduced the rate to be at the national rates. In 2022 the purchase of a new high frequency jet ventilator helped to improve the rates. Other interventions were added to this initiative. The leaders identified a spike in the incidence of CLABSI and a thorough analysis takes place to identify any risk factors.

This year the province provided funding to increase the number of beds in PICU to six beds and to provide the staffing needed. They have a new nurse practitioner. In cases of surges, they can accommodate up to 12 patients in the unit and then to overflow in the PACU area.

A discussion with families of patients in PICU indicated a high level of satisfaction with services provided to them, efficiency of staff, and explanations provided in a timely manner. The staff get regular feedback from patients and families.

Priority Process: Decision Support

Patient and family privacy is a priority in the NICU and PICU. Health records access is limited to only those who are within the circle of care. The paper-based health records provide a significant amount of information, that is well organized. Random audits of the clinical charts are done regularly.

Priority Process: Impact on Outcomes

There is a strong QI and patient safety work in NICU. They have two designated staff to follow through and evaluate events entered in the SIMS (safety incident management system). They will do the analysis and present the trends and findings to the staff. They have more than 30 safety coaches trained as part of Solution for Patient Safety. They celebrate the near miss and good catch moments. The events entered in the SIMS are discussed monthly at the safety committee and there is a quarterly QI newsletter.

Regular mortality and morbidity meetings take place to identify cause of death and what could be improved for future similar cases. The last serious safety incident led to development of a protocol to review the insertion of PICC lines.

In PICU, in January 2024, a delirium screening bundle will be implemented as currently the delirium assessment and level of sedation is not evaluated and documented regularly.

In PICU there is a strong research interest around family presence and how the staff can reduce the anxiety by understanding their needs. The team are planning carefully how to choose patient partners due to high the variety of patients who are admitted into the PICU.

In PICU there was a culture shift with regard the placement of tickets in SIMS. There is a strong culture that events entered into the SIMS system are an opportunity to initiate conversation and improve practice; most are related to medication management and care management. There is a quarterly QI newsletter. There were no CLABSI events for more than three years and the last serious safety event was more than three years ago. There is strong research around the family presence and experience in PICU which is part of three national studies.

Priority Process: Organ and Tissue Donation

IWK has all the required policies and training up to date for the team to work on the development of the donation after cardiovascular policy death. There is an educational binder, and the team are actively evaluating for potential donors. The legacy coordinator is contacted when a family needs to be approached and will gather the consent from the family.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
3.10	The team evaluates and documents each team member's performance in an objective, interactive, and constructive way.	
4.1	The physical environment has clear signage in place to direct clients to the imaging service.	
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
17.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

The team members, physicians, and leaders of diagnostic imaging are committed to providing safe and quality services. There is a robust array of services and programs provided including; MRI, nuclear medicine, bone density, Nova Scotia Breast Screening Program, ultrasound, and x-ray. The services and programs are supported by a dedicated inter-disciplinary team including, technologists, technology assistants, radiologists, nurses and administrative support professionals. The leaders are visible and engaged in quality and safe care and environments for clients and team members. The commitment to quality includes the review and revision of the Quality Committee. A new Quality Committee and Safety Committee will be established in early 2024. The terms of reference and purpose of the committees have been re-defined. It is anticipated that this will result in an enhanced focus on safety, access and quality improvement. The leaders are encouraged to continue with this important work. There is a radiation safety officer. Appropriate licences from Health Canada are in place. Team members participate in huddles and quality assurance activities. Wait times are monitored. The leaders are encouraged to continue to implement robust quality assurance processes. One such opportunity was noted as strengthening document control processes. Quality boards using a standardized format are located throughout the Diagnostic Imaging department however, there is opportunity for the quality boards to be expanded to include increased information about quality improvement. There is evidence of quality improvement initiatives such as the diagnostic imaging booking and registration process review. The leaders are encouraged to continue to support the team members in quality improvement activities. This includes quality improvement education, training and support.

The diagnostic imaging department at IWK Health and the Nova Scotia Breast Screening Program at the Halifax Shopping Centre were clean and well maintained. There were waiting room spaces for clients and families. There were spaces to have private conversations. Clients and families had access to areas to prepare for procedures. The equipment is well maintained with preventative maintenance completed.

There is evidence of people-centered care. The team members work diligently to coordinate appointments for clients and families. The clients and families spoke highly of the care provided. A client stated, “I am having my baby here. I have heard such good things about the hospital.” Another client stated, “As soon as I see [Name] my concerns fade away.” The team members were viewed as caring and compassionate. The clients and families stated that they were treated with care, dignity and respect. The clients and families identified opportunities for improvement including increased parking and improved way finding. A team member was responsive to the needs of the client and walked them to the entrance after their appointment.

Collaboration and teamwork were noted as reasons why team members enjoy working in diagnostic imaging. The team members stated that they received education and training to support them in their work. The orientation process was described as strong. The team members stated that they feel safe at work. They described having appropriate personal protective equipment. A team member identified an opportunity to practice mock codes such as a medical emergency. There is an organizational structure for diagnostic imaging. Radiologists of the pediatric diagnostic imaging department are accountable to the chief of radiology, IWK Health whereas, the radiologists in the adult diagnostic imagining department are accountable to the chief of radiology, Nova Scotia Health Authority. The organization is encouraged to explore the accountability and reporting relationships to ensure clear lines of authority to support safety, quality and access. The team members noted that performance evaluations are not completed on a regular basis. The leaders are encouraged to continue their plan to evaluate and document team member's performance in an objective, interactive and constructive way.

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		
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
9.14	Clients and families are provided with information about their rights and responsibilities.	!
Priority Process: Decision Support		
14.8	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		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
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 (ED) at IWK Health provides pediatric emergency services to the local community and tertiary services. There is a strong partnership within the organization to ensure effective flow through the ED., and the ED has a clear role in the emergency response plan.

The focus of leadership is not only the flow of patients through ED but also gaining full complements of staff, diversifying the skills mix along with expanding the number of physicians and nurses. Staff retention is another goal for the leadership. They have implemented new ways to hire and train new graduating nursing staff using a preceptorship model.

Nurses in the department are very proud to work at IWK Health and the main stated reason is their sense of belonging to the team. The team culture is strong across different areas of ED. The physicians describe the environment as very supportive, and they identified as a positive trait that the safety events are reviewed regularly and discussed with the whole team. The new nurse practitioner was very satisfied with her work, as it allowed her to work to full scope of practice, to see patients independently and to do research and QI work.

A new location for the emergency department is under way and patient and family representatives were engaged in the design process. The staff were proud regarding positive feedback from patients, and they have a Kudos dashboard. Managers have a process in place to review patient and family feedback and actions are taken and implemented if needed. An increased involvement of patients and families in various activities and strategy development is noted. In a phone discussion with a patient/family advisor who was on the Patient and Family ED Committee, it was noted that there are eight or nine patient/family advisors for the ED only and they were involved in various activities and initiatives such as service design and monitoring, and the mix of skills and experience within the team.

