ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Capital District Health Authority

Halifax, NS

On-site survey dates: October 27, 2013 - November 1, 2013

Report issued: December 16, 2013

ACCREDITATION CANADA
AGRÉMENT CANADA

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

Accredited by ISQua

About the Accreditation Report

Capital District Health Authority (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 October 2013. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

Capital District Health Authority's accreditation decision is:

Accredited (Report)

The organization has succeeded in meeting the fundamental requirements of the accreditation program.

1.2 About the On-site Survey

- **On-site survey dates: October 27, 2013 to November 1, 2013**

- **Locations**

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

  1 Joseph Howe
  2 Camp Hill Veteran's Memorial Building
  3 Capital District Health Authority
  4 Cobequid Community Health Centre
  5 Connections
  6 Dartmouth Community Based Services Cole Harbour
  7 Dartmouth General Hospital
  8 East Coast Forensic Hospital
  9 Eastern Shore Memorial Hospital
  10 Halifax Community Based Services Bedford Row
  11 Hants Community Hospital
  12 Integrated Chronic Care Service
  13 Nova Scotia Hospital
  14 Nova Scotia Rehabilitation Centre
  15 Public Health
  16 QEII Abbie J. Lane Memorial Building
  17 QEII Health Science Centre Dickson Building
  18 QEII Health Sciences Centre Halifax Infirmary
  19 QEII Health Sciences Centre Victoria General
  20 Twin Oaks Memorial Hospital

- **Standards**

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

  System-Wide Standards

  1 Leadership
  2 Governance

  Population-specific Standards

  3 Populations with Chronic Conditions
  4 Public Health Services

Service Excellence Standards

5 Case Management Services
6 Managing Medications
7 Cancer Care and Oncology Services
8 Operating Rooms
9 Reprocessing and Sterilization of Reusable Medical Devices
10 Organ and Tissue Donation Standards for Deceased Donors
11 Organ and Tissue Transplant Standards
12 Surgical Care Services
13 Critical Care
14 Emergency Department
15 Point-of-Care Testing
16 Infection Prevention and Control
17 Acquired Brain Injury Services
18 Ambulatory Care Services
19 Biomedical Laboratory Services
20 Diagnostic Imaging Services
21 Hospice, Palliative, and End-of-Life Services
22 Laboratory and Blood Services
23 Long-Term Care Services
24 Medicine Services
25 Rehabilitation Services
26 Substance Abuse and Problem Gambling Services
27 Mental Health Services
28 Blood Bank and Transfusion Services
29 Telehealth Services
30 Organ Donation Standards for Living Donors
31 Community-Based Mental Health Services and Supports Standards
32 Ambulatory Systemic Cancer Therapy Services
33 Spinal Cord Injury Acute Services
34 Spinal Cord Injury Rehabilitation Services

- **Instruments**

  The organization administer:

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

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Working with communities to anticipate and meet needs)	153	4	1	158
 Accessibility (Providing timely and equitable services)	186	1	0	187
 Safety (Keeping people safe)	868	38	41	947
 Worklife (Supporting wellness in the work environment)	277	6	1	284
 Client-centred Services (Putting clients and families first)	489	9	18	516
 Continuity of Services (Experiencing coordinated and seamless services)	137	0	2	139
 Effectiveness (Doing the right thing to achieve the best possible results)	1372	71	23	1466
 Efficiency (Making the best use of resources)	125	4	1	130
Total	**3607**	**133**	**87**	**3827**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	42 (95.5%)	2 (4.5%)	0	34 (100.0%)	0 (0.0%)	0	76 (97.4%)	2 (2.6%)	0
Leadership	45 (97.8%)	1 (2.2%)	0	83 (97.6%)	2 (2.4%)	0	128 (97.7%)	3 (2.3%)	0
Populations with Chronic Conditions	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Public Health Services	39 (100.0%)	0 (0.0%)	8	66 (98.5%)	1 (1.5%)	1	105 (99.1%)	1 (0.9%)	9
Ambulatory Systemic Cancer Therapy Services	45 (100.0%)	0 (0.0%)	1	93 (96.9%)	3 (3.1%)	2	138 (97.9%)	3 (2.1%)	3
Diagnostic Imaging Services	65 (98.5%)	1 (1.5%)	1	58 (96.7%)	2 (3.3%)	1	123 (97.6%)	3 (2.4%)	2
Spinal Cord Injury Acute Services	30 (100.0%)	0 (0.0%)	1	76 (96.2%)	3 (3.8%)	1	106 (97.2%)	3 (2.8%)	2
Spinal Cord Injury Rehabilitation Services	28 (100.0%)	0 (0.0%)	1	74 (97.4%)	2 (2.6%)	1	102 (98.1%)	2 (1.9%)	2
Infection Prevention and Control	50 (94.3%)	3 (5.7%)	0	44 (100.0%)	0 (0.0%)	0	94 (96.9%)	3 (3.1%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Acquired Brain Injury Services	27 (100.0%)	0 (0.0%)	0	74 (97.4%)	2 (2.6%)	0	101 (98.1%)	2 (1.9%)	0
Ambulatory Care Services	35 (97.2%)	1 (2.8%)	2	66 (89.2%)	8 (10.8%)	1	101 (91.8%)	9 (8.2%)	3
Biomedical Laboratory Services	13 (81.3%)	3 (18.8%)	0	36 (100.0%)	0 (0.0%)	0	49 (94.2%)	3 (5.8%)	0
Blood Bank and Transfusion Services	58 (100.0%)	0 (0.0%)	33	24 (100.0%)	0 (0.0%)	17	82 (100.0%)	0 (0.0%)	50
Cancer Care and Oncology Services	29 (100.0%)	0 (0.0%)	0	72 (98.6%)	1 (1.4%)	1	101 (99.0%)	1 (1.0%)	1
Case Management Services	23 (92.0%)	2 (8.0%)	0	67 (93.1%)	5 (6.9%)	2	90 (92.8%)	7 (7.2%)	2
Community-Based Mental Health Services and Supports Standards	18 (100.0%)	0 (0.0%)	0	112 (100.0%)	0 (0.0%)	0	130 (100.0%)	0 (0.0%)	0
Critical Care	29 (100.0%)	0 (0.0%)	1	91 (97.8%)	2 (2.2%)	0	120 (98.4%)	2 (1.6%)	1
Emergency Department	31 (100.0%)	0 (0.0%)	0	91 (95.8%)	4 (4.2%)	0	122 (96.8%)	4 (3.2%)	0
Hospice, Palliative, and End-of-Life Services	29 (100.0%)	0 (0.0%)	0	99 (95.2%)	5 (4.8%)	1	128 (96.2%)	5 (3.8%)	1
Laboratory and Blood Services	81 (100.0%)	0 (0.0%)	0	95 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Long-Term Care Services	24 (100.0%)	0 (0.0%)	0	71 (98.6%)	1 (1.4%)	0	95 (99.0%)	1 (1.0%)	0
Managing Medications	69 (93.2%)	5 (6.8%)	2	51 (98.1%)	1 (1.9%)	0	120 (95.2%)	6 (4.8%)	2
Medicine Services	26 (96.3%)	1 (3.7%)	0	67 (97.1%)	2 (2.9%)	0	93 (96.9%)	3 (3.1%)	0
Mental Health Services	31 (100.0%)	0 (0.0%)	0	67 (94.4%)	4 (5.6%)	0	98 (96.1%)	4 (3.9%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Operating Rooms	65 (95.6%)	3 (4.4%)	1	27 (90.0%)	3 (10.0%)	0	92 (93.9%)	6 (6.1%)	1
Organ and Tissue Donation Standards for Deceased Donors	35 (100.0%)	0 (0.0%)	0	79 (100.0%)	0 (0.0%)	1	114 (100.0%)	0 (0.0%)	1
Organ and Tissue Transplant Standards	59 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	139 (100.0%)	0 (0.0%)	0
Organ Donation Standards for Living Donors	40 (100.0%)	0 (0.0%)	0	76 (100.0%)	0 (0.0%)	0	116 (100.0%)	0 (0.0%)	0
Point-of-Care Testing	32 (84.2%)	6 (15.8%)	0	33 (71.7%)	13 (28.3%)	2	65 (77.4%)	19 (22.6%)	2
Rehabilitation Services	27 (100.0%)	0 (0.0%)	0	63 (92.6%)	5 (7.4%)	0	90 (94.7%)	5 (5.3%)	0
Reprocessing and Sterilization of Reusable Medical Devices	39 (97.5%)	1 (2.5%)	0	58 (98.3%)	1 (1.7%)	0	97 (98.0%)	2 (2.0%)	0
Substance Abuse and Problem Gambling Services	22 (88.0%)	3 (12.0%)	2	67 (94.4%)	4 (5.6%)	0	89 (92.7%)	7 (7.3%)	2
Surgical Care Services	30 (100.0%)	0 (0.0%)	0	60 (92.3%)	5 (7.7%)	0	90 (94.7%)	5 (5.3%)	0
Telehealth Services	29 (96.7%)	1 (3.3%)	0	33 (89.2%)	4 (10.8%)	0	62 (92.5%)	5 (7.5%)	0
Total	**1249 (97.4%)**	33 (2.6%)	53	2222 (96.4%)	83 (3.6%)	31	3471 (96.8%)	116 (3.2%)	84

* Does not includes ROP (Required Organizational Practices)

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Acquired Brain Injury Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Case Management Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Hospice, Palliative, and End-of-Life Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Spinal Cord Injury Acute Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Spinal Cord Injury Rehabilitation Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Surgical Care Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Managing Medications)	Met	4 of 4	3 of 3
Information Transfer (Acquired Brain Injury Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Case Management Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Hospice, Palliative, and End-of-Life Services)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Information Transfer (Spinal Cord Injury Acute Services)	Met	2 of 2	1 of 1
Information Transfer (Spinal Cord Injury Rehabilitation Services)	Met	2 of 2	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication Reconciliation As An Organizational Priority (Leadership)	Met	4 of 4	0 of 0
Medication Reconciliation At Admission (Acquired Brain Injury Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Ambulatory Care Services)	Met	5 of 5	2 of 2
Medication Reconciliation At Admission (Ambulatory Systemic Cancer Therapy Services)	Unmet	0 of 5	0 of 2
Medication Reconciliation At Admission (Cancer Care and Oncology Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation At Admission (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Hospice, Palliative, and End-of-Life Services)	Unmet	3 of 4	1 of 1
Medication Reconciliation At Admission (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Medicine Services)	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			
Medication Reconciliation At Admission (Mental Health Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Rehabilitation Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Substance Abuse and Problem Gambling Services)	Met	4 of 4	1 of 1
Medication Reconciliation At Admission (Surgical Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Spinal Cord Injury Acute Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Rehabilitation Services)	Unmet	4 of 5	0 of 0
Medication Reconciliation at Transfer or Discharge (Acquired Brain Injury Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Ambulatory Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Ambulatory Systemic Cancer Therapy Services)	Unmet	0 of 5	0 of 0
Medication Reconciliation at Transfer or Discharge (Cancer Care and Oncology Services)	Unmet	0 of 4	0 of 1
Medication Reconciliation at Transfer or Discharge (Community-Based Mental Health Services and Supports 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			
Medication Reconciliation at Transfer or Discharge (Critical Care)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Emergency Department)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Hospice, Palliative, and End-of-Life Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Long-Term Care Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Medicine Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Mental Health Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Rehabilitation Services)	Unmet	2 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Substance Abuse and Problem Gambling Services)	Met	4 of 4	1 of 1
Medication Reconciliation at Transfer or Discharge (Surgical Care Services)	Met	4 of 4	1 of 1
Surgical Checklist (Operating Rooms)	Met	3 of 3	2 of 2
Surgical 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			
Surgical Checklist (Organ Donation Standards for Living Donors)	Met	3 of 3	2 of 2
Two Client Identifiers (Acquired Brain Injury Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Hospice, Palliative, and End-of-Life Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Managing Medications)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Spinal Cord Injury Acute Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Spinal Cord Injury Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Substance Abuse and Problem Gambling Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Managing Medications)	Unmet	3 of 4	0 of 1
Concentrated Electrolytes (Managing Medications)	Met	1 of 1	0 of 0
Heparin Safety (Managing Medications)	Met	4 of 4	0 of 0
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Hospice, Palliative, and End-of-Life Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Long-Term Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Managing Medications)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Operating Rooms)	Met	1 of 1	0 of 0
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Spinal Cord Injury Acute Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Spinal Cord Injury Rehabilitation Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Surgical Care Services)	Met	1 of 1	0 of 0
Medication Concentrations (Managing Medications)	Met	1 of 1	0 of 0
Narcotics Safety (Managing Medications)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand Hygiene Audit (Infection Prevention and Control)	Met	1 of 1	2 of 2
Hand Hygiene Education And Training (Infection Prevention and Control)	Met	2 of 2	0 of 0
Infection Rates (Infection Prevention and Control)	Met	1 of 1	3 of 3
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Sterilization Processes (Infection Prevention and Control)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Acquired Brain Injury Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Hospice, Palliative, and End-of-Life Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Unmet	3 of 3	1 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Surgical Care Services)	Unmet	3 of 3	1 of 2
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Case Management Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care and Oncology Services)	Unmet	3 of 3	1 of 2
Pressure Ulcer Prevention (Critical Care)	Unmet	3 of 3	1 of 2
Pressure Ulcer Prevention (Hospice, Palliative, and End-of-Life Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Medicine Services)	Unmet	3 of 3	1 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Surgical Care Services)	Unmet	3 of 3	1 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Unmet	2 of 3	0 of 2
Venous Thromboembolism Prophylaxis (Organ and Tissue Transplant Standards)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Organ Donation Standards for Living Donors)	Met	2 of 2	2 of 2
Venous Thromboembolism Prophylaxis (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Surgical Care Services)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Capital District Health Authority (CDHA) is commended on preparing for and participating in the Qmentum program. The CDHA completed a three-year cycle of its strategic plan, 'Our Promise' in 2013. After consultation with stakeholders via the Community Health Boards and others, a decision was made to stay the course and refresh the current strategic plan going forward. The new document entitled: "Our Promise in Action" sets out five strategic streams that clearly articulate the CDHA's priorities. These priorities are: transforming patient-centred care; citizen and stakeholder engagement and accountability; transformational leadership and innovating health and learning and sustainability.

The decision to continue on the Our Promise path is resonating with staff members across the organization and
community partners that readily refer to 'the promise' when they talk about what the organization stands for and what are its challenges. The teaching and research work is acknowledged, the need to build human resources (HR) capacity is emphasized, transformational change and a sense of stability along a strategic course is identified, and sustainability in an ever-demanding business environment is there alongside the need to be innovative while transforming the patient experience.

The structure of the Community Service Boards, integrated with the District Boards facilitates the inclusion of the voice of the customer in decisions that are made. For example, the region heard Community Service Boards say that people in the various communities served by the CDHA wanted upstream programs close to home so that people could receive care and participate in health promotion and prevention activities that would help them to care for themselves and avoid the need for more intensive access to the acute care system. There is evidence throughout Capital Health that the organization listened and geared its business planning process to find resources from within that could be re-allocated to develop community health initiatives, enhanced chronic disease management services, and more effective use of emergency resources to name a few. There is a culture of quality improvement evident throughout the organization and within clinical teams and support services. Several quality improvement initiatives have been undertaken across the system to engage patients, staff, and community partners in more efficient and effective use of resources and ways of doing business. The District has made some progress in the exploration and implementation of process improvement methodologies to eliminate waste in support of improved resource allocation – supply of inventory at the unit level for example - and this is a direction that could be refined and expanded. The organization is encouraged to make the collection and use of data consistent so that it can be relied upon to inform decision-making and quality improvement. There have also been partnerships with government and some in-house initiatives to take advantage of opportunities to decrease the cost of energy and material consumption and to realize the advantage of shared services.

There is a strong leadership team at the Capital District Health Authority (CDHA). Staff members and community partners describe the chief executive officer (CEO) and team as committed to the Our Promise and accessible to people as needed. The executive team routinely travels to the units and service areas to participate in discussions about what is happening and what can be improved at the point of care. The team is committed to being a learning organization, and there are many examples of research activity, academic endeavour, professional publications, leading practices and activities that promote a culture of safety.

The ethics framework and the activities that flow from it are evident at all levels of the organization. This is an important component of the Our Promise, contributing to the sense of an ethical lens for the setting of priorities and decision making. Staff members and physicians across the organization are engaged and committed to providing care that is responsive to the needs of their patients, clients, and communities. Quality councils

include patient and family representatives in many programs and services. This provides evidence of the organization's patient-centred care agenda in action. The surveyor team experienced a culture of collaboration and commitment to excellence.

The organization has a communications plan that is tied to the priorities identified in the strategic plan. Communications is forward thinking, working cautiously with social media to check out new and innovative ways of communicating with future generations in a way that is responsible and consistent with messaging that the organization wants to be associated with and its mandate.