The aging of the infrastructure is evident and there is a lack of equipment storage, meaning it is often present in hallways. Further enhancement of the current footprint may be considered to be more child friendly.

Priority Process: Competency

There is a comprehensive orientation for new nurses over a three-week period. Online training takes 7.5 hours and seems to be comprehensive. There were a lot of new hires in the last 12 months and therefore the percentage of nursing staff with mandatory training up to date is higher than previously. Comprehensive training is provided through four clinical education days per year, including infusion pump training. Online modules in the learning management system (LMS) provide the mandatory training (confidentiality and privacy, respectful workplace, hand hygiene, and Safety Improvement Management System). Simulations are carried out at least once a week.

Professional development plans and annual performance evaluation for nursing staff in the emergency department are not up to date. There is a plan in place to implement a pilot in certain areas of the hospital with the new format and framework for evaluation. More involvement of patients and families on the training curriculum for orientation could be considered. Nurses have multiple opportunities within and outside the organization to improve their skills and knowledge and promote growth. A more robust process to monitor the renewal in mandatory training may be considered for the ED as it currently is challenging to easily extract the data.

Safety concerns and incidents are managed through the SIMS (safety improvement management system) and all staff had training on workplace safety and non-violent crisis intervention.

Priority Process: Episode of Care

The entrance to the ED is clearly visible. Parking is challenging for families. The triage is clearly indicated for patients and families. Currently in the waiting area, there are two separate zones for segregating the patients based on their symptoms to provide better isolation. The separation is made by a transparent wall. Patients are admitted directly from the ambulance bay.

Rights and responsibilities weren't easily available in the ED, which was raised in the last Accreditation report. Currently the rights and responsibilities document, called Partners in Care: Our Shared Rights and Responsibilities, is being revised and will be rolled-out in 2024. The Partners in Care document was revised with patients and families and awaits feedback from healthcare professionals. We weren't able to review the draft of the document. Patients indicate they feel safe and included in the care.

In the waiting area in the emergency department there were no posters that explained how a patient or family could file complaints or any other feedback. Business type cards were available at the nursing stations with the information needed to file a complaint. The Interpreter on Wheels mentioned in the previous Accreditation report was in place and staff were very satisfied using it. A parent who attended the ED several times, mentioned that the physician used the mobile translator when he couldn't understand the explanations in English well.

Most of the consents for the procedures performed in ED are done verbally and when the decision to admit a patient is taken, a pharmacist is called to start the BPMH process.

Often the discharge information is provided verbally to patients. There are a variety of standardized pamphlets for most of the pathologies seen in ED, but for more complex patients, some physicians may type a letter to provide tailored information and instructions to parents and patients. There is an opportunity to develop a standardized discharge summary in ED as there are in other clinical areas.

Priority Process: Decision Support

In the Emergency Department, there is a hybrid clinical chart and documentation using both paper and an electronic version in Meditech. Most of the documentation is done on paper and a better system to track the paper clinical charts in the department may be considered. In 2025 the aim is to have all parts of the clinical chart electronically by implementing a new EMR.

Evidence-based protocols are in place for key pediatric emergency conditions through care directives. The team participates in TREKK (Translating Emergency Medicine Knowledge in Kids) which allows the team to provide best practices.

Priority Process: Impact on Outcomes

There is a quality, operations and patient safety committee (QUOPS) for the emergency department that includes patient partners. In the binder provided and from discussion with the nurses and the new nurse practitioner, many quality improvement initiatives related to faster triage and faster access to ED services as well as around assessment were identified. The nurse practitioner is currently doing a quality improvement initiative related to double checks for controlled drugs. She was very keen to share the findings of the QI project when available. There are opportunities to increase visibility of the impact of these initiatives through visual management/quality dashboards. The current quality dashboard could be updated with more recent results.

The existence of the ED Patient and Family Advisory Council has been documented to be from early 2020. There is a summary of the priorities discussed at their monthly meetings. Items discussed with patient partners were related to the availability of information about food options available to patients in different zones in ED, the space in the triage and waiting area, as well as the design of the new space. The patient and family advisory council suggested the possibility of launching virtual clinics, access to Wi-Fi and data and to new technology. There was an orientation package for onboarding the patient and family advisory council members.

Priority Process: Organ and Tissue Donation

Nursing staff receive training related to organ and tissue donation. All standards were met in all areas.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.12 A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency	
9.7 Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care	
10.1 Clients and families are provided opportunities to access spiritual and cultural activities.	
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 IWK Pediatric Advanced Care Team (PACT) serves children with life limiting illness in the Maritimes. They provide inpatient and outpatient consultation as well as home visits and primary management of palliative care at end of life when needed. The clinical team is small and mighty and dedicated to providing the best support for their families. The team also provides education and support for teams supporting children with serious illness. The current team is not staffed to provide services 24 hours a day, seven days a week and yet they do so to support their families (one in two calls for the physicians and no vacation or leave coverage for any of the team members). Increased support to promote wellness and sustainability of this essential program is encouraged.

The team members are caring and invested in improving the life of children with serious illness and their families. They are linked with the various pediatric palliative programs across Canada and North America. Some of the members have worked with members in the community and are working on creating a pediatric hospice for the Maritimes, which is lacking unlike other provinces. They hope to provide quality palliative care that includes respite services. Multiple family letters show the need for respite services due to the lack of adequate in-home respite services in the Maritimes.

It would be beneficial to support this enthusiastic team as continued efforts without parallel organizational support can lead to burnout, and work in this field also yields much moral distress. There arerecruitment challenges and succession planning is needed. Overall, the Pediatric Advanced Care Team are determined to provide optimal palliative care for those in Maritimes and would benefit from increased support and recognition.

Priority Process: Competency

PACT (pediatric advanced care team) provides education and support for teams supporting children with serious illness. The current team is not staffed to provide services 24 hours a day, seven days a week and yet they do so to support their families (one in two calls for the physicians and no vacation or leave coverage for any of the team members). This is not sustainable. It is suggested to increased support to promote wellness and sustainability of this essential program.

Priority Process: Episode of Care

The PACT (Pediatric Advanced Care Team) is a consultative service so the Episode of Care criteria may not be entirely applicable. They provide bereavement services for IWK and the rest of the Maritimes. They have worked on streamlining their resources, so they are accessible.

Spiritual care service at IWK no longer exists since the 2019 survey. This is an essential service that supports holistic care. PACT does not have their own spiritual care health professional.

Priority Process: Decision Support

The PACT members are building relationships and formal processes of communication and information sharing with teams such as perinatal services and oncology. As the physicians are also the physicians for the complex care program, there is close linkage between PACT and complex care that can lead to some blurring of roles.