Capital District Health Authority is a tertiary quaternary organization, providing services across Nova Scotia and beyond to the other maritime and atlantic provinces. Considerable work has been done in various programs to build services that extend along the continuum of care and follow the full patient experience. In this context there are challenges associated with building information systems that facilitate quality sharing of information and communication across the system.

The aging infrastructure has been identified as the most significant issue for the organization. This message is consistent from governors, senior leadership, patients and family members and staff. Staff members, patients and family members' experience with the physical environment has led to many comments about the impact conditions are having on the quality of care and ability of the organization to deliver quality care.

Section 2 Detailed Required Organizational Practices Results

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Medication Reconciliation At Admission The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.	· Ambulatory Systemic Cancer Therapy Services 9.14 · Cancer Care and Oncology Services 7.5 · Hospice, Palliative, and End-of-Life Services 7.8
Medication Reconciliation at Transfer or Discharge The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	· Ambulatory Systemic Cancer Therapy Services 16.3 · Cancer Care and Oncology Services 11.3 · Rehabilitation Services 11.3
Medication reconciliation at care transitions With the involvement of the patient, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile patient medications at transitions of care.	· Spinal Cord Injury Acute Services 8.2 · Spinal Cord Injury Rehabilitation Services 8.2
Patient Safety Goal Area: Medication Use	
Infusion Pumps Training Staff and service providers receive ongoing, effective training on infusion pumps.	· Mental Health Services 4.4
Antimicrobial Stewardship The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	· Managing Medications 1.3

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Falls Prevention	
Falls Prevention Strategy The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	· Surgical Care Services 15.2 · Medicine Services 15.2
Patient Safety Goal Area: Risk Assessment	
Pressure Ulcer Prevention The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	· Critical Care 10.6 · Surgical Care Services 7.9 · Cancer Care and Oncology Services 9.4 · Medicine Services 9.4
Venous Thromboembolism Prophylaxis The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.	· Medicine Services 7.4

Section 3 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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 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: Public Health Services		
9.6	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	

Surveyor comments on the priority process(es)

Across the organization there is recognition that the Capital District Health Authority (CDHA) has a strategic direction and lives its mission, vision and values. Many staff talked about "Our Promise" and CDHA's recent decision to refresh the direction in which it has been going for the past several years in collaboration with community partners. People across the organization are supportive of the model that mandates community health boards (CHBs) to facilitate and bring forward a wide range of stakeholder priorities. This reflects the human and geographic diversity of the catchment area.

There is an active ethics committee that focuses on research and clinical matters. The leadership team speaks highly of this body and actively engages with the committee so that there is an ethical lens on strategies, policies and procedures. Although diversity was not specifically defined for the surveyor team and the meaning of the term was not readily visible in all areas, there were many instances in which the value and richness of diversity were mentioned by stakeholders. Also, diversity is inherently included in documents describing the mandate and objectives of various programs.

There is significant agreement across the program areas that understanding and hearing the voice of communities is a priority, and that communities have told the CDHA that they want services that are close to home and promoting health and wellness, prevention and promotion. To this end, the organization has actively begun to re-direct resources to community-based services with wellness as their mandate. There are specific initiatives that demonstrate the commitment to understanding and providing services all along the continuum of care so that people do not end up having unnecessary attendances at emergency services and admissions to acute care. The provincial network of renal services and the chronic disease management program are just two examples of the CDHA's commitment to support health care close to home.

The chief executive officer (CEO) and the executive team are visible in the organization via various mechanisms, with communications, executive walkabouts, and what staff members perceive as open door policies. Staff members are consistently positive about the organizational culture and the sense that although

the organization is large and has many priorities, staff members are part of the CDHA team, sharing common beliefs and priorities.

Like many complex health care organizations, the CDHA struggles somewhat with the development and presentation of a set of measurable and cascading targets and indicators that are clear and accessible to interested parties with variable interests. However, there is work underway across the organization to develop and monitor quality and safety, with more or less rigour depending on the purpose of the data collection. Being a teaching hospital, there are specific initiatives where data collection is organized and targeted. There is also evidence of organized efforts to collect data related to priorities that have been set out in the strategic and business plans for use in informing the work of the board and various programs and services. At the unit level, staff members showed surveyors the data posted on their quality boards. There is varying levels of interest and dialogue about that data however, depending on how interactive the unit managers are for using the board as a communication tool with their staff. These boards do display information about things like handwashing compliance, infection rates and wound management.

Access to good information about the health status of the community has been a challenge. In 2011 a Nova Scotia population health status report was completed that this has given CDHA information that allows the organization to look at population health data at a more granular level than in the past. This is expected to influence the organization's resource allocation decisions going forward.
Managers of the organization speak freely about the need to have transformational leadership skills to keep up with the constant pace of change. Three years ago the organization invested in training toward a leadership model that is built around eighteen capacities and behavioural expectations for transformational leadership. The development of these capacities amongst leaders is now being refreshed and monitored as one of the areas of focus in the strategic plan.

There is recognition that the population served includes various cohorts that are not easy to reach in a traditional medical model. Addictions and mental health clients, youth at risk, the gay lesbian bisexual trans gender (GLBT) community and various other individuals and groups have been identified as not well served in traditional ways. In response, the organization has implemented various models of service delivery to address these populations via community outreach services.

The Capital District Health Authority has operated with a balanced budget in recent years, but faces significant challenges to maintain that position. There is evidence that the organization is rigorous about analysis of its financial position and engaging staff members and managers at all levels in corrective actions to stay on course. Financial analysts work with managers to regularly analyze and deal with variances. Some work has been done to incorporate Lean methodologies to eliminate waste and improve on processes that add value. The surveyor team members observed specific evidence of the organization for a reduction of inventory in supply rooms and in value stream mapping that has been initiated in chronic disease management. Staff members indicate that they are inspired by these opportunities to engage in processes that eliminate waste and move away from cost saving measures that begin with the discussion of "cuts".

3.1.2 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!
13.7	The governing body regularly reviews the contribution of individual members and provides feedback to them.	!

Surveyor comments on the priority process(es)

The Capital District Health Authority (CDHA) board is made up of ministerial appointees. Two thirds of CDHA's board of directors are appointed from names put forward by seven community health boards (CHBs) district wide. The board has established committees that work closely with senior management to give consideration to: audit; governance; chief executive officer evaluation and compensation; health human resources; quality and patient safety; sustainability, and CHB leadership committees. Specific task- focused committees are established for special purposes. Community-based representatives with special expertise may be asked to sit on committees from time to time.

The board does not advertise its meetings or open them to the public rather, the board feels that its connection to the community comes from the relationship with CHBs and the public annual general meeting. Community partners are supportive of the organization and the board. The board describes the relationship with partners as transactional rather than strategic. While interactions are positive, partners seem to be in consensus that the relationship would improve with additional opportunities to participate in the development of strategic targets.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization describes a "3E" economics, evidence, ethics approach to its business planning cycle. The cycle starts with planning principles and objectives that are set at the senior level, with board, provincial, and senior leadership team (SLT). Physician, clinical, and administrative leaders then consult across the organization on operational initiatives in support of the strategic priorities. These are presented to the SLT for feedback and then taken back to the organization for review and adjustment. A package is presented to the board via the sustainability committee prior to approval and submission for funding.

There are policies and procedures in place for the allocation and management of resources. Financial leaders and analysts work with managers organization wide to monitor, analyze, and adjust budgets according to activities that result in variances during a fiscal period. Managers are encouraged to adjust budget lines and propose corrective actions when budget trends are out of line with targets.

The organization has narrowly achieved a balanced budget recently, however, there is significant pressure created by service and infrastructure demands that tend to outweigh revenues. In the previous three years the organization has worked with three, five and 10 percent reduction targets. With the diversity of programs and a strategic plan driven by community demand for new service delivery models, the organization has made deliberate efforts to avoid "across the board cuts". The preference is to engage staff members in cost saving measures, work with provincial partners in energy efficiency initiatives, initiate implementation of an electronic scheduling system, and look at shared services opportunities that are being undertaken across government.

The board presents its audited financial statements annually at an open annual general meeting.

3.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is currently developing a talent strategy for 2013-2015. The strategy outlines four pillars: recruit, perform, develop, retain. The plan speaks to specific areas of focus flowing from these four pillars on which the organization will concentrate. Goals are written as outputs rather than specific measurable targets. Leadership describes a fairly stable population of workers with a low turnover rate. This allows for recruitment efforts to be targeted to specific professions.

Academic community partners report good relationships with the Capital District Health Authority (CDHA). The CDHA is able to facilitate placement experiences for a wide variety of professionals and in return, the colleges and universities are able to supply a diverse workforce. It is evident that 'growing your own workforce' and providing positive experiences during the practical phases of the academic experience are solid strategies.

There is abundant evidence that the organization is investing in ongoing training and professional development opportunities for staff, employee and family assistance program (EFAP), leadership development and initiatives around staff safety and wellness. The work of the ethics committee contributes to the positive worklife culture. It is noted that there is a strong and visible emphasis on patient safety culture which is the highest priority. Perhaps consideration could be given to strategies that raise staff safety to a similar level of visibility. The Worklife Culture Tool and conversations with staff members during on-site walkabouts and tracers indicate that although employees view patient safety as their job number one there is still a sense that improvements could be made around staff safety issues. There is good evidence that some success is being achieved with the 'walk-back' program for safe return to work, and that occupational health and safety committees are active. There is an automated incident reporting system that works well as long as staff members are comfortable with the technology and the technology works well at the time that a report needs to be made. The organization has anonymous reporting in place for patient safety related incidents; this has yielded an increasing rate of return on reports. On the flip side however, staff members and unit managers did indicate that there are challenges with completing the loop on investigation, debriefing, and implementing corrective actions when the reporter does not self-identify. There are also indications that this approach does not necessarily result in staff members feeling that there is a blame-free culture. Worplace incidents are reported through the SAFE line.

Employee files demonstrate that there is a solid process for recruitment and documentation of employee experience. The low rate of performance review and evaluation is indicative of an organization where many out of scope staff members have large numbers of direct reports. This makes it impossible to invest quality time into this one-on-one process with every employee. Some initiative has been undertaken to simplify the forms that are used. This remains a priority for the organization, but many of the initiatives that the talent strategy appears to target positive professional development experiences for categories of employees.

The organization has a comprehensive orientation program that every new employee participates in for one day. This is followed by unit and profession-specific orientations tailored to the job. There is evidence of a solid physician credentialing process that includes application, reference checking, criminal record checks, notification of specific credentialing decisions, and so on. The organization provided evidence of a specific

focus on employee exposure to violence. Non-violent crisis intervention training is one initiative that was highlighted.

3.1.5 Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization identifies: "Transforming Patient Centred Health Care" at the core of the integrated quality and safety framework. The quality and safety framework is evident in multiple documents, guiding the work of the organization and in the work that is being done to improve research and clinical activities. The decision to refresh the strategic plan that has been evolving at Capital District Health Authority for the past several years seems to have resonated with staff members and the public in terms of promoting some sense of stability in the direction of the organization, while change is ongoing and could be significant going forward. The strategy embraces a transformational change agenda and from this, significant initiatives flow all the way across the organization to generate ideas about how to improve quality administratively and at the point of care. Some of the more visible initiatives that the surveyor team saw were the Lean initiatives. Initiatives were undertaking around reducing waste with better management of inventory, reducing wait-times, infection prevention and control, and energy efficiency. The organization is making some bold moves to implement strategies that have come forward by way of strategic planning initiatives that have engaged citizens via the community health boards (CHBs). These initiatives require rigorous attention to allocation of resources in a tight fiscal climate.

At the unit level, staff members told surveyors that they are encouraged to identify opportunities for improvement and that support is available to initiate, explore, and implement innovative ideas when there is consensus to move forward. Surveyors reported many examples from their tracers. Examples were found on the renal unit where the team has undertaken several quality improvement initiatives to connect with the continuum of care internally and externally for people receiving services across the province. Another example is in the chronic disease management service where reduction in wait-times was identified as a high priority if the program is to be sustainable and deliver on Our Promise of quality patient-centred health care experience. Quality bulletin boards can be found on patient care units displaying information on key metrics that may be of interest to people working and visiting. In some cases these are more visible and up-to-date than in others. It would be worthwhile for the quality team to look closely at the experience of the value stream mapping exercise in the chronic disease program and perhaps elsewhere, and then build on the use of frequent staff huddles and dynamic visibility boards to facilitate real-time quality improvement activities.

The organization has contracted for risk management assessments two times in the past several years and most recently, in 2011. These assessments have helped to identify those areas of highest consequence and likelihood so that the mitigation strategies and activities can be focused on reduction of risk in those areas. Consistently, people across the organization identify aging infrastructure as the area of highest risk.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

For research ethics, the Research Ethics Board (REB) has four panels and includes the required variety of people necessary to vet research and academic proposals. The organization describes the components of its ethics framework as Capital Health Ethics Support (CHES). CHES is made up of people who represent each of the four quadrants of the program: ethics education, clinical ethics consultation, policy development and review, and organizational ethics. There is evidence of the ethical lens across the organization from the strategic level to the point of care.

The surveyor team members heard descriptions of ethical consultation and review in a variety of circumstances. The data show that in the recent annual reporting period there were sixty-six requests for consultation, including twenty-five clinical, fourteen policy, eleven organizational, and fourteen ethics education requests. There is a form with a well-described process to request service. The committee makes itself widely accessible with a common call-in input line, information on Quickcast monitors, Intranet, pamphlets, public panel discussions and presence in the units.

Currently, there is a module under development for how to do a personal directive to guide staff members in their contact with patients. While the committee is largely built on voluntary participation and fiscal considerations limit the work that can be done, this committed group has focused attention on its strategic objectives, limitations, communication strategies and audiences. The surveyor team members were introduced to the organization's privacy policies and considerations with a video that had been developed from the work of the ethics committee.

3.1.7 Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Communications are much aligned with the: "Our Promise In Action" strategic planning document. The organization makes clear and consistent statements about what it is attempting to achieve and how it is going about that. The strategy is to have various stakeholders tell stories about their health care experiences that speak to what the organization is trying to achieve, support system transformation initiatives, and build pride amongst the organization's staff. The plan is to build capacity and skill sets of managers as leaders who communicate daily with staff members and are spokespeople in the public. Initiatives will be undertaken to improve the patient experience so that people who consume services will have positive experiences and can relate, consistent with the organization's values. The organization will also continue to use appropriate media and work with community partners to obtain citizen engagement in the plans and strategies. The organization is cautiously monitoring and using social media sites to ensure that communication initiatives keep up with current practice for connections with community.

The patient safety plan is front and centre as a priority for the organization. There is a patient representative service that has a central intake process for the organization. The service has a concern-handling process that attempts to quickly resolve items brought to the organization via an electronic or telephone reporting option. The electronic intake form provides a framework to collect useful data for retrospective analysis and planning around the volume and nature of concerns received. The database is accessible to senior managers so that reports can be routinely extracted to provide decision support. While patient safety advisors have specific responsibility to connect with patients and families around concerns, every employee of the organization is expected to receive customer service training in the "Cleveland Model" during the next two years.

Feedback from discussions with various people involved in on-site tracer activities indicates that there may be opportunity for improvement around the feedback loop. Specifically, patient representatives need to be included in quality improvement initiatives that emerge out of efforts to respond to and resolve complaints. There is a tendency to respond to concerns from a risk to the organization perspective, which may or may not fully consider and utilize the value of the voice/story of the patient.

3.1.8 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: Leadership		
9.1	The organization's leaders verify that the physical space meets applicable laws, regulations, and codes.	!
9.2	The organization's leaders protect client and staff health and safety at all times and particularly during periods of construction or renovation.	

Surveyor comments on the priority process(es)

Capital District Health Authority carries out its activities in 36 buildings on 10 campuses, with an additional 19 leased sites in the community. The aging infrastructure has been identified as the most significant issue for the organization. This message is consistent from governors, senior leadership, patients and families and staff. In response, the organization, in collaboration with government, has initiated a feasibility study to determine the best way to complete the much-needed upgrades. The facilities master plan calls for all inpatient specialty services to be concentrated at the Halifax Infirmary site, and eventual demolition of the Centennial building at the Victoria General site and departure from the Purdy building at the Nova Scotia Hospital site.

The situation at the Victoria General site has created significant risk for the safe delivery of patient care. There are regular floods, and there is Legionella bacteria in the water, necessitating the development of: "Water Rules" with staff members needing to ensure careful communication about which/what/where patients can drink the water, shower, and so on. This building is the location where care is being provided to some of the organization's most complex and vulnerable patients, and patient safety is dependent on staff members' good judgement every day. Staff members, patients and family experience with the physical environment has led to many comments about the effect conditions are having on the quality of care and the ability of the organization to deliver safe care.

The organization has recognized that it needs to more thoroughly prepare for the eventuality of a critical event that might lead to some of its current space not being useable for a prolonged period. Once the capital redevelopment plan receives firm approval and required resources confirmed, it will still likely be five years before replacement space is available for patient care. Work has begun to develop contingency plans, beginning with the Centennial building, in the event that some current space becomes unusable. This will be a challenge for the organization as it needs to determine how available space can be re-purposed quickly, if required.

Looking beyond the risk at the Victoria General site, there are many examples of upgrades, renovations, or new construction that have had positive impact on the environment. Examples include: renovations to patient bathrooms; renovations and painting of patient units and other patient care settings; creating improved environmental conditions; new furniture and window coverings; new Simpson Landing bungalows at the Nova Scotia Hospital site; emergency power generator upgrades and electrical switch replacement and systems to support the safety of clients prone to wandering.

Issues remaining to be addressed include: spaces being used for purposes other than what was originally intended resulting in overcrowding for the volume of work; bathrooms that are not wheelchair accessible; insufficient power supply necessitating careful management and creativity in use of power; challenges with elevators' speed and breakdowns and insufficient numbers of hand-hygiene sinks and dirty utility rooms.

For leased spaces, the challenge is ensuring the lease arrangement with the landlord includes clear responsibility for upkeep of the physical environment.

In general, those sites that have made the most progress in addressing long-standing physical environment issues are where there are dedicated leaders that have taken it upon themselves to ensure improvements are made. This leadership is resulting in issues being identified, prioritized and addressed. Over time, the environment begins to take on a revitalized character, despite its age, and recognizing that there is still more to do. A good example of this is the Nova Scotia Rehabilitation Centre and the "Revitalizing Rehab" initiative.

Insofar as the usual business processes related to routine physical environment issues, the organization has a solid work order system. Staff members place orders online and needs are prioritized and mapped to available resources. Teams report there are challenges to keep up with all requests consequently, the prioritization system is important.

It is noted that the organization has had some difficulty filling some maintenance positions, and heating ventilation and air conditioning (HVAC) is one example. Commendation is given for instituting an in-house training program that is about to be launched.

There is a preventative maintenance program for all large pieces of equipment, and it is standardized across Capital District Health Authority.

There are regular leadership safety rounds where issues are highlighted and action plans to address them are developed. These are now of long-standing and have become an expected event across the organization.

The organization has been proactive in a number of respects with 'green' initiatives to improve the environment and in some cases, resulting in efficiency and cost savings. One example is an embedded energy advisor in relationship with Efficiency Nova Scotia, with a goal to reduce electrical consumption by 15 percent, with five percent reduction achieved to date. Other examples are partnering with a farm which wants the organization's compost and development of the Urban Community Farm at the Halifax Infirmary site, and recycling of soiled linen bags.

3.1.9 Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
14.9	The organization's leaders develop and implement a business continuity plan to continue critical operations during and following a disaster or emergency.	

Surveyor comments on the priority process(es)

Capital District Health Authority (CDHA) has well-developed relationships with the broader community, ensuring that its emergency services plan is part of a broader district plan. Regular meetings of planning tables provide opportunity for the organization to review and revise its plan.

The organization has an overall master plan, with sites having their own customized emergency response plan developed by a site-specific emergency response planning team. Plans are posted on Share Point for leadership staff members and front-line staff members have hard copies of the plans in binders. Plus, there is evidence of physical copies of at least some aspects of the plan being posted or easily accessible in visible locations in the workplace.

Expectations of front-line staff members in preparing for emergencies are part of the formal orientation process. Ongoing education is available via the organization's online learning management system (LMS). The LMS tracks how many people have taken a particular training program.

It is noted that there appears to be variation between sites and individual teams regarding ongoing education. For example, exercises are conducted more regularly at some sites because of interest, and some programs/departments have particular expectations of staff members for their education. Those responsible for emergency preparedness indicate they: "recommend that every employee take the training" but it is not clear if this is an organization-wide expectation. Those sites that have well-developed emergency planning protocols and excellent staff training appear to have a particular champion that has taken leadership in this regard.

For example, it is reported that 1,200 staff members have taken the code red training program this calendar year. However, it is not evident if this meets or exceeds the goal/expectation. The organization is strongly encouraged to have a clear expectation of all staff members, with clearly defined responsibility to ensure this expectation is being met.

There is an expectation that each fire zone has an appointed fire warden 24/7. Fire Wardens are provided with full training given for all emergency codes on a regular basis and therefore in theory, will be available to guide other staff. However, this was not consistently validated during the on-site survey tracers. Risk of people off sick, on vacation, and so on without a clear process to ensure a fire warden has been appointed creates risk for the organization.

The physical infrastructure has been identified as the most critical issue yet the inconsistency in training and not having trained staff members available across the organization at all times leaves the organization vulnerable to incidents and in a situation where it may find out after the fact that an incident has occurred without enough staff prepared to respond.

It is acknowledged that the organization has had experience with drills or events requiring the emergency response system to be activated, and to test theory versus reality. In the last year, there have been 24 actual events requiring activation of the organization's decision-making process, and 16 drills.

There are strong protocols in place for the investigation and resolution of public health emergencies. While responsibility for management of the emergency rests with Capital District Health Authority, the protocols and resources base is in firm partnership with the province.

The reality of the aging facilities has elevated the risk. At the Victoria General site campus for example, infrastructure plumbing is a significant issue, and has resulted in several floods, and a reliable electrical supply is also an issue. Further details are provided in the Physical Environment report section. What this means for emergency preparedness is that the organization needs to be on higher alert than might normally be the case, and ensure it is confident that staff members are prepared to respond in emergency situations. Also, the organization must be prepared with contingency plans should an incident result in space being unusable for an extended period.

3.1.10 Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
11.5	The operating room team contacts clients or follow-up service providers to help evaluate the effectiveness of the procedure and the post-surgical transition, and makes improvements to its services as appropriate.	!

Surveyor comments on the priority process(es)

Capital District Health Authority (CDHA) has made significant headway in patient flow management since 2010. The focus on this issue, bringing together the major clinical stakeholders, has yielded major gains. The recognition that this is a system problem, not the accountability of any single department, is acknowledged across the organization. This cultural appreciation has evolved from the work with data from the various stakeholder areas and has provided information that has driven several initiatives.

The time currency in the major areas varies. The emergency department (ED) deals in minutes/hours; the medicine teaching unit (MTU) deals in days; and continuing care deals in weeks/months, and each program/service contributes to improving the efficiency of flow for overall benefit. Some outcome indications are: 40 per cent improvement in ED flow and capacity in the past year; notable reduction in code census from about daily to less than once a month; stabilization of alternate level of care (ALC) patient numbers in the past year to approximately, 50 from 75.

There is no one item that can be pointed to for this success. In the ED, the rapid assessment unit continues to prove effective, the over capacity protocol works, the integration of paramedics and nurses in ambulance off-loads appear to work well, and the discharge planner is active with community contacts as is the inpatient counterpart.

The management framework has recently included increasing coordinator time, moving to standardized utilization protocols including a data platform namely, the bed utilization management program (BUMP), discharge planning from admission and bullet rounds. This latter item is noteworthy in its intense focus on asking: "what are the barriers to discharge?" versus an extended focus on clinical detail. There is also a strong element of peer pressure and of holding clinicians to their 'promises' of discharge. All this is done with an appropriate eye on unintended consequences such as increasing re-admission rates for these patients. To date, there has not been a rate-shift judged significant.

Although the long-term care (LTC) sector is not within the CDHA's management, there is extensive liaison with the Department of Health and contribution of resources to effect increased movement out of the acute system and to support patients in the community. A repatriation policy is in place to deal appropriately with out-of-district patients that use tertiary/quaternary services.

Commendation is given for the organization's approach to flow and on the accomplishments, especially recently, while noting it continues to be a ongoing struggle not only in the CDHA but across the country.

3.1.11 Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.1	The individual responsible for the overall coordination of reprocessing and sterilization activities within the organization reviews and approves the team's set up and policies and procedures for cleaning and reprocessing.	
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Operating Rooms		
12.5	The operating room team appropriately contains and transports contaminated items to the reprocessing unit or area.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
3.6	The organization selects materials for the floors, walls, ceilings, fixtures, pipes, and work surfaces that limit contamination, promote ease of washing and decontamination, and will not shed particles or fibres.	
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!

Surveyor comments on the priority process(es)

The sterilization processing department (SPD) regularly collects information on all its activities, as do the other departments involved in reprocessing, such as diagnostic imaging (DI), operating room (OR), Cancer Care, Endoscopy, otolaryngology (ENT), and Cystoscopy. Each of the involved departments has an accountable individual for its reprocessing function with central coordination of reprocessing policy, training and auditing done by SPD and infection prevention and control (IPAC). The common issue is the prevention of the potential spread of infectious agents. The SPD, with IPAC, has been instrumental in setting the local policy, standards, training and auditing tools for the devices used in these various departments. Of particular note is the help with DI, which had several issues arising from the previous accreditation survey. These have now been cleared and the process meets standards. It is suggested that the organization consider centralization of management for all reprocessing functions to SPD, but retaining distributed delivery for consistency in policy application and quality assurance/quality improvement processes.

Staffing has been an issue from time to time, but currently it is sufficient. Recent efforts at measuring workload have aided SPD in providing evidence for reasonable staffing levels. All pertinent staff members must attain the SPD technician qualification and there is an imminent move to mandatory certification for SPD workers which is supported by Capital District Health Authority (CDHA). Orientation of staff members is

extensive and includes all areas of the department with close monitoring and competency tests carried out and ongoing yearly checklists completed for all staff. If any deficiencies are evident, individual follow-up is undertaken.

The CDHA does use reprocessed single-use devices however, this service is totally outsourced to Stryker Sustainable and is overseen by a third party reprocessing committee. The SPD has worked diligently to reduce the use of flash sterilization across the organization having achieved a 60 per cent reduction in flashed instruments in a four-year period, with the major input being the influence on management to increase the inventory of the commonly flashed items. The analysis also shows improvement across several other productivity areas. This is a positive accomplishment.

The current physical plant for the SPD at the Victoria General campus site is old and was not purpose-built. In consideration of several issues such as ceiling material, sensor or knee operated handwashing and full separation of clean and contaminated transport, it does not meet standard. The obvious recommendation to refurbish it competes with the high cost and declining life of the site. Meticulous attention to IPAC issues is the current default strategy. The Halifax Infirmary and Dartmouth General Hospital (DGH) SPD sites contrast with the Victoria General facility as being relatively modern, purpose-built facilities, although they too have fibre ceiling tiles on the clean side and a lack of sensor or knee operated sinks. The DGH site has a non-functioning contaminated elevator, so contaminated OR supplies must use a partially public pathway. This is another issue of cost of refurbishment versus new construction. The clean supply elevator is under repair at the moment, but is expected back in service quickly. The Hants Community Hospital SPD function is small with a recently revised flow pattern that meets the standards.

There is a complete set of standard operating procedures (SOPs) based on manufacturers' information and instructions. These are updated regularly and available to all staff. With the introduction of an electronic system, there will be online access to all manuals and device/set information for the Victoria General and Halifax Infirmary sites, with the Dartmouth General Hospital to follow.

All sterilization equipment is on an internal preventive maintenance (PM) program. The records are extensive, detailing all interventions for at least 10 years. Detailed records are kept of sterilization cycles and part of the orientation/training for steam sterilization involves noting nine and soon- to-be 10 parameters for a satisfactory cycle. The reprocessing procedures from acceptance in decontamination, through decontamination/cleaning, inspection, preparing sets, configuring loads and sterilizing follows the SOPs. A recent recall at the Victoria General site, the first in over a year, demonstrated the team's appropriate response in that it was able to track all instruments in all potentially un sterile loads quickly and before any of the questionable packs were used in a patient procedure.

The team has developed an extensive set of audit forms which are used regularly to inform their adherence to their standards. These audits include: dress code, instrument set or tray or Steri-peel, hand hygiene, and decontamination.

Commendation is given for instituting a district reprocessing committee to ensure thorough evaluation of products/services from the reprocessing perspective as a core part of the acquisition of new devices/services.

3.2 Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Chronic Disease Management

- Integrating and coordinating services across the continuum of care for populations with chronic conditions

Population Health and Wellness

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

3.2.1 Standards Set: Populations with Chronic Conditions

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

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

The Integrated Chronic Care Service has done significant work to follow through on the commitments identified in the 2010 survey. This is a multi-disciplinary team taking referrals primarily from family practitioners and NPs. Historically, the program has been over-subscribed with a long waitlist and lengthy periods of service that were seen to be promoting dependency and excluding new clients from timely access. Work has concentrated on quality improvements that support independent living by "integrating the physical and psychosocial needs of individuals by focusing on the person instead of the disease and on improving functional health and quality of life". To this end, significant work has been done to define care pathways with specific interventions and milestones in diagnosis and treatment clearly identified. These are shared with the client prior to admission. The pre-admission package engages the client in the development of the care plan from the outset. The admission package was developed with feedback from clients. A client interviewed during the survey shared that the previous package was repetitive and onerous. The clinic acknowledged and responded to this feedback, acknowledging that the pre-assessment and orientation portions of the service are critical places to establish expectations and focus the patient on what can and cannot be provided here. Again, the emphasis is on supporting the client to acquire the skills and knowledge to be mindful and self-aware, live independently, engage in self-care, and access community services that currently exist in the world outside of the health care system. Clients are also encouraged to explore and begin to use modes of treatment that reflect current best practice and maximize mobility and independence. For example, treatments that can be taken orally are preferable to IVs.
The team identifies its targets and monitors its outcomes by using straightforward data about the number and nature of referrals, interventions, improved health status, and discharges. The information collected and analyzed by the team is useful data to inform continuous improvement initiatives. For example, there have been adjustments to the care pathways that have resulted in a significant reduction in the number of people waiting. In addition, attention to the details of referrals sitting on the waitlist have allowed the organization

to remove a significant number of clients who are no longer interested or have perhaps been misdirected for the kind of service they need or want.
The quality improvement work in this unit is impressive. There was evidence that Lean methodologies are being employed with the support of expert advisors from the quality improvement service. The surveyor reviewed a value stream map that could easily be related to what is value added and non-value added in the client experience. Through this process the team has taken a methodical and detailed look at the experience of the patient from referral to discharge. The process hi-lites all of the areas where resources and time are wasted, and the team is developing plans to take a deeper dive into opportunities for improvement that have been identified at several places along the value stream map.
The manager and others involved in the surveyor visit were enthusiastic about the process that has been undertaken to introduce transformational change to a service that had historically become bogged down in a model that kept patients waiting and then held on to them when the real value in chronic disease management is to promote independence and self-care through meaningful interaction, consultation, teaching, and care from expert providers.
The team is commended for its commitment to research and peer reviewed publications that promote and inform best practice in their field.
This is a service that will really benefit from interoperable electronic health records, especially with clients who tend to have multiple points of contact with the health system for issues related to chronic conditions. Currently, the team is scanning documents such as diagnostic results into the system that they have for recording client progress.

3.2.2 Standards Set: Public Health Services

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Population Health and Wellness

Following up on reviews completed following the SARS outbreak in 2003 and again in 2005/6 Public Health commenced on a renewal of it's mandate starting with truly "understanding" the needs of the population(s) served. This included collecting and understanding surveillance and population health assessment data in a new way to focus the team on understanding root causes of population health issues and learning how to engage the various stakeholders in identifying possible solutions. One of the outcomes of this has been the reorganization of its services in order to focus it's scarce human resources where they will make the most difference. While this is still a work in progress, evidence is emerging that suggests they are making difference in improving health issues such as early treatment of selected STDSs, healthy beginnings (eg infant feeding), and youth health work.

This change has had an impact on how staff do their work. Staff who were interviewed discussed how difficult the changes have been, yet they all voluntarily said that they believed in the reasons behind the change and were able to describe how they would know the change was a positive one and were looking forward to seeing the data. They were also able to talk with pride about the difference they made individually and as a collective.

The unit has adopted some very innovative and courageous communications strategies such as the syphilis campaign and various social media activities which were developed in response to advice from their clients and community partners.

The population health team is encouraged to continue on it's journey, continue to explore ways to make sense of their data from the population and client perspectives, and to continue to work with their partners and clients to ensure that health promotion activities are appropriate for their audiences and the results that are intended. As it develops more experience and trust in it's processes, the time intervals between awareness of issues, adaptation of data collection methods and implementation of action plans will decrease. Having said that, the team appears to be able to respond very quickly during critical situation such as outbreaks.

As with other service areas in Capital Health efficiencies will be gained as systems become automated such as recoding and tracking vaccines, and analyzing and sharing surveillance information.