Priority Process: Impact on Outcomes

The PACT team is mindfully working on creating a family advisory council with membership from parents with varied lived experience. They have input from families and patients directly and seek to make improvements as requested by families. The clinical team manages and tracks the QI projects as well as clinical performance measures. More support by the organization for QI and clinical performance measurement as well as a paid patient/family partner would be helpful.

There is space limitation at IWK and the current clinic allotment for PACT is only one day per week and in a room that does not meet the needs of the patients (for example, wheelchair, lift system). There is a barrier to accessible washrooms that limits care for patients in wheelchairs and who needs a lift. A parent's letter indicated that the clinic space is not family-centred and trauma-informed.

Many of the patient population overlap with that of the patients served by the Complex Care service. Both physicians also work for Complex Care. Complex Care service is relatively new and does not yet have an infrastructure. As PACT and Complex Care serve a population that is growing in number and complexity, it would be helpful for the organization to increase the support for the two programs.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
14.1 There is a quality improvement plan for the IPC program.	!
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

The Infection Prevention and Control (IPAC) team at IWK Health is to be commended for the leadership and expertise that they have provided both within and outside of the organization during the COVID-19 pandemic. The team is passionate about their work and described a cohesive, collaborative approach to handling the ever-changing landscape during the pandemic. Their ability be nimble and flexible to respond to staff, physician and client needs was evident in the ongoing work they were able to accomplish. They credit their success with their ability to foster collegial, trusting relationships that makes the IPAC team a true partner across all aspects of the organization. They are to be commended for their exemplary record throughout the pandemic of having no outbreaks within the facility.

The team has 2.5 FTE IPAC trained staff and co-leadership of a Pediatric Infection Control Disease Specialist and IWK leadership. This demonstrates a commitment to patient safety and delivering evidence and best practices in the field. The Infection Prevention and Control Committee has representation across the organization to support IPAC practices. This interprofessional committee oversees the operation of the IWK Healt's IPAC program. The overarching aim of IPAC is to minimize the transmission and acquisition of healthcare-associated infections through the application of evidence-based guidelines and practices. This committee takes ownership of policy and procedure guidelines regarding the application, implementation and evaluation of infection prevention and control standards. They review and evaluate infection control initiatives for improving patient care practice and health outcomes using targeted surveillance for healthcare associated infections, support education and research strategies, as well as evaluate health-centre wide infection prevention and control activities.

The team is dedicated to improving client outcomes through gathering and sharing of information on health care-associated infections and significant findings are shared with other organizations, public health agencies, clients and family and their community. Trends are monitored and tracked to understand opportunities for improvement. Additionally, the team provides expertise for ongoing construction, renovation and maintenance projects. They play an important role during all stages of a construction project. They have input into decision making, complete practice audits and ensure thorough cleaning after the completion of the project.

There is evidence of hand hygiene education, auditing and monitoring to ensure compliance. The team has seen an improvement in metrics and continue to have an elevated presence across the organization to

There is evidence of hand hygiene education, auditing and monitoring to ensure compliance. The team has seen an improvement in metrics and continue to have an elevated presence across the organization to promote practice. There was a desire/request in the surgical program-PACU to have hand hygiene audits performed. Considering new ways of being able to incorporate outpatient areas in audits to support the delivery of safe care is encouraged.

The Environmental Services Department has clear processes in place to support staff to understand expectations, roles and responsibilities within the organization to promote health and safety through cleaning practices. Staff are supported through auditing followed by feedback and course correction as needed.

Areas for improvement were identified in establishing formal processes for bringing new equipment and products into the organization that involves IPAC team input to ensure they meet applicable standards to promote best practice. The team is not currently involved in all equipment and product evaluations but are consulted randomly. Another area to consider is formal audits of the areas throughout the organization on an annual basis to ensure the teams are meeting best practice standards through an IPAC lens. Some units were noted to have surfaces that would not be able to be cleaned effectively and paper posted in clinical areas that was not laminated or behind plastic that could be properly cleaned.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
1.6	Services are reviewed and monitored for appropriateness, with input from clients and families.	
Priority Process: Competency		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
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		
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Pediatric Medical Unit (PMU) has a dedicated, enthusiastic leadership team, committed to ensuring safe delivery of care to the paediatric population they service. They are funded for 19 beds but have capacity for 24 inpatients. Patients can be admitted with a variety of diagnoses with respiratory illnesses identified as the most common presentation treated. The rooms are well designed to support family-centered supportive care and the unit is child-friendly and welcoming.

The Pediatric Medical Team Committee meets to develop annual goals and objectives for the Pediatric Medicine Inpatient Unit. The plan includes policies, priorities, implementation and evaluation procedures. They review current practice, and recommend, develop and implement new components to the service as well as provide a forum for collaboration and communication. The team has recognized that imbedding a patient partner on this committee could provide valuable insight to inform program design, with goal setting that meets the needs of the population they care for. Other methods of capturing patient feedback could be through rounding and patient surveys. Currently survey response rate is very low. Considering how to improve response rates is encouraged.

There is a multidisciplinary approach to providing care on the pediatric medical unit and strong partnerships exist across Children's Health Services at IWK to meet identified needs. An example of an initiative that supports patient care is the implementation of a shared care model for patients requiring both medical and mental health care. Both teams collaborate on the best approach to care by developing a care plan to address the needs of the patient, including safety plan, care needs and appropriate space needs.

Priority Process: Competency

The team has developed a very comprehensive orientation program designed to ensure staff are confident and competent to provide care on the unit. Ongoing education ensures that staff have additional skills to provide safe care. The team has expected competencies that they must demonstrate as they progress from novice to competent in all aspects of care on the unit. The team monitors staff progression to ensure an appropriate skill mix because half of the current team has less than two years' experience. Staff report feeling well prepared and supported to work on the PMU (pediatric medical unit) through educational offerings and learnings available to them.

There is evidence of a documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, training, evaluation of competence and a process to report problems with infusion pump use is implemented. This is in alignment with the organization's strategy for infusion pump safety.

There is an ethical framework within IWK to guide practice however a need was identified to ensure that staff feel comfortable in handling ethical issues including conflicts of interest, conflicting perspectives between patient and family and/or team members, and varying beliefs or practices.

There is a strong leadership presence within the inpatient program to help support staff and guide practice. The expectation is to provide formal feedback to staff annually. The process/program for delivering performance discussion is under review and the team is encouraged to continue to move this project forward and imbed it into routine practice. Staff interviewed felt like they received informal feedback but were looking for more feedback on performance.

The interdisciplinary team works collaboratively to provide care working closely with patients and families through daily rounds. Bedsidedaily rounds also occur with the patient and family present to be involved in

decision making and care planning. The team has adopted standardized tools for transition between care providers and other teams. The tools were observed to be consistently used. Considering the implementation of bedside shift reports to continue to improve delivery of safe patient care is encouraged. White boards in patient rooms are used as a communication tool for patients but were noted to be inconsistently filled out with all the relevant information.