3.3 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Organ and Tissue Transplant

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

Organ Donation (Living)

- Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures

Episode of Care - Ambulatory Systemic Cancer Therapy

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

Clinical Leadership

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

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Surgical Procedures

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Blood Services

- Handling blood and blood components safely, including donor selection, blood collection, and transfusions

3.3.1 Standards Set: Acquired Brain Injury Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	The team has access to the supplies and equipment needed to deliver acquired brain injury services.	
Priority Process: Competency		
4.10	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
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 Acquired Brain Injury (ABI) program at the Nova Scotia Rehabilitation Centre (NSRC) provides an interdisciplinary team approach to the care and treatment of survivors of traumatic and non-traumatic (including stroke) brain injuries. Families are seen as integral members of the team. The program approach to care and treatment includes the 7th floor ABI unit, ABI Day program, an ABI outreach team, and ABI outpatient services.

There is strong leadership and a strong interdisciplinary team on this unit, committed to meeting the needs of the patients and their families. The team is commended for its leadership in advocating for the needs of patients with ABIs for community-based services to facilitate better transition from the NSRC to the community. The program has been strategic in advocating to eliminate policy barriers that prohibit effective services for ABI survivors, such as long wait-lists for long-term care beds.

Team members interviewed during tracers demonstrated a passion for their work, and several commented that they "loved" their jobs. On both the ABI and the spinal cord injury (SCI) units there was evidence of collaborative practice amongst the members of the interdisciplinary team, and a desire to evaluate and improve the effectiveness of interventions. The members of the interdisciplinary team working in the NSRC function within a program management model; allied professionals have the support of practice leaders, as well as program leaders.

Quality and patient safety is included as a standing agenda item at program and team meetings. Hand hygiene and infection rates were visibly posted on staff communication boards. The corporate patient safety reporting system (PSRS) for reporting of patient safety incidents is used for reporting of errors and safety related incidents. The reporting of near misses seems to have increased over time. During the tracer an attempt was made to log an event (slip/fall) in the PSRS. It was not possible to complete the incident report as the PSRS's drop-down feature to record the location of the event was non-functional. Staff members reported frequent problems with the system and that a back-up manual reporting system was not available. It is recommended that the PSRS be reviewed with users to explore the nature of the reporting problems, both inputting events and generating reports, as both issues were evident during the tracers. Please also refer to comments made under Impact on Outcomes report section on the use of data/information about incidents.

The equipment available to the team to deliver rehabilitation services on both the unit and in the common treatment areas is antiquated. The therapeutic pool has been out of service for more than two years due to problems with leaking pipes. The treatment plinths in the gym are not height adjustable, and there is only one ceiling lift on the unit. The lack of necessary equipment and technology limits the ability of the team to accommodate patient needs and to provide efficient and effective care and treatment options for this complex patient population. In addition, neuro-cognitive/behavioural issues that are inherent in the ABI patient population would be better addressed with the availability of therapeutic quiet rooms and/or private (bed) rooms.

Priority Process: Competency

There is a strong interdisciplinary team in place on this unit. The team presented as capable and passionate about their work with this complex patient population. A matrix reporting relationship exists for clinical staff members that report to both program and discipline/practice leadership. The team is positive about the hospitalist model and rounds. Family members are seen as an integral part of the team and there are opportunities for families to 'room-in' to learn and participate in the care routines for their loved one.

New staff members have orientation meetings with their manager and an acquired brain injury (ABI) team leader. A staff mentor is assigned to support skill development. An orientation checklist is in place. Capital District Health Authority (CDHA) has an online learning management system (LMS) for staff education related to corporate, and mandatory topics such as falls assessment. Students are welcomed on the unit.

Priority Process: Episode of Care

The acquired brain injury (ABI) program has an integrated interdisciplinary assessment and goal-planning process in place. The team collaborates to develop a care plan that focuses on behaviour modification strategies for aggressive behaviours. Staff members have received training in non-violent behaviour modification strategies. Case conferences focus on a preventive approach such as preventing escalation of behaviours. The ABI program is commended for the efforts to provide a full continuum of services for the ABI clients to address the challenges of re-integration to community living. Beyond the Nova Scotia Rehabilitation Centre (NSRC's) inpatient program, a robust day program, outreach team, and out-patient services are offered.

A new format for the day program was introduced to better meet the needs of the clients, streamline processes, reduce duplication and increase efficiency. This initiative is an example of patient/citizen engagement as the new format was implemented as a result of feedback from patients that suggested staggered start times for the program, group format, and so on. Feedback is solicited after every session and outcome measures are tracked. The program has a mandatory core program component, followed by theme-based options such as the relaxation series which includes acupuncture each for a six-week period. The focus is on teaching strategies to help patients manage identified areas of difficulty.

The ABI outreach team supports people with ABI in a geographic area that for the most part coincides with the geography of Capital District Health Authority. The team supports patients and families in the transition from hospital to home, and strives to build community capacity to support these patients.

The program tracks wait-time for admission and priority criteria are in place to monitor urgency of referrals for inpatient beds. The program approach to care and treatment of patients with ABI is commendable, as it promotes and supports early discharge of patients from the inpatient unit. This is particularly relevant, as staff members indicated that there are limited services available in the community to support patients with ABI. The inpatient integrated team assessment includes standardized outcome measures and an integrated goal sheet. Outpatient therapists also use standardized outcome measures to monitor goal attainment. Chart audits are completed. Inpatients receive an excellent discharge planning binder/booklet with education material and discharge instructions.

The transfer of accountability (TOA) checklist ensures that critical information about patients is effectively transferred at transition points that is, transfer between units, at shift change, and when a patient leaves a unit for a procedure. The checklist ensures that the exchange of information is documented. The TOA checklist was completed on all charts reviewed during the tracer.

The unit staff members are commended for their focus on infection prevention and control (IPAC). Housekeeping, nursing, allied health, and family are all viewed as having an important role in keeping patients safe by ensuring a clean environment. Staff members questioned during the tracers were aware of the unit's hand-hygiene audit rates and the four moments for hand hygiene. For patients on isolation precautions, personal protective equipment is placed outside the patient room. A housekeeper questioned during the tracer had 'all the right answers', when asked about cleaning protocols for the rooms of patients on isolation precautions.

The Pyxis medication system is in place on the unit for dispensing of medications, as is a robust, staged/phased self-medication program for patients. Medications are dispensed from the Pyxis medication system and then taken to the patient and the blister packages opened and administered on location. Nurses were observed during the tracer and they were only taking the medications for one patient at a time, returning to the Pyxis machine for the next patient's medications.

Feedback from patients and family members interviewed during tracers was positive and best summed up by one patient's comment that the care on this unit is: "second to none". The mother of an ABI patient indicated that the team has been extremely supportive and "like family".

Priority Process: Decision Support

The acquired brain injury (ABI) team hosts the inter-professional Atlantic Canada Stroke conference. This conference promotes advances in evidence-based practice in stroke care across the continuum, as advances relate to the Canadian best practice guidelines, as well as practice experience in stroke assessment and rehabilitation. The conference also generates revenue for the program.

The team is commended for its creativity in advocating and promoting best practices for their patient population, including the patient, family and staff engagement. The video being produced in partnership with an artist-in-residence and a documentary filmmaker associated with Dalhousie Medical School is an example of an innovative approach to engagement. The video will feature real life stories of real patients and their families, documenting their experiences related to their injury and rehabilitation, and will be produced in an environment that promotes and explores creative expression. Patients, families and staff members will also learn to use a camera and record sound bytes. The video is expected to be completed in December 2013.

Priority Process: Impact on Outcomes

The team benchmarks its performance against the Canadian best practice guidelines from the Canadian Stroke Network, which has been endorsed by the Nova Scotia Ministry of Health, and the minimum data set from the Nova Scotia Stroke Strategy. Benchmarks for traumatic brain injury are less well developed, as the Canadian Institute for Health Information's acquired brain injury (ABI) indicators and data are gross measures.

Standardized outcome measures recommended by the Canadian Stroke best practice recommendations are used with inpatients. The outpatient team uses goal attainment scaling to monitor progress of patients. The day program uses standardized outcome measures on admission to the program, at the end of each of the series/sections of the program, and again at discharge.

Team huddles take place three times per week, and registered nurses (RNs) review key indicators at the patient level at shift change regarding isolation status, code status, Braden scores, Morse scores, and so on.

A quality and patient safety team scorecard has been developed to align operation related team goals with Capital District Health Authority's 2013 milestones and 2016 strategic goals and to track trends in improvement in the ABI unit. Most of the indicators on the scorecard are rate based, and although compliance is tracked, no targets were apparent.

Patient satisfaction scores are reported on a fiscal year basis, but no trending information or targets were noted during the survey. Open text comments were transcribed, but not linked to any key themes arising from the quantitative data. Long-term trend reports of incidents on the ABI unit were provided and these show numbers of incidents over time, but little to no interpretation of the data was noted. It is suggested that run-charts, with trend lines, may be a more effective way for displaying these results complete with annotations to help explain trends or changes over time to front-line leaders and clinicians.

3.3.2 Standards Set: Ambulatory Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for ambulatory care services are measurable and specific.	
Priority Process: Competency		
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.9	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
7.5	The team monitors and works to reduce the length of time clients wait for services beyond the time the appointment was scheduled to begin.	
11.6	The team follows the organization's established policies on storing and disposing of medications safely and securely.	!
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
18.3	The team compares its results with other similar interventions, programs, or organizations.	
18.4	The team uses the information it collects about the quality of its services to identify successes and opportunities for improvement, and makes improvements in a timely way.	
18.5	The team shares evaluation results with staff, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is an ambulatory clinic leadership team which does not include endoscopy services therefore, planning services is spread over several service lines.The orthopaedic clinic has a quality team which meets monthly and it has a patient/citizen on the team. There is a strong working relationship between the ambulatory clinics and in-patient units at the larger sites and between the endoscopy unit and OR services at the smaller

sites. This collaboration facilitates maximizing of services, space and staffing. There were many examples of changes to services based on the changing needs of clients, for example, addition of administration of iron at the Hants site.

Reprocessing of scopes for endoscopy is either done in the department such as at the Victoria General site or by central processing at the Hants site. All equipment including sterilizers are part of a preventive maintenance program. Preventive maintenance logs are kept by the maintenance department and priority is given to reprocessing equipment. The maintenance department follows manufacturers' guidelines for servicing. Staff members follow established processes for transporting soiled equipment.

The distance between the respiratory clinic at the Halifax Infirmary site and the pulmonary function area was identified as a challenge for respiratory compromised clients.

Priority Process: Competency

There are strong orientation programs for all of the clinics and endoscopy suites visited during the survey. There are skills checklists that outline required competencies for staff members and renewal of skills is done yearly and tracked. Staff members were generally satisfied with the amount and type of education provided with the exception of the respiratory clinic at Halifax Infirmary where they felt additional educational offerings would benefit these staff members and their patients.

Although infusion pumps are seldom used in several of the ambulatory services, all appropriate staff members have had inservices and they update this skill on an annual basis.

There were several examples where staffing changes had occurred to maximize scopes of practice and also to improve access to services. There are robust mechanisms in place for sterilization and there are frequent audits done by the infection control practitioners. Staff members responsible for reprocessing are proud of the work they do and are vigilant with their processes.

Priority Process: Episode of Care

The teams have mechanisms to ensure that clients are seen in a timely manner. There is flexibility in some of the clinic schedules to facilitate quick access if necessary. At the endoscopy clinic at Victoria General site there has been a great deal of work done to clean up wait-lists and more transparently in aligning them to patient need. The team is strongly encouraged to continue this work as increasing volumes are out stripping capacity.

All observed areas monitor their no-show lists and have mitigated by following up to find out the reason why a client did not show up and also, they now have a telephone reminder process.

Medication reconciliation is only done in clinics such as the respiratory clinic as it is a significant part of the population needs such as patients with cystic fibrosis. Appropriate consents are obtained for invasive procedures following district policies/procedures. Few medications are administered in the ambulatory clinics or program and when they are then appropriate procedures are followed.
There is good clinical pharmacy support to the teams and patients.

In Dartmouth a concern about patient privacy resulted in the construction of dividing walls which now enables difficult discussions to occur in a respectful and private manner. The HPF electronic record is used and transfer of information at transitions is well done. Discharge summaries are either sent via facsimile to family physicians or scanned into the permanent health record. There is a wide array of educational

information for clients and teams are encouraged to ensure that the materials are at appropriate literacy levels.

The team at Halifax Infirmary is encouraged to modify the approach of calling out a patient name in the large waiting room to indicate that a particular patient can proceed to the clinic.

Priority Process: Decision Support

At all of the clinics visited during the survey there were many examples of evidence-based practices such as the treatment of congestive obstructive pulmonary disease (COPD), common orthopaedic conditions, endoscopy indications for treatment and so on.

The recent development of a working group of medical gastro (GI) physicians, family practice and GI surgeons is showing promise for standardizing referrals for irritable bowel, and at what point do they need an endoscopy. Research activities are undertaken at several of the clinics and staff members are well-versed in the accepted protocols and processes for ethics reviews and patient consent.
There has been a recent change that requires sign-off from the administrative director to ensure that the team has capacity to fulfil the requirements of a particular research study.

Priority Process: Impact on Outcomes

All staff members interviewed are aware of the falls prevention strategy and at all sites visited during the survey the reported falls have been minimal for example, two in the past four years at one site, and zero at another site. Patient satisfaction surveys have been conducted at some sites with high positive comments. All clients interviewed reported high satisfaction with services and care and caring of the team. Two clients identified transportation as a challenge to attending their clinic.

3.3.3 Standards Set: Ambulatory Systemic Cancer Therapy Services

Unmet Criteria			High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy			
9.14	When medication therapy is a significant component of care, the team reconciles the client's medications with the involvement of the client, family or caregiver at the beginning of service. Reconciliation should be repeated periodically as appropriate for the client or population receiving services.		ROP
	9.14.1	The team provides documented rationale for the selection of target clients or populations to receive formal medication reconciliation.	**MAJOR**
	9.14.2	There is a demonstrated, formal process to reconcile client medications at the beginning of service, and periodically as appropriate for the client or population receiving services.	**MAJOR**
	9.14.3	The team generates or updates a comprehensive list of medications the client has been taking prior to the beginning of services (Best Possible Medication History (BPMH)).	**MAJOR**
	9.14.4	The team documents any changes to the medications list (i.e. medications that have been discontinued, altered, or prescribed).	**MAJOR**
	9.14.5	The team provides clients and their providers of care (e.g. family physician) with a copy of the BPMH and clear information about the changes.	**MINOR**
	9.14.6	An up-to-date medications list is retained in the client record.	**MAJOR**
	9.14.7	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
16.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.		ROP
	16.3.1	There is a demonstrated, formal process to reconcile client medications at referral or transfer.	**MAJOR**
	16.3.2	The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	**MAJOR**
	16.3.3	The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	**MAJOR**

16.3.4	The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	**MAJOR**
16.3.5	The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	**MAJOR**
Priority Process: Clinical Leadership		
2.5	The team has sufficient space to accommodate its clients and to provide safe and effective services.	
Priority Process: Competency		
3.5	Sufficient workspace is available to support team functioning and interaction.	
5.11	Team leaders regularly evaluate and document each team member's performance and competency in an objective, interactive, and constructive way.	
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: Episode of Care - Ambulatory Systemic Cancer Therapy

The Cancer Centre is a tertiary centre for all adult patients in the province of Nova Scotia. Pediatric patients are treated at the IWK Health Centre facility.

The systemic ambulatory program is separated into two ambulatory clinics. Solid tumours are treated on the eleventh floor and hematology patients are treated on the fourth floor. There is an ethical framework available to assist staff members in decision making. The staff members provide a robust self-management program for patients' own medication in particular, oral medication which is brought into the clinic or taken after systemic treatment. There is a robust process to document independent double checks on the infusion pumps prior to administration and the patient is shown the medication infusion pump prior to starting the infusion.

The patient medication orders are scanned into the visit history for retrieval at next visit however, this is system is not consistently reliable and on occasions, the scanned copy cannot be found. The order is also sent

via facsimile to the pharmacy and the 'faxed' copy has been used as a back-up for those occasions when the scanned order could not be retrieved. It is recommended that the Cancer Centre implement a computerized physician order entry (CPOE) system to improve patient safety, timely processing of medication orders and improved coordination with the radiation oncology department.

The nurses collect the best possible medication history (BPMH for the patient but medication reconciliation is not in place.

Priority Process: Clinical Leadership

The ambulatory systemic treatment area redesign (ASTAR) has recently embarked on a project to consolidate the solid tumour (11 Victoria) and hematology (Medical Day) systemic cancer treatment areas and also redesign the model of care in order to sustain timely access to safe, appropriate and consistent patient care. One of the goals is to change from a five-day per week clinic to a 365 day per year clinic and this will address the increased demands for systemic treatments. The redesign work is being led by the clinical staff members and physicians working in the two units and supported by a clinical engineer. In addition, several patient focus groups have been held to obtain their input. As the work continues, patient input will be solicited again. The goal is to bring these two ambulatory units into adjacent space along with the chemotherapy pharmacy area. The employee engagement is outstanding and the depth of understanding and appreciation of the inter-professional team achieved to date is remarkable.

The pharmacy prepares the chemotherapy for outpatient clinics, the medical day unit/hematology and the 11th floor chemotherapy unit. Currently, staff members prepare about 100 doses per day using the two laminar air flow hoods. There is no ante room available so orders are received and medications and intravenous (IV) sets/bags are pre- assembled in the same space as chemotherapy is prepared in the hood and the final product is checked. This is cramped space for the volume of chemotherapy prepared and this is a patient safety concern.

Once completed, the final produce is 'portered' to the units. The schedules of these two busy clinics are not integrated which presents challenges for the pharmacy to prepare the medications in a timely way. Ideally, the chemotherapy pharmacy should be adjacent to the chemotherapy outpatient clinic. The ASTAR project is standardizing practice in the two clinics and eventually, the plan is to consolidate the clinics in the same space. As well, the chemotherapy pharmacy should be co-located and should be designed to meet the US Pharmacopeial (USP) 797 standards. This will be a significant patient safety improvement. The management and team are applauded for their commitment to patient care in undertaking this process redesign.

Priority Process: Competency

There is an electronic learning module available for training of staff. New staff members receive comprehensive orientation and mentoring by experienced staff. In addition, the systemic clinics provide orientation to new staff members working on the inpatient hematology and bone marrow transplant units.

There is insufficient space in the pharmacy to safely prepare the volumes of daily doses, as described in the comments for the Clinical Leadership priority process.

Staff members report there is inconsistency in performance appraisals completion.

Priority Process: Decision Support

The program currently participates in 75 clinical trials which are supported by dedicated clinical trial nurses and pharmacy technicians.

The patient chart is a paper based and requires processing by the nursing staff on the 11th or fourth floor and then portering to the pharmacy on the sixth floor. The team would benefit from a computerized physician order entry (CPOE) system which would improve not only the coordination of information amongst professionals, but also decision support tools embedded within the software.

Priority Process: Impact on Outcomes

Members of the nursing team reported issues with the Hospira intravenous (IV) sets which resulted in a national recall of these faulty sets and a risk to patient safety. Cancer Care Nova Scotia and the Canadian Cancer Society patient educational materials are provided to the patients. Staff members are vigilant about reporting incidents, in particular those medication related, and every incident report is discussed at staff meetings, and strategies to prevent further events are regularly implemented.

The pharmacy has created a unique clinical pharmacy technician role to assist the clinical pharmacist and ensure that staff members are working to their full scope of practice.

Owing to patient volumes in the 11th floor chemotherapy clinic, nursing staff members mentioned that they do not want to interrupt the pharmacist while entering orders.

Priority Process: Medication Management

There are notices to avoid use of cell phones on the ambulatory clinics and notices in the pharmacy preparation area to minimize noise and potential distractions. There have been reviews of chemotherapy preparation areas conducted by Nova Scotia Cancer Care and recommendations such improvements in labelling and other processes have been incorporated into the work flow in the pharmacy.

The team is proud of the many safety checks which have been introduced in their daily work flow and how they enhance patient safety.

The pharmacy is located on the third floor and the medical day clinic/hematology unit is located in the fourth floor and the systemic chemotherapy clinic is located on the 11th floor. Currently, there is no ability for the scheduling system to coordinate the workload of these pharmacists.

The pharmacy has recently improved safety by priming the lines for the nursing staff under the IV hood but there is opportunity to enhance safety with the introduction of a closed system such as PHASEAL.

3.3.4 Standards Set: Biomedical Laboratory Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Laboratory		
3.1	The laboratory has a procedure to transport samples to and from the laboratory. ISO Reference: 15189-07, 5.4.6.	!
4.7	If tests are performed outside the laboratory, the appropriate individual applies the same processes and procedures as used in the laboratory.	!
6.1	The organization has defined those situations in which testing and analysis may occur outside the laboratory.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Laboratory		

Processes around transportation of specimens within and between sites/locations varies and this needs to be reviewed.

The specimen transport container, including the pneumatic tube system require validation to ensure temperature fluctuation during transport does not adversely affect sample integrity.

Tremendous work has been done in collaboration with nursing educators in the development of the new laboratory collection manual.
Clinical areas are encouraged to recognize the need for the importance of document controlled references.

3.3.5 Standards Set: Blood Bank and Transfusion Services

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

Surveyor comments on the priority process(es)
Priority Process: Blood Services
Transfusion medicine has recently completed an intense audit by the American Association of Blood Banks (AABB) and a previous survey was undertaken in 2011. Significant improvements were noted between the 2011 and 2013 surveys. Work is now underway following the recommendations of the AABB to improve the processes related to validating, calibrating, cleaning and preventive maintenance (PM) on general laboratory equipment such as refrigerators, freezers, plasma thawers, centrifuges and others along with biomedical, refrigeration specialists and others. The criteria for inspections and PM schedules need to be clearly defined for each type of equipment, along with timely feedback to the laboratory at each of the sites. Should biomedical and/or refrigeration specialists be unable to meet the demands and requirements for timely preventive maintenance, calibration and so on of essential equipment such as blood bank refrigerators due to competing priorities or lack of resources, then the option to engage commercial providers of this service should be considered for laboratory equipment. Opportunities exist for increased collaboration between transfusion medicine and clinical staff for matters related to the transfusion of blood and blood products. For example, education on the ever changing and challenging standards and regulations around transfusion medicine at all sites. The teams also work together to simplify and streamline the charting for transfusion of blood and blood products. Competencies of all nursing staff members performing transfusions needs to be done on a regular basis, documented and audited. 'The laboratory is commended for developing a state-of-the art electronic system or dashboard to provide real time monitoring for the status of blood and blood components. This is resulting in significant positive outcomes such as reduced wastage due to outdating, and being able to monitor any patients with reduced platelet or hemoglobin results to predetermine potential transfusion requirements. The same system also tracks the status of other laboratory tests throughout the process, from receipt to result and in real time. The screen is colour coded (green red or yellow) indicating whether a sample is on target for turn around time or not. The large screens are strategically placed for technicians to view and monitor.

3.3.6 Standards Set: Cancer Care and Oncology Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.6	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.		
Priority Process: Episode of Care			
7.5	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.		ROP
	7.5.1	There is a demonstrated, formal process to reconcile client medications upon admission.	**MAJOR**
	7.5.2	The team generates a Best Possible Medication History (BPMH) for the client upon admission.	**MAJOR**
	7.5.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
	7.5.4	The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
	7.5.5	The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	**MINOR**
9.4	The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.		ROP
	9.4.5	The team has a system in place to measure the effectiveness of pressure ulcer prevention strategies, and uses results to make improvements.	**MINOR**
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**

11.3.2	Depending on the model, the prescriber uses the Best Possible Medication History (BPMH) and the active medication orders to generate transfer or discharge medication orders (proactive), OR, the team makes a timely comparison of the BPMH, the active medication orders, and the transfer or discharge medication orders (retroactive).	**MAJOR**
11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
11.3.4	Depending on the transition point, an up-to-date medication list is retained in the client record (internal transfer), OR, the team generates a Best Possible Medication Discharge Plan (BPMDP) that is communicated to the client, community-based physician or service provider, and community pharmacy, as appropriate (discharge).	**MAJOR**
11.3.5	The process is a shared responsibility involving the client or family, and one or more health care practitioner(s), such as nursing staff, medical staff, and pharmacy staff, as appropriate.	**MINOR**

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 Cancer Care program has strong administrative and physician leadership. The team has established goals which link to the recently approved: "Our Promise in Action" strategic priorities. There are specific metrics which have been identified under each of the five goals and the program is encouraged to quantify these metrics for monitoring purposes.

The program has recently moved a nurse practitioner (NP) from the medical hematology clinic to the hematology inpatient unit to provide improved continuity of patient care. The feedback from staff members is extremely positive and on occasions, the NP had attended a family meeting in the hematology clinic to provide for continuation of care as the treating hematologist had not yet met the patient.

The leadership team has recently realigned the manager responsibilities of the Systemic Chemotherapy clinics and Ambulatory clinics under the Cancer Care program. As a result of this change, the ambulatory systemic treatment area redesign (ASTAR) has recently embarked on a project to consolidate the solid tumour (11 Victoria) and hematology (Medical Day) systemic cancer treatment areas. This will include a re-design of the model of care to sustain timely access to safe, appropriate and consistent patient care.
In the radiation oncology department, a new physicist manager has been recruited internally. The new radiation services committee and radiation executive are a highly motivated and energized group which has successfully implemented the new electronic medical record (EMR) system.

Priority Process: Competency

The members of the inter-professional team complete extensive training and education to provide excellent patient care. On the hematology unit and ambulatory clinics, nursing educators support staff members, and assist with orientation and adherence to best practices. In the radiation oncology department, the medical radiation technologists (MRT) in that department are supported by two full-time equivalent (FTE) educators. The nurses, physicists, and MRTs attend continuing educational conferences and are encouraged to attend the oncology grand rounds. The program supports training of students from all disciplines along with research.

There are strong links between the medical day clinic and inpatient bone marrow transplant (BMT) hematology unit to support and facilitate transitions of care for the patient.

There is insufficient physical space for clinical team to document in quiet areas on the inpatient hematology unit (8A/8B) and this needs to be addressed.

Priority Process: Episode of Care

There are well-established inter-professional cancer tumor site team meetings to discuss the treatment plan of patients. These meetings include surgeons, medical oncologists, hematologists, and radiation oncologists. In addition, other members of the inter-professional team such as nurses and radiation therapists are encouraged to attend as educational opportunities.

There is a comprehensive process in place for patients that are considering a bone marrow transplant (BMT) facilitated by the BMT coordinator including education, selection of a suitable donor of allogenic or autologous stem cells and coordination with the hematologists/BMT unit. Extensive educational supports are provided for patients.

There is an excellent package of information provided to patients on how to access service after hours. For example, the patients receive a yellow: "Patient with Cancer and Fever" card, with patient instructions on one side of it, and management recommendations for patients with cancer who are febrile neutropenic when presenting to the emergency department. As well, the medical day hematology clinic is open 365 days per year. Patients reported that requests for information were provided in a timely manner in all areas of the Cancer Centre.

There is a beautiful family room on the hematology unit for families to gather and the waiting are in the radiation oncology area is spacious. There are plans to improve safety related to the administration of narcotic infusions, with the introduction of pain controlled analgesic (PCA) pumps in January 2014.

The patient medication is reconciled on admission and discharge for the hematology inpatient unit but this is not occurring in the radiation oncology clinic.

Priority Process: Decision Support

The radiation oncology clinic has recently introduced an electronic medical record (EMR) which records the patient radiation plans, treatment and clinical notes of all members of the inter-professional team. Extensive training was provided to nursing staff, educators, radiation therapists, medical physicists and radiation oncologists. There are ongoing quality assurance audits conducted to ensure accuracy of information documented. Staff members will provide feedback when improvements are required.

Given the fact that between 20 and 25 percent of patients receive concurrent chemotherapy and radiation therapy, the Cancer Centre is encouraged to implement the EMR module for the chemotherapy clinics to ensure accurate flow and documentation of patient orders and information. As an interim solution to improve flow of information, the radiation charge therapists and charge nurse in the hematology clinic meet weekly to ensure patients requiring combination radiation/chemotherapy treatments are booked on the same day and radiation/chemotherapy stickers are affixed to the chart.

The Cancer Centre participates extensively in clinical trials, including both systemic therapy and radiation therapy. The radiation oncology department has a systematic project management approach to assessing new technology and new radiotherapy techniques.

Priority Process: Impact on Outcomes

The leadership in all areas of the Cancer Centre has fostered a culture of patient and staff safety. Front-line staff members are encouraged to document incidents in the patient safety reporting system. As a team they discuss the occurrences and how to implement system improvements in their respective areas. For example, the manager on the hematology unit achieved significant improvement in the incorrect cytomegalovirus (CMVR) blood products ordered after reviewing the incident reports. The manager determined the root causes and implemented strategies such education to unit clerks and residents on the ordering/input of these blood products. The improvement has been sustained.

The radiation oncology team has staff members dedicated to data quality management to ensure accurate information is being submitted to the Department of Health and Wellness. The quality review team is providing timely feedback to staff members so that corrective action can be taken. There are numerous safety checks built into the processes to ensure the patient receives the prescribed radiation for their treatment.

The radiation oncology department recently purchased three new machines. With the advanced functionality, there is opportunity to make changes in practices. A rigorous methodology was used to study every process step for safety and efficiency. The team is congratulated for the excellent work.

3.3.7 Standards Set: Case Management Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The organization uses a team approach to develop its goals and objectives.	
Priority Process: Competency		
4.8	The organization regularly evaluates and documents each staff member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
6.10	The organization assists its clients and their families in accessing essential services 24 hours a day, seven days a week.	!
8.10	The organization follows a process to identify, address, and record all ethics-related issues.	!
11.5	Following transitions or at the end of service, the organization contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end-of-service planning.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
2.3	The organization's goals and objectives for its case management services are measurable and specific.	
15.2	The organization monitors clients' opinions on the quality of its case management services.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This is the first accreditation survey for case management services known as integrated continuing care Services. The core services provided by the continuing care team were previously managed by the Nova Scotia Department of Health which still funds, audits and licenses care provider agencies. Continuing care coordinators and placement staff members were devolved to Capital District Health Authority (CDHA) between 2009 and 2011. Since then, services have been enhanced with the addition of rehabilitation services, a transition unit in Halifax and the development of initiatives such as the Home Again program. Services are aligned with two of the organization's strategic directions namely, customer service and appropriateness.

The organization is commended for embracing the Home Again philosophy that enables more people to be served at home by way of coordination of a wide range of services. Specific resources are dedicated to providing intense case management and personal care services after hospital discharge or to prevent emergency admissions. A provincial Home First program has since been added to the range of available services. In addition, CDHA has implemented a transition fund to pay for up to $500.00 of expenses for people being discharged from hospital, on approval by continuing care staff. These programs have resulted in reduced long-term care (LTC) waiting lists and alternate level of care (ALC) days in hospital.

The team maintains close partnerships with many agencies and services across the communities in the CDHA and provincially. Public and stakeholder education services are provided to raise awareness of services for example, making presentations to seniors' groups.

Continuing care coordinators are organized according to client needs and level of complexity in five pods, or groupings. Clients are assigned by intake coordinators according to the expected degree of case management and geographic location. This approach has streamlined responses to requests for referrals and information. The organization is encouraged to continue to assess workload equity for coordinators and the need to minimize client transfers between pods.

The staff work space at the Joseph Howe building contributes significantly to effective communication, safety and workplace wellness. Staff members appreciate the wellness (quiet) room and the outdoor deck. Information systems support is available when needed for troubleshooting and education.

Priority Process: Competency

Interdisciplinary teamwork has been enhanced by the integration of rehabilitation staff members and the behavioural consultant into the continuing care team.

The continuing care staff orientation program is comprehensive and includes mentorship by an experienced staff member. Staff education on the necessary skills, knowledge and philosophy is provided during team meetings and forums. Staff members report good access to opportunities for further education and training. The team has a dedicated educator and staff report that opportunities for continuing development and compliance with mandatory education requirements are available in many formats.

There is easy access to online access to policies, procedures and guidelines.

Priority Process: Episode of Care

The team has improved the timeliness of responding to requests for information and services from the public and other referral sources as a result of process improvement and work redesign.

The organization is currently using the request for proposal (RFP) process to select home support (HS) agencies. This will enhance accountability for quality of care and services and should help address the issue of patients waiting for discharge in acute care beds because of inadequate access to personal support in the community.

The internationally standardized resident assessment instrument, home care (RAI HC) assessment tool is used to conduct assessments for every client. This is done using the provincial SEAscape computer system. The circle of care has been expanded to include the Dartmouth Hospital and Halifax Infirmary emergency departments. There is now capability to generate 'star flags' when clients are admitted to emergency or inpatient units. Hospital-based care coordinators are now using the assessment to determine access to both

home-based and long-term care services. Assessments are shared with external service providers in the circle of care and are transferred to the next level of care.