Priority Process: Episode of Care

The team has met all the Required Organizational Practices applicable to the Pediatric Medical Unit. To prevent falls and reduce the risk of injuries from falling, universal precautions are consistently implemented, education and information are provided, and activities are evaluated. There was evidence of daily falls risk assessments completed on charts. If a fall occurs the incident is recorded in the safety management system allowing the team to review processes to make improvements when needed.

Upon admission a Best Possible Medication History (BPMH) is generated and documented. The admitting physician and pharmacist reviews each medication and orders the appropriate therapy for the patient. Compliance with medication reconciliation is tracked and monitored for improvement opportunities.

To strengthen patient safety and reduce the occurrence of harm to patients by ensuring timely response to medically deteriorating patients the team has implemented Children's Early Warning Score (CHEWS) on the medicine unit. This tool helps teams identify subtle changes in patients' clinical status to initiate early intervention and management to improve patient outcome.

Priority Process: Decision Support

The team is currently working towards upgrading the organizational health information system. Current state is a paper document with a few electronic modalities available. A more robust system can help coordination of care and improve patient outcomes. The desire is for the new system to facilitate clear and comprehensive documentation of all aspects of patient care including care planning and the transition of patients from one area of care to another. Staff are looking forward to this change. Recommended is clear and consistent communication to staff regarding the upcoming changes and the impact to their workflow to ensure success. Ensuring that all stakeholders are included in the planning and implementation of a new system is encouraged.

The team performs audits of documentation to look for areas for improvement. They use a standardized tool to check for completeness and accuracy. The organization has policies and procedures for securely storing, retaining, retaining and destroying client records that are in accordance with legislations.

Priority Process: Impact on Outcomes

The team is moving towards having a Patient Family Advisor for the Pediatric Medicine Team Committee. This initiative will help ensure the voice of the patient is imbedded in informing the team. The purpose of this committee is for discussion, recommendations, planning, implementing and evaluating quality management for the medicine program.

Patient safety incidents are reported according to the organization's policy. The team reviews incidents to understand opportunities for improving process and patient satisfaction. Quality reviews are conducted as needed or requested. The team strives to promote a Just Culture to support staff in understanding and embracing the process.

The team could consider a formalized approach to monitoring and displaying quality indicators important to quality and safety on the unit. Sharing the metrics make it possible to monitor progress towards meeting quality improvement objectives. Analyzing data helps identify trends and may reveal areas that could be considered for future quality improvement initiatives. Sharing the data helps engage frontline staff to become problem solvers and ensure they are informed of quality improvement initiatives that are aligned to program goals and the corporate strategy.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Medication Management

The Drugs and Therapeutics Committee is an integrated multidisciplinary team that looks at mechanisms to guide the medication management system for IWK Health clinical operations. The organization has recently implemented a Medication Management and Safety Steering Committee that is focused on improving safe medication management practices. This is described as an initiative that goes beyond maintenance of the formulary and development of protocols that support clinical practice.

The strategic directions of the organization speak to a focus on improving safety by reducing/eliminating adverse events. The Safety II approach has been adopted as a framework. This approach focuses on prevention of serious incidents by catching near misses and identifying and mitigating upstream issues instead of retroactively looking at the fallout of incidents that have already occurred The Medication Management and Safety Steering Committee is aligned with the intent of this organizational initiative.

Planned renovations to the pharmacy have been undertaken since the survey in 2019. These renovations improve workflow, enhance workplace safety, and reduce distraction for individuals who are performing quality assurance activities. Investments in technology such as Omnicell storage and distribution systems, Pyxis dispensing systems, and the system that performs volumetric/gravimetric verification of sterile products demonstrate the organization's commitment to a safe and efficient workplace.

Medication storage, preparation, and distribution areas throughout the facility were seen to be dated but well organized, secured, and observant of safety and patient flow. There is a rigorous program to maintain and update smart infusion pumps along with annual training on their use.

There is good engagement at the point of care in safe medication management practices, free of distraction, and allowing for communication with patients and family members. In pediatric oncology the unit has implemented a "take your MAR with you" approach to improving quality and safety in medication administration.

A number of measures have been undertaken to address medication reconciliation. This is a process that was seen to have various interpretations in various units. There are consistent approaches to collecting information to create a Best Possible Medication History but variation in the understanding of the next steps to complete the process.

The presence and engagement of pharmacists in consultation with staff and physicians at the unit level is notable. Many quality assurance activities were witnessed throughout the tracer activities for this priority process.

As noted in the 2019 Accreditation survey IWK Health is recognized as a leader in the country for its Antimicrobial Stewardship Program. This work has a continuous quality improvement approach built in. The work continues to identify best practices, to incorporate those practices into policy and procedure, and to communicate, educate, and offer consultation service to practitioners.

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	
9.15 Access to spiritual space and care is provided to meet clients' needs.	
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 mental health leadership team has developed a robust program plan with a set of key performance indicators to measure the success toward goals.

Priority Process: Competency

The Mental Health Program has a robust plan that is documented, implemented and evaluated to ensure staff are trained and competent to deliver services based on standardized approaches that are evidence informed.

Priority Process: Episode of Care

Some standardized assessment tools are used for the assessment such as falls risk, suicide risk and risk for skin breakdown, however there is NOT a standardized psychiatric/mental status exam tool to ensure consistent assessment upon admission to hospital.

There was a manual on the unit to guide staff to create individualized care plans for patients, however there were no references to what evidence these guides are based on. The inpatient team would benefit from having a more standardized protocol for treatment approaches that is evidence-informed, then customized for each patient as needed.

Most patients wear wrist bands. The patients who refuse or remove them are asked their full name and DOB.

The team uses a standardized transition communication tool at each 12-hour shift and more thorough standard tools are used upon transitions such as at discharge.

Priority Process: Decision Support

The team has a process whereby the Nurses on night shift follow a checklist every night to ensure patient records are complete. Impressive.

Priority Process: Impact on Outcomes

The leadership team is very focused on continuous quality improvement and measureS key performance indicators aligned with program and organizational goals. However, there was little to no visible evidence of this being used or communicated on the unit.

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		
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
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		
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.6	New or existing indicator data are used to establish a baseline for each indicator.	
18.7	There is a process to regularly collect indicator data and track progress.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Women's and Newborn Health Program (WNHP) has a comprehensive team approach to obstetrical, newborn and gynecological care. There is a co-leadership model that is shared between IWK administration and physicians to drive excellence in care and practice. The operational team works closely with individual department teams to connect departmental goals and objectives to the overall strategy of the organization. There are approximately 4,500 deliveries annually by a dedicated group of obstetricians, family practitioners and midwives. They review the demographics of the area to ensure that they are meeting the demand within the system and try to plan for fluctuating needs. The team provides care to both high risk and low risk obstetrical patients. Care is delivered in many locations starting in a triage area linked to a seven-bed early labour assessment unit, progressing to a 13-room birthing unit with two dedicated operating rooms for Caesarean sections and a swing OR. The postpartum unit has capacity for

40 patients and there is a 12-bed high risk antenatal unit partnered with a 12-bed surgical gynaecology unit. All units have a multidisciplinary team providing evidence based, best practice care to ensure excellence in patient care.