Priority Process: Decision Support

The ability to access acute care client information including flags to indicate client admissions to emergency or an inpatient unit via the acute care information system has improved communication, safety and care planning. Staff members use the provincial SEAscape system to collect and analyze resident assessment instrument (RAI) data for chronic clients, including outcome scales to monitor client status and needs. The team is encouraged to advocate to obtain other RAI out-puts including quality indicators and case mix.

The team is encouraged to benchmark and compare outcome and quality measures with other similar teams in other health districts and provinces. Comparative information developed from RAI assessments is starting to be reported by the Canadian Institute for Health Information (CIHI) at the provincial level but breakdowns by region and geographic area would prove useful.

Key indicators such as the prevalence of nursing service provider capacity alerts demonstrate improvements to client flow. Transfers from long-term care facilities to emergency departments have decreased by 40 percent because of the care by design program including regular physician visits, order sets and enhanced services from paramedic staff.

The organization is reviewing and adopting the national case management guidelines with input from staff.

Priority Process: Impact on Outcomes

Criteria have been developed to assess priority for admission to long term care. The team is encouraged to continue to work with contracted home support agencies to reduce wait-lists for services.

Information on hospital alternative level of care (ALC) patients waiting for placement was used to develop the Home Again program. Since its introduction three years ago, the number of clients in the home support program has increased to an average of 60 per day, thereby reducing acute care lengths of stay and maintaining clients at home longer. The program was expanded to include serving clients before they need to go to the emergency department (ED), based on data collected on client needs and use patterns.

There are challenges with wait-times for long term care (LTC) in acute care and the community. The organization is encouraged to explore more housing options so that clients are not added to long term care wait-lists in advance of needing that level of care and capital investment. Wait-times for personal care particularly need to be addressed. Investment in community services to address waiting in hospitals for home care will need to be considered when the contracts fall under the responsibility of Capital District Health Authority (CDHA).

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The community-based mental health programs at Cole Harbour, Connections Dartmouth, and Abbie J. Lane Day Treatment program all provide an excellent client-centred approach to care. The teams take a patient-centred, strengths-based approach in providing services and supports. At Cole Harbour, the service and supports are recovery oriented and focused on well being. With the newly integrated addiction and mental health program at Abbie J. Lane, an enhanced recovery focused model is under development. The Day Treatment program has a limited understanding of the population needs beyond the consultation process completed by the organization. There is an opportunity for improvement to complete a comprehensive needs assessment of the community mental health and addictions service needs. For example: methadone programs and enhanced rural service delivery and community models of care. There is also an opportunity to develop a complex care focus.

The Day Treatment program is a great example of how the organization reviews service demands and utilization to adjust programs based on client feedback, now introducing topics required to focus on wellness for example, nutrition.

The team has good access to supplies and equipment needed to deliver mental health services however, opportunities have been identified to have improved access to spiritual care, food and nutrition services, neuro psychiatry testing, and access to mental health and psychiatric services in rural areas.

There is excellent team functioning and leadership support reported by staff members, with good access to professional development opportunities.

There are good partnerships with community organizations, corrections, foundations, consumer and family organizations and Health Minds Co-operative is just one example. Partnering with organizations to deliver mental health promotion sessions in the community is an opportunity for improvement. The organization has a good partnership with the police with education and training, and with the mobile crisis team.

Cole Harbour services a large geographical area, including the diverse African Canadian community at Preston Lake. An environmental scan and community needs assessment has been carried out to collect information about the community served. Working with family physicians has helped to further identify community needs. Family physicians refer between 80 and 90 percent of the referrals. The organization is moving into a collaborative care model with family physicians (FPs) in the remote communities of Sheet Harbour and Middle Musquodoboit to build capacity and support for FPs.

The organization's goals and objectives are aligned with the strategic priorities. Wait-times are below the expected standard of two weeks. Clients can virtually be seen within one or two days. There are good relationships and communication between FPs and the psychiatrists. First visit summaries are sent to the FP, with ongoing correspondence for any changes in mental status, a change in medications, or when discharged from care. The team is high functioning and supported by the leadership of a manager and psychiatrist clinical academic leader.

Priority Process: Competency

The organizations supports multidisciplinary learners. At Cole Harbour site there are between six and eight persons at any given time.

Staff members have excellent access to conference and training, non-violent crisis intervention, assessment, suicide prevention and management therapies, with good clinical supervision evident in the mental health (MH) day treatment program.

Performance reviews are done together by both the manager and physician leader at Cole Harbour for all staff. The leaders believe it is extremely important for staff members to make the best contributions they can, to see where they bring value to the program, and where they have opportunities for growth. They also provide supervised practice for staff members to learn new therapies.

Orientation for new staff members in the MH program is provided by Capital District Health Authority (CDHA), and then on-site training is also provided. There exists a positive internal culture of trust and respect.

Community safety is a priority for staff members and there are protocols in place. Staff members report positive access to supports in the programs/organization, and EAP programs

There is good transition of care information in the day treatment program at admission, with an opportunity to improve transitions with discharge and follow-up with clients.

Priority Process: Episode of Care

There is consistent use of the Nova Scotia suicide assessment scale to monitor individuals at risk of suicide.

Medication reconciliation is consistently adhered to on admission and discharge, and reviewed with pharmacy, nursing physicians and clients.

There is excellent client and family feedback at the day hospital about the services offered such as the case management model, the respect from caregivers and the information provided.

There is a feedback and experience action team (FEAT) at Cole Harbour site. This team developed a mental health outpatient and inpatient satisfaction survey, as well as mental health outpatient family and friends satisfaction surveys. The FEAT team is made up of clients, families and staff. The information from the surveys go back to this committee to make improvements to services, and it involves collaboration with individuals living with mental illness, families and friends, care providers and community groups.

Priority Process: Decision Support

The program has processes to select evidence-based guidelines for its services. Examples are electroconvulsive therapy (ECT), psychotherapy, early psychosis program, day treatment program, shared care, and the mobile crisis services.

A provincial information technology (IT) strategy for an electronic health record (EHR) has been identified as the most urgent improvement initiative and area of risk. Currently, documents are scanned into the EHR, but there is no organizational flow to the chart. The clinicians must scroll through multiple documents. When addressed, this will be a significant patient safety advancement.

Priority Process: Impact on Outcomes

Numerous brochures are available in public areas at the Community Centre. Patient and family brochures are provided on admission to the day treatment program and note is made of the Guide for Family and Friends. This was developed in partnership with the mental health foundation and healthy minds co-operative with the CHDA.

Patient safety reporting is completed through the Patient Safety Reporting System (PSRS) and staff safety reporting is though the Safe Line.

Outcomes measures are limited, with minimal formal evaluation completed. At Cole Harbour site, first visit outcomes are measured, as well as after treatment. On an individual client basis, achievement of client goals are collected however, an opportunity for improvement would be to develop outcomes measures for the program.

3.3.9 Standards Set: Critical Care

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.2 The team's goals and objectives for its critical care services are measurable and specific.	
Priority Process: Competency	
4.6 Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care	
10.6 The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	ROP
10.6.5 The team has a system in place to measure the effectiveness of pressure ulcer prevention strategies, and uses results to make improvements.	**MINOR**
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 teams are extremely responsive to the needs of the community, the province and the Maritimes as per Capital District Health Authority's (CDHA's) regional and provincial responsibilities. The Critical Care program is a high performing service focused on providing leading edge care. There are three intensive care units (ICUs), and multiple intermediate care units (IMCUs) between the Victoria General and Halifax Infirmary sites. There are well-established collaborative relationships among the administrators and physician leaders of Critical Care, Heart Health, Neurosciences, Neurosurgery, and Cardiovascular services. These important relationships support the delivery of highly complex care, and assist with patient flow and access to the most appropriate beds during times where surge capacity is required. The teams collect data relative to the quaternary care provided across the Atlantic provinces, along with data related to secondary and tertiary care provided to the provinces of Nova Scotia and Prince Edward Island. Data are used to set priorities for planning and service design, benchmarking, and to support excellence in education and research. A critical care database would enable further research capabilities.

At Dartmouth General Hospital site, there is one eight-bed critical care unit that provides care for patients requiring ICU/CCU and step down levels of care. The team is responsive to its community needs and has developed a process for managing an increased demand for ICU beds. The leadership team identified a need for improved access to consultative and acute mental health services due to the high volume of mental health patients served in this community. There are good processes for the transfer of patients to the Halifax Infirmary site for a number of referral services. Repatriation can be challenging, and every effort is taken to accept patients as timely as possible. There are patient flow bed coordinators across all sites that work together to coordinate access to appropriate beds and services. A process called "Code Census" is implemented when the emergency department (ED) capacity meets a certain threshold.

All teams are encouraged to continue working together on the development of specific measurable goals and objectives that align to CDHA's five strategic streams.

A new model of care was implemented at the Dartmouth ICU site, which introduced the role of clinical team assistant (CTA). Team members had input to role design and responsibilities.

The critical care units are open concept, well-organized spaces, free of clutter with good lighting. There are multiple hand-hygiene stations and at the entry to every patient room. Family members have access to quiet rooms or waiting areas adjacent to the units. Equipment needs are regularly assessed by the teams and there is a process to request capital and non-capital requests via the manager.

Priority Process: Competency

Nursing recruitment has been challenging at various times across the ICUs in the Capital Health District. The human resources (HR) advisor assigned to the Capital District Health Authority (CHDA) created a centralized ICU pool, to fill site-specific vacancies based on skill and competencies required. The province has funded a three-month critical care program, which has been in place for about two years, and has proved beneficial.

There has been two ICU bed closures at the Victoria General 3A site during the last year because of the registered nursing staff vacancies however, as mentioned, innovative strategies have been implemented to provide bed capacity and appropriate staffing complements. A highly collaborative and collegial work ethic has afforded nurses the ability to work across Halifax Infirmary and Victoria General sites to provide a consistent quality of service. Many policies, procedures and equipment are standardized and this enables staff to transition safely across units. Staff members commented on the value of 24/7 respiratory therapy (RT) coverage. Staff members at the Dartmouth ICU are concerned about their staffing ratios, ability to cover the QRT responsibilities and respond to the code pager. The leadership team is aware of the concerns and has a plan to work with the teams to make improvements.

There is excellent educational support and training provided by talented clinical nurse educators and respiratory therapy educators, in addition to the resources via the learning management system (LMS). When staff were asked what they were most proud of, all responses were related to team functioning, level of talent among team and ability to provide quality patient-centred care.

Interdisciplinary rounds are conducted daily. Team members are engaged and have an opportunity to discuss care plans and goals for client care. There is also a discussion regarding the interventions needed by each of the disciplines to achieve the desired outcomes.

There is low compliance to performance reviews across many service areas. Managers are struggling with workload and large spans of control. An organizational strategy to review the tools and processes is recommended.

Some staff members seemed unaware of team-based recognition programs or activities.

Priority Process: Episode of Care

There is a quick response team in place at the Dartmouth site. The team is made up of ICU nurse, respiratory therapist, and family practice hospitalist on call. The team assesses and stabilizes patients on the units, and transfers to ICU as necessary. The team's current role does not provide follow-up assessments on patients discharged from the ICU.

This service is highly valued by the teams across the organization. Although there was no evidence to support the assumption, it is felt that transfers to ICU have been reduced since the team's inception. The team is encouraged to formally evaluate this service in order to evaluate the impact on outcomes to patient care.

The teams have implemented standardized practices to reduce duplication, such as multidisciplinary rounds to determine daily goals and treatment plans for every patient, and the recent implementation of electronic medication cabinets (Pixys). Venous thrombo-embolism (VTE) prophylaxis has been incorporated into the paper order sets and is assessed on all patients admitted to the ICU. The teams are committed to early ambulation within the limits of clients. Consideration of a ceiling lifts would prove beneficial to prevent staff and patient injury.

Pain management scales, Braden scale, Morse fall scores and delirium protocols have been implemented and documentation can be found in the client record. It is suggested that formal pressure ulcer prevalence/surveillance audits at regular intervals such as annually could be used to measure the effectiveness of pressure ulcer strategies and to make further improvements.

The team commented that documentation of incident reporting, classified as near misses are not reported as often as they should due the complexity and time requirements to complete the online form. This process requires reviewed.

Standardized paper-based client experience surveys are provided to clients prior to discharge from the unit. Clients and families are complimentary of staff members across all services. Additionally, patient satisfaction surveys are mailed to patients post discharge.

Priority Process: Decision Support

All Capital District Health Authority intensive care units (ICUs) are closed units with specialist leads.

The team identified the need to advance to an electronic health record (EHR) to reduce redundancies and the risk associated with paper-based documentation. Accomplishing this will be a significant patient safety advancement.

An electronic learning management system (LMS) is used by staff for mandatory education, and other self-administered education programs. Managers can collect data for individual staff members to track utilization.

Priority Process: Impact on Outcomes

The Safer Healthcare Now bundles for ventilator associated pneumonia (VAP) and central line infections (CLIs) have been implemented and data are posted on the quality boards in each of the units. Targets are currently being achieved. Safety briefing/huddles are held every morning to identify and mitigate potential risks to clients or staff.

Quality improvement boards with metrics are posted on each unit. It is not clear how these units are using this data to inform improvement activities. Units are encouraged to develop specific targets and goals for a small number of focused improvement initiatives.

Unit practice councils or quality councils are encouraged to focus on action plans, monitoring outcomes and ongoing opportunities to make further improvements. Teams are beginning this work at this time. Leadership members participate on the Capital District Health Authority critical care and quality councils.

Client information brochures have been developed to provide to clients and families. Clients and families are educated about their role in promoting safety, such as falls prevention strategies, and the importance of hand hygiene. Paper-based client experience surveys are provided to clients prior to their discharge from the unit. Encouragement is offered to consider an electronic means for client survey (iPads), with a automated program to aggregate results and trends.

Priority Process: Organ and Tissue Donation

Please refer to survey team comments that can be found in the report sections on Organ Donation standards.

3.3.10 Standards Set: Diagnostic Imaging Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
3.11 Each team member has an up-to-date, comprehensive personnel file or employment record.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Imaging	

Diagnostic imaging (DI) is fortunate to have a high functioning team of 250 full-time equivalents (FTEs) that provide service across 10 sites. The DI department is well organized with a strong leadership team. All major modalities are represented including positron emission tomography (PET) with an attendant Cyclotron facility.

Wait-times for plain films are essentially walk-in, computed tomography (CT) wait-times are about three weeks, and Fluro is about a week. Ultrasound is the major wait-time issue with about a 150-day period at the moment and this is due to lack of ultrasonographers despite of funded positions. There is really little elective magnetic resonance imaging (MRI) done as all slots are filled with urgent cases.

There have been challenges in the recruitment and retention of ultrasound and MRI technologists. In addition, many new hires may have completed a general MRI program without experience in specialized areas and this requires additional training and orientation of new staff.

The introduction of voice recognition technology has eliminated 12 of the 14 stenographer positions. There have been some challenges with the transcription error rates which the team is working on to improve.

With focused work flow redesign, turnaround times are now 12 hours for the ED, 24 hours for inpatients and 96 hours for outpatients.

Recently, an electronic survey was sent to referring physicians requesting feedback on the DI service. The physicians felt that the DI hours of service were limited and in response, DI has extended the hours from 0730 to 1800 hours Monday to Friday, and 0730 to 1500 hours on Saturdays. The DI department has provided explanations on wait-times and is undertaking an intensive education piece with the referring family physicians to set out appropriateness guidelines. This has been received positively and serves to maintain a collaborative relationship.

The breast cancer screening program is moving to the IWK but at the Cobequid Health Centre site, diagnostic mammography is still provided.

Dedicated training for hand hygiene has been provided to DI staff members along with training of DI staff members on the cleaning of the ultrasound probes. The department is commended on attention to patient and staff safety.

During the past five years, standardization of policies, procedures and preparation has occurred across all the CDHA sites. The staff members rotate across all the sites and this assists in the standardization process. The

DI department is considering peer review of diagnostic examinations. This may be initiated by the province but it would require a delay to wait for this process therefore, CDHA is considering starting this program on their own.

The DI department received a Capital Health Quality Award for process improvements with the GI examinations. The department is currently working with the orthopedic clinic on process improvements to improve turn around times.

A five-year capital equipment plan has been established with a prioritization process to determine the ranking of equipment. These rankings are subsequently submitted to the corporate process prior to approval. There is a shared service contract for equipment between vendors and their own staff. This works well and is economic.

There were some inconsistencies observed in the completion of performance appraisals.

Some of the challenges in DI are the aging equipment and long-term sustainability of the service due to the cost of the equipment. There are ongoing challenges in the recruitment and retention of sonographers to support ultrasound. Finally, there is increased demand for MRI, which is a mismatch of the resources allocated to this modality at a system level.

3.3.11 Standards Set: Emergency Department

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The team works together to develop goals and objectives.	
Priority Process: Competency		
3.6	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.13	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
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		
16.5	The team shares evaluation results with staff, clients, and families.	
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency departments (EDs) in the district work together to plan services and they have standardized policies and practices. As part of the network, services are continuously evaluated. There are many examples where services have changed or been modified based on the changing needs of their population for example, care of the frail elderly. There are strong links to community services such as the mobile service, and having a continuing care position as part of the team facilitates discharges. There are well established processes in place to isolate clients and screening is done at triage. The team tracks wait-times and uses them to make improvements, for example, at Halifax Infirmary (HI) site the team tracked wait-time for various consultants, posted the results, focused on outliers and improvements were realized. There are multiple students in the EDs and there are well-established processes in place for oversight. Volunteers are used in the triage area at the HI site.

The team is encouraged to develop service goals and objectives that specifically align with the organization's strategic plan.

Priority Process: Competency

There is strong evidence of interdisciplinary teamwork including for ambulance services. Security, nursing, physicians, social work, community liaison and discharge planner at Halifax Infirmary (HI) site and nurses, doctors and site chiefs at Cobequid Community Health Centre (CCHC). Staff members interviewed reported a robust and thorough orientation process, with flexibility, if more time is required from a new staff member.

The charge nurse ensures that workload and assignments keep up with the flow in the department. Infusion pump training occurs on an annual basis. Virtually all children go to the IWK centre and at Cobequid, staff members have the competencies to care for children if necessary. All thee staff members have pediatgric advanced life support (PALS) and pediatric trauma training. Staff members reported good in-service education, much of it online, and nurses have annual skills updates which include education on how to deal with violent behaviour. The paramedics and security personnel also reported good support for professional development. There is small simulation space at HI site and Cobequid also uses case scenarios to supplement other professional development.

There are challenges at Cobequid site as there is no access to consultants. There is limited flexibility of maximizing staff members due to different unions on the same site.

Priority Process: Episode of Care

The emergency department (ED) teams use the Canadian triage acuity scale (CTAS) process to triage patients for both walk-ins and ambulance arrivals and wait-times are tracked using the CTAS guidelines. At the Halifax Infirmary site there is an off-load team of nurse and paramedic which is decreasing the time that ambulance personnel are waiting in the ED. In fact, the ED teams work closely with the ambulance service.

At Halifax Infirmary (HI) site there is information on the television (TV) screen about what wait-times means in the ED setting. Periodically, the triage personnel or charge nurse at HI may alert patients in the waiting room as to how the long the wait might be. Patients are reassessed in the waiting room depending on their presenting condition and CTAS score. The rapid assessment unit at HI site has proven to increase the flow in the ED, as has the quick response team.

There is a robust assessment process. The sharing of information is greatly enhanced by the use of an electronic record. The environment is adequate to provide ED services and there were ample hand-hygiene dispensers in the department and waiting rooms.

There is strong evidence of medication reconciliation at HI site, and it is completed by the pharmacy technician or physician. At the Cobequid site, medication reconciliation is completed by physicians and nurses. Local pharmacies are contacted for verification if necessary.

Access to diagnostic imaging and laboratory services were reported to be satisfactory. Access to emergency services at Cobequid is 17 hours per day and after closing time, patients are taken to Halifax or Dartmouth. If patients present after hours, security on site call 911 and patients are transported by ambulance if necessary.

Consent to treatment is collected as necessary. Team members are all educated in resuscitation. If patients require in-patient care at Cobequid site they are transferred and appropriate information is transferred as part of that process. Information is transferred to patients' family physician via facsimile on admission and

discharge. At the Cobequid site, nursing does all the transition teaching, follow-up appointments and so on as there is a small team in place.

The ED uses evidence-based guidelines such as advanced cardiac life support (ACLs) to guide care and also the pain protocol which originated in Dartmouth.

Priority Process: Decision Support

The electronic patient record in the emergency departments (EDs) meets all requirements including privacy and confidentiality standards. The record greatly facilitates appropriate sharing of information and in particular, the ability to see services the patient has received in the past.

There is evidence of research activities in the Halifax Infirmary site and staff members were aware of the need for consents and processes that need to be followed for studies to be conducted. At Cobequid site, the team has used scenarios based on clinical issues to improve their communication amongst and between the team. Team members have also used their patient satisfaction survey results to focus the improvement opportunities.

Priority Process: Impact on Outcomes

Team members are aware of risks in the emergency departments (EDs) for example, violent clients. Re-assess protocols are in place. Two patient identifiers are used and family members are used if there is an issue of competency or consciousness.

There are well established mechanisms in place to report adverse events and errors and staff members are aware of the policies related to disclosure. The team collects data on many indicators and shares these with staff members, and indicators include falls, wait-times and others. Staff members were aware of some of the indicators that are tracked such as for hand hygiene, wait-times and
left without being seen to name a few.

The EDs seek patient feedback and use data to inform their changes. An example is setting up the rapid assessment unit as part of their flow strategy.

Priority Process: Organ and Tissue Donation

At the Halifax Infirmary (HI) the team members were all aware of their role in organ and tissue donation. At Cobequid site, they follow the CDHA's policy regarding donation and play a role in particular tissue and corneal donation. Patients may remain in the emergency (ED) at Halifax Infirmary if necessary and they work closely with the ICU and transplant team to ensure that appropriate measures are taken and policies followed.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.11	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
7.8	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.	ROP
7.8.3	Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	**MAJOR**
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.1	The team identifies and monitors process and outcome measures for its hospice palliative and end-of-life services.	
17.2	The team monitors clients' perspectives on the quality of hospice palliative and end-of-life services.	
17.5	The organization shares evaluation results with the team, clients, and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The palliative care team has minimal data available to access and use to determine service needs and program developments. The team does however, recognize the population served , inclusive of those with cancer, chronically ill and elderly. This is in addition to end-stage cardiovascular disease, kidney disease, and other clients requiring symptom management and pain control. Recognizing the acute care and community needs, a more integrated program with inpatient, home-based and consultation/clinic services has been developed.

Excellent partnerships exist with home care, Victoria Order of Nurses (VON) and other contracted services, medicine and the interdisciplinary team. In addition, there is a number of Foundations supporting patient care as required and professional development of the team. An identified gap by the team is the opportunity to enhance pharmaceutical support to clients, families, staff and physicians in palliative care, given the type and strength of medications used.

The team works with outreach programs and the community, addressing diversity to raise awareness of services offered.

The Hospice and Palliative Care program is commended for the current review of services, goals and objectives to standardize and introduce new processes. One example is to determine how to address more efficient and appropriate referral and intake processes and transition between services, amongst others. Planning is also underway with the Rotary Club, the Greater Society of Halifax and Capital District Health Authority for a Hospice to become available.

There is good access to supplies and equipment by way of purchasing and donations.

Priority Process: Competency

An interdisciplinary team is in place to deliver palliative and end-of-life services including physicians, primary and expert palliative care physicians, nurses, occupational therapy, physiotherapy, recreation, spiritual support, interpreters, students, volunteers, and community partner organizations.

Space on the inpatient unit at Victoria General site is small, requiring patients to be placed on off-service units and requiring staff members to be creative to support team communication and functioning.

Staff members of the team have ongoing access to professional development opportunities, including provincial, national and international conferences on palliative care, with support from external funding. Rounds and sessions are also accessible. There is excellent support to students in medicine and across disciplines. There is ongoing review and tracking of staff education and training needs. The nurse educator role was reported as a strong resource to the team with orientation, supervision and ongoing training provided.

There is an active and valued volunteer program in place and it is facilitated across the organization by way of applications, screening and orientation.

Staff members report excellent support is offered them to cope with client deaths, grieving and cumulative deaths, and this is provided by their direct supervisor, spiritual care/support and the organization's employee assistance program.

Priority Process: Episode of Care

The team is actively involved in palliative service redesign to improve teamwork, and improve appropriate and efficient access and transition between services. Access to this program is excellent, with physicians facilitating direct community referrals between in-patient acute care and community-based and consultative services. While current and potential clients/patients and families can access palliative care expertise, opportunities for improvement are evident for enhanced access to Capital District Health Authority services 24/7 for home-based care.

Clients report excellent communication by the team specific to information requests, and response for services. Assessment is completed in paper chart format with care plan/kardex development and use by nursing staff. Pain assessment and use of the Edmonton symptom assessment scale (ESAS) is a consistent practice of the team and indicator data on the percentage of clients where a standardized pain assessment tool was used is collected on a monthly basis, with excellent scores.

Staff members are aware of the required organization practice (ROP) for medication reconciliation however, are not completing this in a timely manner on admission, as evidenced in chart audit process results. Ongoing education and attention to medication reconciliation as a standardized component of the admission assessment is encouraged.

The team actively includes the client and family, and other providers to identify service goals and expected results. Clients report positive feedback to the team specific to communication, and clarity with service information and expectations.

The palliative team work closely with family members and community partners as required, based on assessed needs. Clear involvement with family physicians and community pharmacists, and amongst other care providers contracted for services. Client and family feedback identifies an opportunity for this team to enhance community based and home based service expansion and access, particularly in the smaller centres and rural areas.

There is an excellent bereavement program in place and it is supported by the bereavement coordinator.

Priority Process: Decision Support

The team participates in the provincial, national and international palliative care conferences for evidence-based practice and several members are affiliated with the University of Dalhousie and the professional practice colleges.

The recent announcement of a research chair is considered positive to assist the team to move forward with evidence-informed care and service delivery.

Priority Process: Impact on Outcomes

The team has actively worked to identify resources needed to achieve goals including enhancing community services given current caseloads and clients transitioning to home for symptom and pain management in addition to the identified need for pharmacy support and evaluation resources.

There is a comprehensive falls strategy in place. Staff members report and analyze incidents, and adverse events and see this as a quality improvement initiative to disclose and learn.

3.3.13 Standards Set: Infection Prevention and Control

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
7.3	Information provided to clients and families is documented in the client record.	!
7.5	Staff, service providers, and volunteers encourage clients, families, and visitors to follow effective hand hygiene behaviour.	!
8.1	Staff and service providers store, prepare and handle food appropriately.	!

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The organization is commended on the allocation of specific resources to infection prevention to track infections, provide education, undertake policy development, support and a consultative, collaborative approach to address infection rates and processes overall. Excellent examples of collaboration across the teams, including medicine, infection prevention and control (IPAC), facilities and engineering, food and nutrition services, housekeeping, emergency preparedness, occupational health and safety, and sterile processing services.

Several good examples exist of the organization's attention to tracking and monitoring infection rates in addition to analyzing the information to identify cluster, outbreaks and trends. This includes ventilator associated pneumonia (VAP), resistant enterococcus, methicillin resistant staphylococcus aureus (MRSA), clostridium difficile (C-diff) infection and central venous catheter bloodstream infections rates.

The organization uses health care associated infections definitions as defined by the United States Centres for Disease Prevention and Control and adopted by the Public Health Agency of Canada for use in the Canadian nocsomial infection surveillance program.

Several examples exist of the organization's evidence of effective interventions to prevent and manage C-diff per 10,000 client days including the introduction of enhanced cleaning procedures. Infection control practitioners review all new communicable disease infections (CDI) cases. Of note are the development and use of an antimicrobial handbook to optimize the use of antibiotics with pharmacy; the environmental and housekeeping audits; the room cleaning schedules and excellent relationship with the Medical Officer of Health, amongst others.

There is good evidence of audits with scope cleaning and reprocessing, environmental audits, hand hygiene, practice audits, and product evaluation audits.

IPAC at Dartmouth General site:

There have been renovations completed in the bathrooms in the transitional care unit and third floor due to mould which grew in the bathrooms. The IPAC worked closely with the maintenance department to ensure hoarding and safety measures were in place during the renovation project. The IPAC has created a

hand-hygiene educational training package which is posted on the learning management system (LMS). Hospital staff members are required to complete the program every year. The IPAC trains all new nurses, pastoral staff and volunteers.

Quarterly updates of infection rates are posted on the CDHA's intranet, and available for staff across the organization and in addition, there is information access for the public, patients and families.

New legislation with the Patient Safety Act from the Nova Scotia Department of Health and Wellness requires district health authorities in the province to report adherence rates for hand hygiene of health care workers and for which CDHA is compliant.

There are four moments of hand hygiene that the organization evaluates: before patient contact; before an ascetic task, for example checking a wound or changing a dressing; after body fluid exposure risk; and after patient contact. Consistent with the Department of Health and Wellness's reporting requirements, CDHA reports rates for proper hand-hygiene compliance for the first and fourth moment. Auditors can only record what care providers do before going into a patient room and after they leave. They do not go inside, to protect patient privacy. Audits are conducted four times per year, for most inpatient units across the organization.

As units/service staff are aware of the audit team and activities, the organization/team is encouraged to expand capacity in the organization to include other disciplines and staff members in other departments with the auditing process. This opportunity for improvement would support the team's identified need for additional resources, and also introduce the ability to perform more objective auditing and more request audits where compliance scores have dropped. An example would be with handwashing on some of the acute care units at the Victoria General site.

Efforts at providing education and training are noteworthy as CDHA is showing improvement in compliance, evidenced by the percentage of overall compliance at 74 percent in the third quarter in 2013. This is a steady increase for the years tracked, beginning in 2010 where only a 44 percent compliance rate was achieved, to 66 percent in 2011, 60 percent in 2012 and 74 percent in 2013.

The organization has several policies and procedures in place to limit infections including policies about preventing and controlling infections. These are current and based on best practice information. For example: C-diff infection management, influenza immunization, cleaning and disinfecting, hand hygiene, nail care, outbreak management and supply cleaning. Opportunity for Improvement exists in the preparation and handling of food to avoid direct skin contact and contamination.

The organization prevents the on-site reprocessing or sterilization of single use devices (SUD) using third party reprocessing coordinated by a reprocessing committee that deals with the contract process.

There is awareness of evidence-based international, federal and provincial infection control guidelines which are followed, as evidenced in policy development, guidelines, and adoption of updated IPAC guidelines

There is excellent review of IPAC polices and brochures with patients and families and staff. There are several good examples of online resources and resource development and a good example is the patient and family guide to infection prevention and control of C-diff and MRSA. The practice of educating clients and families about this is inconsistent across the organization.

There is evidence of good compliance and knowledge of cleaning, disinfection and sterilization of devices in the sterile processing department (SPD) at Victoria General site. Overall, CDHA shows evidence to demonstrate IPAC as a priority in the organization by addressing several recommendations of the 2012 Nova Scotia Auditor General Report.

3.3.14 Standards Set: Laboratory and Blood Services

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	

The organization has met all criteria for this priority process.

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

Laboratory internal and external stakeholders highly respect and appreciate the laboratory staff members and clinical expertise. Their availability for consultation and efforts to improve efficiencies are highly commended.

A strong and cohesive leadership team is fostering continuous quality improvements via such tools as volunteer external reviews, varied dashboards, Lean methodology and an excellent document control system.

Laboratory staff members are commended for their positive attitude and commitment to quality and teamwork under the challenges they may face with reorganization of the regional laboratories.

The organization is encouraged to continue to pursue opportunities to improve information systems for better communication and reduce patient risk across the region.

In order to build and maintain an effective laboratory quality assurance program over multiple sites significant resources and supports are required.

3.3.15 Standards Set: Long-Term Care Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
16.4 The organization shares benchmark and best practice information with its partners and other organizations.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The goals and objectives of the long-term (LTC) care teams are more related to their quality measures than program objectives, such as the change at Haliburton to move from a hospital model to a resident care model. The veterans' LTC has strong relationships with a myriad of other care providers and services including formal ones such as Veterans Affairs and more informal ones such as the legions.

Each of the sites visited had a good understanding of their population. Services have changed over time to meet changing needs such as the fact that the veterans are aging and as such, more of them have dementia than in the past, which means programming has been modified to accommodate those changes.

Both teams reported that they had the equipment and supplies to provide good care to their residents. There are strong volunteer programs on both teams and appropriate screening and processes are in place. In addition, the military volunteer at the veterans' facility helps tend the garden and clear up and so on. Students are welcomed in the facilities and represent most of the disciplines on the team.

Priority Process: Competency

There is a robust interdisciplinary team at the veterans' site including dedicated physicians, nurses, occupational therapy and physiotherapy and recreational therapists, chaplain, social work and pharmacy. At Haliburton Place there is minimal access to these team members.

There are mechanisms in place to check that staff members have appropriate credentials and those people interviewed during the survey indicated that they had received a performance review during the past two years. Resident assignments are designed to maximize continuity to residents.

Priority Process: Episode of Care

In Haliburton the care by design model is proving beneficial to residents. Small groups of physicians in alternate payment plans provide services to residents which also includes the off hours. The goal of improved quality and reduction of emergency department visits has decreased by 40 percent and thus, it appears to be working.