The WNHP program continues to thrive and evolve despite the ongoing staffing challenges faced by many of the departments and documented across the healthcare industry. The team within each department monitors staffing levels and skill levels regularly to ensure staff and patients are well supported. They recognize that there is an increased need to focus on recruitment, retention and the well-being of their staff as evidenced by the clinical supports in place for frontline staff. The team is supported by departmental managers, operational managers, clinical nurse specialists and clinical operational leadership.

Priority Process: Competency

The Women's and Newborn Health Program recognizes the importance of education and training to support the safest and highest quality care to their patients. A thoughtful approach to mandatory training is in place that meets practice recommendations. Clinical leaders of development are responsible for coordinating/leading educational offerings as well as tracking compliance with mandatory education. The educational orientation is comprehensive, and staff felt well prepared, confident and competent to work in the areas. The team has a solid plan to support and continue to provide ongoing education to all staff. An opportunity to continue to advance a culture of patient safety on the unit is to bring MOREOB or a similar program to the obstetrical program. The team identified that, due to the increasing number of novice staff, there would be a benefit from this comprehensive performance improvement program that creates a culture of patient safety in obstetrical units. The team regularly runs mock codes for obstetrical emergencies and should continue using this method as a valuable learning tool.

The team is encouraged to continue their efforts with implementing the Fresh Eyes approach to fetal health surveillance as a way to provide consistency in hand-over communication and promote patient safety. Additional tools are consistently used throughout the various programs to enable safe transitions in care. Bedside whiteboards were available for two-way communication with patient, family and between teams but were noted to be inconsistently used.

There is evidence of a documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, training, evaluation of competence and a process to report problems with infusion pump use is implemented. This is in alignment with the organization's strategy for infusion pump safety.

There is a strong leadership presence within the Women's and Newborn Health Program to help support staff and guide practice. The expectation is to provide formal feedback to staff annually. The process/program for delivering performance discussion is under review and the team is encouraged to continue to move this project forward and imbed it into routine practice. Postpartum will pilot the new process early next year.

There is an ethical framework for the organization but a lack of understanding of the application at the frontline. Consideration of further education at the frontline for the ability to identify and navigate issues is encouraged.

Priority Process: Episode of Care

Staff are trained to provide care in the two operating rooms on the unit following ORNAC standards. Dedicated staff for planned Caesarean sections are trained in an approved operating room course and help train all birthing unit staff to scrub and circulate in this area. The surgical safety checklist is used to confirm that safety steps are completed for Caesarean sections. The team has expanded the three-phase checklist to a four-phase checklist for added safety.

The team has a comprehensive admissions procedure that is completed in partnership with the patient. They use an OB triage acuity tool to help standardize a consistent approach to identify and classify women/pregnant individuals based on acuity to direct flow and care delivery within the department. Nurses working in triage are trained to apply and understand the tool.

The team across the program has policies and procedures in place to meet all Required Organizational Practices. They have included SOGC guidelines for best practice within policies for oxytocin administration and fetal health surveillance. The team participates in the WHO Baby Friendly Initiative and are currently seeking recertification. There is evidence of the required practices in the feeding policies/practices and skin to skin immediately following birth either with mom or dad.

The midwifery clinic at Highfield centre serves patients who would like to have a home birth and meet specific criteria (low risk for birth complications and system barriers). The midwives are well integrated to the IWK and feel valued and well supported by leadership. The clinical care guidelines and policies used by midwives are those endorsed and supported by the IWK and/or the Midwives Association of Nova Scotia. Self-referral is possible and continued care through the bridging program for unattached newborn program. There is a clear process for patients to receive escalated delivery support should care needs change. Compared to 2019, there continues to be a high demand for this service and the waitlist is long. They have hired many midwives to meet the demand but in the short-term period there is understaffing due to parental leaves. The clinic location will move in 2024 when the midwifery clinic moves to the new Dartmouth clinic where they will be with other professionals serving maternal health - obstetrics, family practice and physiotherapy. They receive feedback from patients formally as the patient receives a feedback form along with a postage paid envelope. Patient do not receive a copy of their medication list but receive a copy of the birth record. Increasing support for quality improvement activities is encouraged, such as the current midwife led QI activities that have been well received - for example, water birth at IWK.

Priority Process: Decision Support

The Reproductive Care Program of Nova Scotia has a perinatal database that contains demographic variables, procedures, interventions, maternal newborn diagnosis and morbidity and mortality information for all pregnancies and births occurring in Nova Scotia hospitals. The Women's and Newborn Health Program receives regular reports that describe mortality, morbidity and selected outcomes for their population. The team is encouraged to use this data to facilitate and improve care to mothers and babes by linking information and providers to address care gaps. Ensuring this data is shared across the program and with frontline staff to aide in identifying opportunities to improve care is encouraged.

The team is currently working towards upgrading the organizational health information system. The current state is a hybrid combination of both paper and electronic charting. A more robust system can help coordination of care and improve patient outcomes. The desire is for the new system to facilitate clear and comprehensive documentation of all aspects of patient care including care planning and the transition of patients from one area of care to another. Staff are looking forward to this change. Recommended is clear and consistent communication to staff regarding the upcoming changes and the impact to their workflow to ensure success. Ensuring that all stakeholders are included in the planning and implementation of a new system is encouraged.

Priority Process: Impact on Outcomes

Patient safety incidents are reported according to the organization's policy in the safety incident management system (SIMS). The teams expressed a comfort with the SIMS and were able to articulate safety risks they would enter. The incidents are monitored for trends and tracking to help inform practice and quality improvement opportunities. The team on the post-partum unit have daily safety huddles where events can be discussed. The teams have informal debriefings after an event and safety concerns can be escalated for formal reviews, root cause analysis and case reviews. The team recognizes that they do not always link back with the frontline staff for follow-up and an opportunity exists to close the loop.

The team was able to articulate many quality improvement activities that were in progress, however there is not a quality board on the unit to understand what teams are working on. Indicators that monitor progress for quality improvement are not consistently collected or displayed at the front line to align unit goals and objectives with the overall strategy of the organization. Consider having consistent quality boards that would allow frontline staff to participate in quality improvement opportunities and align their work to corporate strategy.

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	
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: Organ and Tissue Transplant

The team providing care and coordination for pediatric renal transplant services are passionate, caring and knowledgeable in the service provided and truly deliver a high level of excellence for their patients. Renal transplants have been performed for IWK patients in partnership with Nova Scotia Health Authority since 1971. While most renal transplant surgeries are performed at the IWK, the coordination of the surgeries and surgical expertise itself are provided by the staff and physicians of Nova Scotia Health's's Multi Organ Transplant Program (MOTP). There is a memorandum of understanding the clearly outlines the sharing of transplantation services which outlines responsibilities and accountabilities.

Review and update of policies, processes and procedures are the responsibility of MOTP every two years. Pediatric patients are assessed using set criteria to determine their eligibility for placement on the renal transplant wait list. Once a patient is identified there is a clear shared accountability for preparing the patient for transplant, managing the condition while waiting, coordination of the transplant through a living or deceased donor and post-transplant care. Collectively the teams manage all aspects of the patients journey to ensure seamless wraparound care.

Priority Process: Clinical Leadership

Pediatric renal transplants have been performed at Izaak Walton Killam (IWK) Health Center since 1971 in partnership with Nova Scotia Health Authority. While most renal transplant surgeries are performed at IWK, the coordination of the surgeries and surgical expertise are provided by the staff and physicians of Nova Scotia's Multi Organ Transplant Program (MOTP).

A memorandum of understanding clearly outlines responsibilities and accountabilities for the teams to enable seamless coordinated delivery of care. Policies and order sets are in place to guide practice and standardize care based on best practice.

IWK is commended for continuing to provide kidney transplant services during COVID-19 to ensure patients continued to receive the care they needed while many organizations paused their transplant services.

Priority Process: Competency

There is attention to ensuring staff have the expertise within the various programs to care for transplant patients perioperatively and within the inpatient settings. Teams have access to transplant workshops, online resources and clinical experts to receive and maintain the skills necessary to deliver care.

The MOTP (multi organ transplant program) provides coordinators and surgeons that work collaboratively with the team at IWK for the purpose of facilitating pediatric kidney transplantation. There is a nephrologist at IWK that is the medical director for the transplant team.

Priority Process: Episode of Care

There are many checks and balances in place to ensure the patient receives the necessary care preoperatively, operatively and postoperatively. The team describes their approach as spoke and hub as they support outreach clinics within four provinces. They credit this approach with improved access to care, diagnosis, treatment and follow up care. They have also had success with involving the Adult Team early to be able to transition care from Pediatric to Adult to avoid any interruption in care delivery.

A patient family interviewed were able to describe their experience with the intake process, education received and care management. It was evident that the team's attention to detail and dedication to the delivery of quality care was demonstrated in the family's preparedness for the journey they were on. The family felt well supported and included in the care planning for their child.

Priority Process: Decision Support

MOTP provides IT/data services. Performance metrics are monitored as required and shared with the teams. The organization has recognized the need to transition from paper-based documentation to an electronic system to enhance safety, communication and transitions in care.

Priority Process: Impact on Outcomes

There is a MOTP Quality Improvement and Safety Team with IWK team representation. Some of their responsibilities include reviewing the performance indicators and scorecard to monitor and evaluate the quality of care being provided to observe trends to identify problem issues and to create a culture of continuous quality improvement in provision of services. They also initiate, where appropriate and required, prospective or retrospective quality reviews and track and review progress with the implementation of quality review recommendations.

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	
10.15 Clients and families are provided with information about their rights and responsibilities.	!
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 pediatric perioperative team are commended for their compassion, family and patient centered commitment to care, teamwork and emphasis on quality and patient safety. The program consists of eight busy operating rooms, a pre-assessment clinic, intake, admission day surgery, PACU, and inpatient surgical unit of 28 beds. Four large surgical services (Orthopedic, neurological, general and cardiac) are very active. The Women's Health perioperative program includes a care team that manages four operating rooms, a redesigned breast surgery operating room, and inpatients beds in the same ward as obstetrics.

There is a high number of learners among nursing and physicians. Nurse practitioners have become an important member of the team and support several specialties.

Further provincial funding was infused in the perioperative services ot provide space redesign and hire more personnel. The space design involved new operating lights and the build of another operating room.

For the next financial year, there is a plan to redesign the PACU area from two stages to one stage to provide more patient-centried care and to allow the parents and family members to be reunited with their children sooner in recovery. All the PACU areas will be single rooms to increase the privacy and reduce the noise. This was planned with patient and family partner involvement.

Developoment of a new endoscopy room is planned to free some OR capacity as all GI scopes are done in the main operating room. Currently there is only one procedure room where small interventions take place such as bone marrow biopsy and lumbar punctures.

The leaders are aware of long surgical waiting times (40 per cent out of window) and further measures aim to increase the throughput by 25 per cent by increasing the operating room space, hiring more nurses and anesthesia assistants. The specialties with the longest waiting list are dentistry, ENT and spine surgery. The leadership identified another site where for two days the surgeons could perform certain surgical procedures on patients older than five years of age and who do not require admission. The pediatric inpatient unit is well designed and very children and family centric. The private rooms allow a parent to have a bed where they can stay overnight and full facilities (toilets, sinks).

The pediatric perioperative team has an excellent program for children with autism.

In the Women's health perioperative area, the Lean initiatives implemented previously were sustained.

Safety huddles and rounds are conducted in the wards by a multidisciplinary team. There is a Quality and Patient Safety Committee that meets regularly for each of the perioperative areas, for children and for women's health.

Priority Process: Competency

The mandatory training is in the LMS (learning management system) and the nurse clinical facilitator has compiled all expiring dates for mandatory training into an Excel sheet. All the nursing staff are up to date with their training. The training for the infusion pump is renewed every two years. The orientation period depends on the skills the nurses have. The nurses are trained to float among admission, recovery room, pre-operative area and the team has an excellent skill mix. There is a fantastic filing system developed by the nurse educator for each of the employees where their annual appraisal is recorded, as well as the self-targeted goals for professional development. Educational opportunities are available for all staff. All the policies are up to date in the perioperative area whereas in the wards this varies between 60 to 70 per cent. The poster related to respectful workplace was present, but the rights and responsibilities for patients was missing.

The safety boards were placed in patient and parent facing areas in the perioperative area and had the hand hygiene rates, and the list of quality initiatives currently being implemented in the perioperative area. In the wards there was an education board and another dashboard on quality and patient safety.

Priority Process: Episode of Care

Pre-assessment clinic is in person, virtual and over the phone and patients are placed across the day surgery area. Not all the patients are evaluated in the pre-assessment clinic. The rooms are friendly. The women's program pre-assessment clinic is private and allows confidential information.

Operative processes and practices in both perioperative areas are very good. The staff is extremely patient, family-centred, and focused on safety and risk practices. Two client identifiers are used when there is a staff change or transitions between areas in the patient's journey. The information is repeated to have the right patient at the right place. The briefing is done in the perioperative area thoroughly by each of the team members. A new quality initiative is to bring all team members in one place to do the briefing together. There was a very genuine approach to respect the patients and families as partners, and both perioperative teams are to be commended for this. Parental presence is encouraged and supported on anesthesia induction. In the pre-operative area, there is a room assigned for patients who require a quiet place or for children who could be anxious and agitated due to new environment. There are standardized discharge instructions, and the recovery team won the Excellence Award.