There is an extensive process for accepting a client into care and it often starts with a visit and information sharing and discussion about expectations. Once the person is admitted to the facility as a resident a thorough assessment is undertaken and a period of settling in occurs. This is followed by a conference with family and resident to ensure that any concerns are being addressed.

A falls and skin assessment are part of the initial intake process and there are consistent time lines for reassessments. Pressure ulcers and falls are tracked and staff members at sites visited during the survey knew their numbers and where to find them. If a resident needs to go to hospital, his/her chart goes with them, with a transfer summary sheet.

There is a short wait-list for the veterans' facility but the wait is longer than six months for the Haliburton facility. Each of the sites has excellent written information about the care home and the programs that are available. At the veterans home medications are reviewed at least every two months and more often if necessary for example, if falls have increased. There has been a concerted effort to focus on pain and symptom management and staff members have developed expertise in recognizing symptoms of pain or discomfort in residents that cannot verbalize how they are feeling. Family conferences are held on a regular basis and as required or necessary or at family request. All team members including care aides utilize the electronic system for reporting incidents. Advance directives and code status were present on resident charts.

Significant progress has occurred in moving to least restraint and currently, only Posey lap restraints are in use.

There are good recreational programs for residents, and families are encouraged to participate in special events. The veterans' site even has a pub! Food is plated at point of service and there are choices for every meal.

End-of-life care is well done and the team has access to palliative care resources and spiritual care.

Priority Process: Decision Support

There are three separate sources of documents for every resident, with the emerald system, personal care and care plan book and client record. Team is encouraged to consolidate the information about each resident and move towards a single source of 'truth' using an electronic system.

There are excellent clinical guidelines related to blood sugar targets and blood pressure for the elderly. Care teams are mindful of privacy and confidentiality, particularly in the small communities.

Priority Process: Impact on Outcomes

There is good support from foundations, auxiliaries and legions to ensure that residents have appropriate services/equipment such as wheelchairs and overhead lifts.

The team members identified the process for using two resident identifiers, pictures, verification with resident or patient bracelet for those with cognitive impairment. Team members are strongly encouraged to be vigilant about the two identifiers as an observation was made where medications were given without a second identifier.

Teams are aware that all of their residents are at risk for falls, skin issues, wandering and so on and safety huddles are conducted daily. Strategies are monitored on an individual basis to ensure that outcomes are being achieved. At the veterans' site there are veterans on the planning committees and also there is a strong veterans advisory council in place.

Sentinel events are investigated and improvements are put in place, for example, a choking incident resulted in education on dysphasia for all staff members. Resident and family surveys are undertaken and if possible, improvements are made.

3.3.16 Standards Set: Managing Medications

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
1.3	The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	ROP
1.3.1	The organization implements an antimicrobial stewardship program.	**MAJOR**
1.3.5	The organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.	**MINOR**
3.1	The organization purchases commercially-manufactured medications when available to minimize compounding in the pharmacy.	
7.4	Medications for client service areas are stored in labelled, unit dose packaging.	!
7.5	Unit dose oral medications remain in the manufacturer's or pharmacy's packaging until they are administered.	!
10.10	The pharmacy and other service providers accept telephone orders for medication only in emergencies.	!
11.4	The pharmacy computer system is used to perform dose range checks and to warn staff and service providers about low and high doses for high alert medications.	!
13.3	The pharmacy dispenses medications in unit dose packaging.	!

Surveyor comments on the priority process(es)

Priority Process: Medication Management

Since the organization's previous survey, the Capital District Health Authority (CDHA) has implemented significant improvements to its medication management system. In 2011, the Pyxis automated dispensing cabinets were installed widely at the Dartmouth General site and selectively at the Queen Elizabeth (QEII) and rural sites. This is providing enhanced patient safety. The organization is encouraged to continue converting to Pyxis units to improve safety and accuracy. The Pyxis CSafe at Victoria General site has enhanced the management of narcotics.

A decentralized order entry system (Fax connect) requiring physician orders to be sent via facsimile to pharmacy has been implemented enhancing quality and safety, especially for units with decentralized pharmacists that provide valuable support to the interdisciplinary team.

Owing to the extensive research role played by the organization, there is a separate program and staffing to manage investigational drugs.

During the last two years, a new pharmacy practice model (PPM) was implemented. A rigorous program was introduced to train pharmacy technicians to verify pharmacist orders in the central pharmacy prior to dispensing the medication. A pharmacy technician 'super trainer' spends a week with every technician and validates accuracy for all prescriptions until sufficient numbers have been achieved. Technicians also perform chemo-order entry, order checking and order entry. The PPM has enabled enhanced clinical pharmacy services as well as cross-coverage and more clinical consultation, drug education and research. The hours of service at the Dartmouth General site were increased and by extension, coverage of the tri-facilities served by that site also increased.

There is an active drugs and therapeutics committee, with members from medicine, pharmacy, nursing, administration, health economics, ethics and the lay public. Policies and processes to support and improve the organization's medication system including the formulary are working well. An interdisciplinary pharmacy medication safety committee identifies quality and safety issues and implements improvement initiatives such as an internal error tracking system, near misses by drug, and a new physician order form that lists common do-not-use/use abbreviations. The nursing pharmacy committee has been revived to address medication administration issues. The appropriate committee needs to ensure that the methadone program at the Nova Scotia Hospital site meets all regulatory guidelines.

At Dartmouth General site, patient-specific medications and patient's own medications are stored in a locked cabinet located immediately outside the patient room beside the patient medication administration record (MAR) and chart. This decentralized model is inefficient for unit clerks and nursing staff members that transcribe orders onto the MAR and then send via facsimile the order to the pharmacy for filling at the nursing station. At Victoria General site, medications are stored in one locked cupboard per room where there is inadequate space and potential for errors in the three and four-bed rooms. At Twin Oaks site, medications for up to 10 days are stored in the medication room and poured before the nurse travels to the patient rooms even though they are in unit dose format and often not charted on the MAR until his/her return. The Nova Scotia Hospital site is the last site with a traditional drug distribution system and presents risks. The organization is encouraged to complete implementation of the unit dose drug distribution system to improve patient safety. This will require the purchase of a new and more reliable unit dose machine.

Pharmacy technicians and pharmacists effectively support the medication reconciliation process. Medication reconciliation at admission and discharge has been successfully implemented. Medication reconciliation on admission in Ambulatoy Care has been initiated in the Renal Clinic at the Victoria General with a plan established for the organization. Medication reconciliation on transfer has been initiated in Neurology and Neurosurgery to Rehabilitation with a plan established for the organization.

Audits show that abbreviation use has decreased by 40 percent by way of creative education. The drug use management program has contributed to significant cost savings

The centralized intravenous admixture (CIVA) service operates out of the Victoria General site with batching of drugs to support the other sites. Intravenous medication with short stabilities and epidurals are prepared at some remote sites for example the Dartmouth General site.

Chemotherapy is prepared at the Victoria General site to support the Cancer Centre outpatient clinics namely medical day unit/hematology and the 11th floor chemotherapy unit and inpatient units. The number of doses prepared has increased by 40 percent over 10 years and currently, staff members prepare about 100 doses

per day using the two laminar air flow hoods. There is no ante room so orders are received, labels generated and medications/IV sets/bags are pre assembled in the same space as chemotherapy is prepared in the hood and the final product is checked. This is cramped space for the volume of chemotherapy prepared and creates a patient safety concern. The chemotherapy pharmacy is located on the sixth floor and supports the two busy outpatient clinics located on the 11th and fourth floors. Once completed, the final product is portered to these units. The schedules of these two busy clinics are not integrated, which presents challenges for the pharmacy to prepare the medications in a timely way. Ideally, the chemotherapy pharmacy should be adjacent to the chemotherapy outpatient clinic. There is a project underway to standardize practice in the clinics and eventually, consolidate the clinics in the same space. As well, the chemotherapy pharmacy should be co-located and should be designed to meet the USP 797 standards.

Paper medication administration records (MARs) are being used in most locations. Pharmacy-generated electronic MARs are provided to a few locations including Camp Hill Veterans site. The organization is encouraged to roll out electronic MARs to all inpatient units as it has been shown to significantly reduce medication transcription errors. At the Nova Scotia Hospital site, the use of seven-day electronic MARs should be considered to reduce potential errors.

3.3.17 Standards Set: Medicine Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.2	The team's goals and objectives for its medicine services are measurable and specific.		
Priority Process: Competency			
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
7.4	The team identifies medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) and provides appropriate thromboprophylaxis.		ROP
	7.4.2	The team identifies clients at risk for venous thromboembolism (VTE), [(deep vein thrombosis (DVT) and pulmonary embolism (PE)] and provides appropriate evidence-based, VTE prophylaxis.	**MAJOR**
	7.4.3	The team establishes measures for appropriate thromboprophylaxis, audits implementation of appropriate thromboprophylaxis, and uses this information to make improvements to their services.	**MINOR**
	7.4.5	The team provides information to health professionals and clients about the risks of VTE and how to prevent it.	**MINOR**
9.4	The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.		ROP
	9.4.5	The team has a system in place to measure the effectiveness of pressure ulcer prevention strategies, and uses results to make improvements.	**MINOR**
Priority Process: Decision Support			
12.2	The team meets applicable legislation for protecting the privacy and confidentiality of client information.		!
Priority Process: Impact on Outcomes			
15.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.		ROP
	15.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
Surveyor comments on the priority process(es)			

Priority Process: Clinical Leadership

Medicine services have dedicated compassionate care teams across all service areas. Teams identified the increasing age of the population as an area where the management of care has either been adapted such as the geriatric assessment unit (GAU) and Progressive Care, or will need to be such as for cardiology. The Heart Health team, Stroke/Neurology and Renal programs have aligned scope of services with the organizational strategy and provincial programs. Teams review services and make changes accordingly. One such example, is the initiative for Emergency Medicine Services (EMS) to admit directly to the catheterization laboratory, with an improved metric for contact-to-balloon times. The Twin Oaks Hospital, Musquodoboit defines its scope and sets priorities for services supported by it' local Community Health Board (CHB).

The heart health teams are highly collaborative and committed to providing state of the art person-centred health care. The division of cardiology collects data relative to quaternary care that is provided across the Atlantic provinces, and data related to secondary and tertiary care provided to the provinces of Nova Scotia and Prince Edward Island, and primary care to patients in the regional municipality on Halifax. The data are used to set priorities for multiple service planning needs, benchmarking, and to support excellence in education and research.

The Heart Health program is proud of its many leading practices. Atrial fib ablation, implantable cardioverter defibrillator (ICD), electrophysiology, and trans catheter valve therapy (TAVI) are just a few examples. The heart health team has implemented practices to improve access to care and bed flow across multiple service areas. A cardiologist working with an RN bed manager reviews requests for admissions and triages patients to ensure the most critical patients are prioritized, and all beds are optimized.

The teams are encouraged to continue working together on the development of specific measurable goals and objectives that align to Capital District Health Authority (CDHA's) five strategic streams. The lack of specific measurable goals seemed to be consistent across many service areas. Quality boards are now posted in all clinical areas, with current data elements, and the quality teams or practice councils are beginning to work on determining specific unit goals and objectives.

The teams support an extensive range of students and learners from all disciplines.

Note is made of the Leading Practice, palliative and therapeutic harmonization (PATH) for treating frail elder adults. This was recognized as a leading practice in the 2010 survey, and has since won the 3M Quality Award, and the Deloitte Public Sector Leadership Award. Since 2010, this evidence-based program has spread to the cardiology and nephrology programs. Currently, it is being rolled out to three CDHA long-term care facilities. In addition, four teams have been trained in Ontario and Vancouver. The teams are commended for spreading this great work!

Equipment needs are regularly assessed by the teams and there is a process to request capital and non-capital requests via the manager. A need for bariatric equipment was identified in some service areas across medicine.

Priority Process: Competency

There are many dedicated interdisciplinary teams. Team membership includes specialist physicians, residents, nurse practitioners (NPs), clinical nurse specialists (CNSs), clinical nurse educators (CNEs), social worker, physiotherapists, occupational therapist, dieticians, pharmacists, and all levels of nursing. Together, they are providing compassionate patient-centred care. Different types of rounds including bullet rounds,

stroke rounds, and team rounds are conducted regularly and care is planned with input from all the appropriate disciplines.

Some position profiles could be improved to reflect specific roles. For instance, clinical team assistants (CTAs) have been implemented on some medicine units, and the feedback given was that this has been found to be an effective role.

Compliance to performance review completion was low across many service areas. Managers struggle with workloads and large spans of control. An organizational strategy to review the tools and processes is recommended. Some staff members seemed unaware of team-based recognition programs or activities.

Education is provided in an effort to improve team functioning. Inter-professional education (IPE) placements are provided for learners in partnership with Dalhousie University. There is an intensive new graduate orientation program, Charge nurses and nursing leadership programs are provided across the organization. Specific education and training is provided in specialty areas such as elder care and cardiology.

Priority Process: Episode of Care

There are several examples of collaborative inter-professional care, with a patient-focused approach to interdisciplinary assessments and care delivery. An integrated documentation tool developed by the neurology/stroke allied health team, called the interdisciplinary assessment report is evidence of care that is focused around the patient. This approach improves efficiencies and reduces redundancy in documentation. This tool should be shared across units to standardize the interdisciplinary assessment documentation process.

The geriatric assessment unit (GAU) and progressive care unit have implemented an innovation strategy to facilitate discharge. There is a 'Hospital Transition Fund' available to fund expenses that will expedite a client discharge.

The unit white boards could be better utilized as a visual management tool to include important information such as expected date of discharge (EDD), discharge destination, clients at risk for falls, and so on. A good example is on the 3-East Medicine unit at Dartmouth site where the team utilizes its board for daily bullet rounds and discharge planning.

Although there is a hospital policy for venous thrombo embolism (VTE) prophylaxis, it has not yet been fully implemented across all services.

The best possible medication history (BPMH) is completed on admission, in the emergency department if possible and is done by a pharmacist, and reconciled by the inpatient clinical pharmacist and/or physician within 24 hours of arrival to the inpatient unit.

There was no evidence of a system to measure the effectiveness of pressure ulcer prevention strategies, such as recent prevalence surveillance audits. The teams are encouraged to continue to advance a formal pressure ulcer prevalence program based on best practices that include clinical pathways for pressure ulcer prevention at each stage, product standardization, and annual pressure ulcer prevalence audits.

A couple of examples were cited where ethics consults were requested, where substitute decision makers were involved in end-of-life decisions and about a feeding issue with a dying patient.

There is not a standardized process for consistently carrying out transfer of information at transition point. In some cases, there was a telephone report, face-to-face meeting and the use of a transfer of accountability form. The transfer of accountability form used on 3- East Medicine unit at Dartmouth site is a best practice and should be standardized across all service areas.

A new project is currently being evaluated to support transitions in care following end of service, with follow up telephone calls two days after discharge. The team members will use a standardized script in this regard.

Priority Process: Decision Support

The team identified the need to advance to an electronic health record (EHR) to reduce redundancies and the risk associated with paper documentation. This will be a significant patient safety advancement.

The team determined an evidence-based guideline for delirium prevention using the confusion assessment method (CAM) is an appropriate clinical guideline Evidence-based guidelines are introduced from professional associations, literature reviews, and conferences. The clinical nurse educators share and educate staff members on best practices at the unit level.

An opportunity for improvement is more detailed analysis of unit level data, which can be shared with staff members and clients in a meaningful way to guide improvements.

Priority Process: Impact on Outcomes

The geriatric assessment unit (GAU) and progressive care (PC) team shared best practices at a national conference.

Team training is ongoing. Examples of creative staff education events are the GAU/PC's Patient Safety Town and The Amazing Patient Safety Race.

Daily safety huddles identify potential safety concerns, including patients at risk for falls. Compliance to falls prevention strategies is not consistent on all units such as armband identifier, and picture above head of the bed. Other strategies for populations at risk include exercise programs, focus on mobility, medication review, and restraint review.

The GAU and PC team evaluates data on falls reduction or frequency of falls. All units are encouraged to undertake this kind of review to continue to make improvements to falls prevention strategies.

Data relative to falls was not received in a way that could be used to make improvements to falls prevention strategies. An opportunity for improvement is more detailed analysis of unit level data, which can be shared with staff members and clients in a meaningful way to guide improvements.

The teams monitor a number of indicators on quality boards in the units in an open and transparent manner..

The teams in the various units including stroke, general neurology and cardiology develop educational information and pamphlets with written information for clients and families about their role in promoting safety. The television network shows videos on safety including the: "Ask, Listen, Talk" CHDA pamphlet on safety.

3.3.18 Standards Set: Mental Health Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
4.4	Staff and service providers receive ongoing, effective training on infusion pumps.		ROP
	4.4.1	There is documented evidence of ongoing, effective training on infusion pumps.	