Flash sterilization was decommissioned in Women's Health, but it is used with some regularity in the pediatric operating rooms. The institution is highly encouraged to reduce/eliminate the use of flash sterilization as it is not a recommended best practice.

There are thermometers in each operating room, as well as suction devices and smoke evacuators. In women's health, the team pays special attention to avoid any pressure injuries and they added this item in the surgical safety checklist (timeout). All team members are very cognizant of normothermia maintenance and warmers for blankets are present in each operating room and patients have an under or over body bear hugger. In the women's health operating rooms, there is a pilot running with a new thermometer probe to have a consistent and accurate temperature monitoring.

The dirty linens and equipment have a separate designated elevator on the children's site and on the women's health perioperative area, they have a well standardized process to contain the used instruments and equipment in a stainless-steel cart. The MDRD had significant flooding this summer and significant efforts were made to return the area to its former purpose. All the equipment and sterile instrumentation are in the pediatric central core area and the health care aids were very knowledgeable there. Equipment is also stored in the women's health perioperative area and the equipment for the procedures comes in the same stainless-steel carts.

In the pediatric and gynecology wards, there was a significant number of new hires and significant efforts are in place to support their growth. There are more safety events related to medications and infusions that are related to the influx of the new hires. This is a reflection on nurses who are feeling very comfortable to place safety events in SIMS to initiate a discussion and to have a wider look into the education and current practices. Retention of new hires is one of the main goals of ward managers along with staff wellness.

Across all areas, there is a very strong team spirit and people are very proud to be part of their team and highlight collegiality and support when needed. The perioperative area is to be commended for their team spirit and their culture. The patients and families appraised highly the services provided by all teams highly.

Priority Process: Decision Support

Health records are all manual and patient tracing in the preoperative area is with the help of a whiteboard while maintaining the patient privacy. Only the physicians and discharge summaries are dictated and printed. Health records are complete and organized in sections. The handovers between teams are accurate and standardized. Staff are readily able to locate the forms and information when they need to review the folder with patient data.Health records are all manual and patient tracing in the preoperative area is with the help of a whiteboard whilst maintaining the patient privacy. Only the physicians and discharge summaries are dictated and printed. Health records are complete and organized in sections. The handovers between teams are accurate and standardized. Staff are readily able to locate the forms and information when they need to review the folder with patient data.

Priority Process: Impact on Outcomes

There are significant quality improvement initiatives across the pediatric perioperative areas. There is also an overwhelming sense of pride in all perioperative areas and inpatient units. Staff are very engaged and happy to work in their areas. The patients were very satisfied with the services provided to them.

From the quality initiatives perspective, anesthesia implemented an initiative to amend the fasting guidelines and further PDSA (plan, do, study, act) cycles are needed to improve the parents' and patients' education.

Under the guidance of the NSQIP champion there are several quality initiatives in progress in the perioperative area related to timing of skin preparation, adequacy in choosing the skin preparation, and multidisciplinary briefing as part of the surgical safety checklist. The IWK is also part of the Solution for Patients Safety. There is a request to have a patient representative on the Perioperative QI Committee.

The time booked for the procedures and the waiting list out-of-window is tracked monthly. The turnaround time in the operating room is tracked and is staying at 17 minutes which is a great achievement.

There are regular audits and standardized documentation for ROPs related to pressure injury, DVT/PE prophylaxis, and fall precautions in all perioperative areas.

On women's health, there has been a NSQIP program for the last four years and the surgeons are engaged in addressing surgical site infection and UTIs. Certain elements were added to the previously implement surgical site infection prevention bundles. Early results are promising.

Priority Process: Medication Management

Medication processes are safe and managed well in both pediatric and woman's health ORs. Medications are stored in the central core and the local anesthetic is stored in each operating room. A Pyxis dispenser is present in the core area but also in the wards. The narcotics are locked under a key which is locked in Pyxis. For anesthesia, all the medications taken from the Pyxis were labeled appropriately. Syringe pumps were used during the OR procedures. All the criteria were met in the wards and in the perioperative area.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
2.1	The organization has the appropriate mix and number of staff to carry out POCT. CSA Reference: Z22870:07, 5.1.1.	
10.2	The lab director or suitably qualified health care professional develops and maintains a POCT quality improvement manual.	
Surveyor comments on the priority process(es)		
Priority Process: Point-of-care Testing Services		

There is a strong commitment to quality point of care testing. A Point of Care Interdisciplinary Committee meets on a quarterly basis. A medical director provides oversight for point of care testing. This committee reviews resource requests, audits, accreditation, and safety issues, to name just a few. The leaders are encouraged to continue to review the committee terms of reference and to make changes accordingly. Training sessions are held for team members. The team and leaders are developing key performance indicators. They are encouraged to continue to develop and monitor quality improvement indicators. The team member and leader noted that a POCT Quality Improvement Manual has not been developed. The leaders are encouraged to ensure that a POCT quality manual is developed. The team members and leaders are encouraged to continue to strengthen document control processes.

The team members stated that the workload for point of care testing has increased significantly. For example, there are approximately nine different types of devices in service, 80 devices in service, greater than 1,000 users, and 50,000 tests annually. There are several new initiatives being implemented including, ABL90 and CLINITEK. The leaders are encouraged to continue to review workload and to make changes as appropriate.

The team members and leaders are proud of the work that they do in supporting point of care testing. They work collaboratively with team members and leaders across the IWK Health. They are dedicated to providing a quality program and work diligently to ensure that quality processes are implemented. They are encouraged to continue to grow point of care testing to meet the needs of team members, clients and families.

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	
6.3 The organization limits access to transfusion work areas to authorized team members only.	!

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Universal fall precautions are identified and implemented in transfusion medicine. There is strong commitment to ensure a safe environment that prevents falls and reduces the risk of injuries from falling. The leaders and team members were unable to recall a recent client fall. The leaders are encouraged to continue to implement universal fall precautions.

Priority Process: Transfusion Services

The transfusion medicine team members and leaders are passionate about providing quality transfusion medicine services for clients. A Transfusion Committee meets on a regular basis. A medical director and technical supervisor support and oversee transfusion medicine. There is a Blood Component Utilization Provincial Program. Weekly huddles occur. Preventative maintenance is completed on equipment used in transfusion medicine. There are strong partnerships with organizations such as, Canadian Blood Services and the Nova Scotia Health Authority. There are quality boards and team members participate in quality improvement initiatives. The leaders are encouraged to continue to engage team members in developing and implementing quality improvement initiatives.

The transfusion medicine program was described as, “A great place to work.” The strong collaboration and teamwork were described as reasons that team members enjoy working in this program. Additionally, they articulated the importance of this service for the people that they serve. The team members stated that they receive education and training to support them in their work. They described robust orientation processes which prepared them to work in transfusion medicine. The team members noted that they feel safe at work and that they have resources such as personal protective equipment to support their safety. They noted that they have the resources to do their work. The team members have identified the need for a clinical educator.

The transfusion work area is clean and well organized. There is sufficient lighting and workspaces. There is a corridor between the transfusion work area and another laboratory department. Team members use this corridor to walk between the two areas. The transfusion team have placed a stop sign with lights at the entrance to the transfusion work area which will be turned on in the event that the transfusion staff are busy and require no interruptions. The leaders are encouraged to ensure that access to the transfusion work area is for authorized team members only.

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: May 9, 2022 to June 8, 2022**
- **Number of responses: 21**

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.	5	0	95	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	5	95	94
3. Subcommittees need better defined roles and responsibilities.	90	5	5	69
4. As a governing body, we do not become directly involved in management issues.	0	5	95	85
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	10	90	94

	% 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.	5	0	95	97
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	93
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	95	0	5	63
10. The composition of our governing body contributes to strong governance and leadership performance.	0	5	95	94
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	96
12. Our ongoing education and professional development is encouraged.	10	10	81	82
13. Working relationships among individual members are positive.	0	0	100	96
14. We have a process to set bylaws and corporate policies.	5	0	95	96
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	5	0	95	98
16. We benchmark our performance against other similar organizations and/or national standards.	5	25	70	76
17. Contributions of individual members are reviewed regularly.	0	21	79	63
18. As a team, we regularly review how we function together and how our governance processes could be improved.	5	16	79	79
19. There is a process for improving individual effectiveness when non-performance is an issue.	18	59	24	57

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	5	15	80	79
21. As individual members, we need better feedback about our contribution to the governing body.	50	25	25	40
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	11	89	76
23. As a governing body, we oversee the development of the organization's strategic plan.	5	0	95	96
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	74
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	10	90	87
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	5	95	90
27. We lack explicit criteria to recruit and select new members.	95	5	0	79
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	5	95	90
29. The composition of our governing body allows us to meet stakeholder and community needs.	5	0	95	89
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
31. We review our own structure, including size and subcommittee structure.	0	10	90	90
32. We have a process to elect or appoint our chair.	0	10	90	93

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 * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	10	90	82
34. Quality of care	0	10	90	83

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2022 and agreed with the instrument items.

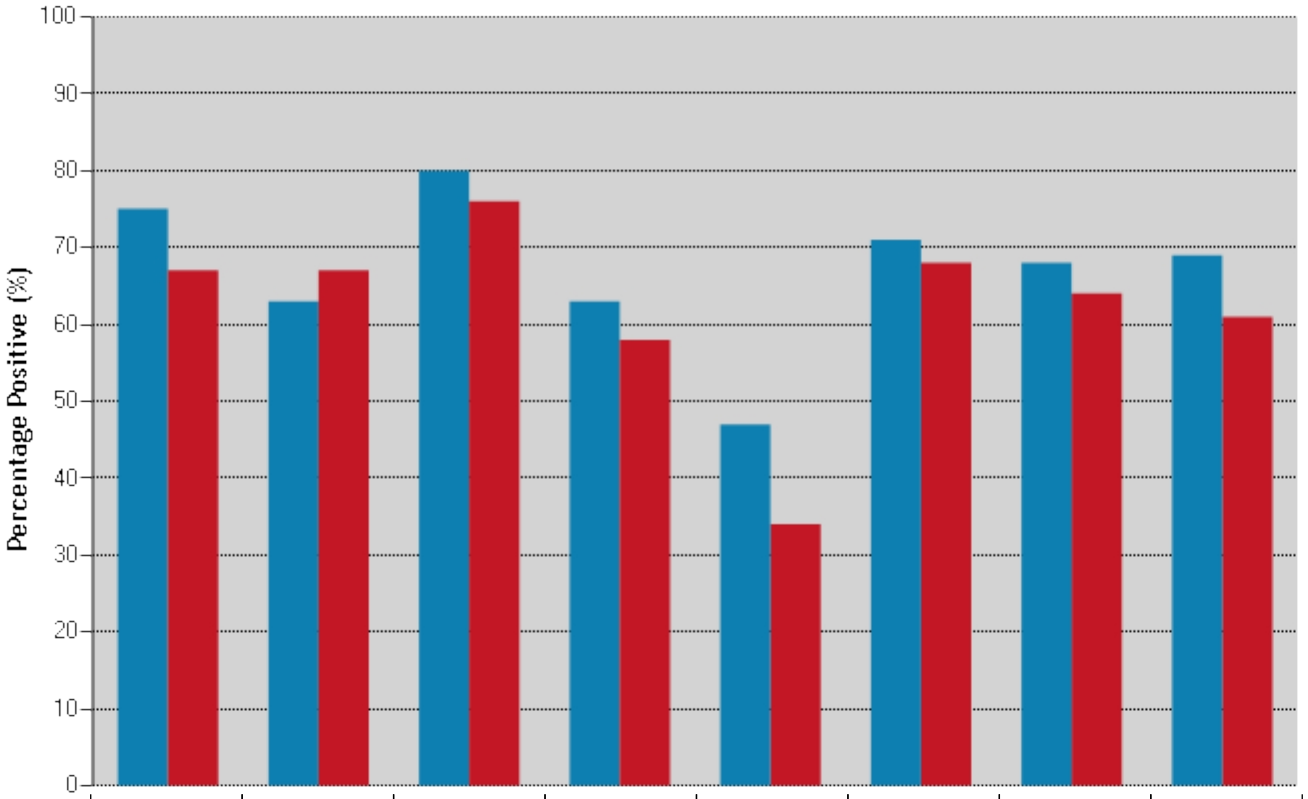
Canadian Patient Safety Culture Survey Tool

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: November 30, 2022 to January 4, 2023**
- **Minimum responses rate (based on the number of eligible employees): 324**
- **Number of responses: 382**

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
	75%	63%	80%	63%	47%	71%	68%	69%
	67%	67%	76%	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 January to June, 2023 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.

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

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

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 20 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
Communication	Communicating effectively at all levels of the organization and with external stakeholders.
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety.
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services.
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings.
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.
Principle-based Care and Decision Making	Identifying and making decisions about ethical dilemmas and problems.
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources.

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and direction to teams providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services.
Decision Support	Maintaining efficient, secure information systems to support effective service delivery.
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Partnering with clients and families to provide client-centred services throughout the health care encounter.
Impact on Outcomes	Using evidence and quality improvement measures to evaluate and improve safety and quality of services.
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families

Priority Process	Description
Living Organ Donation	Living organ donation services provided by supporting potential living donors in making informed decisions, to donor suitability testing, and carrying out living organ donation procedures.
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.
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
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge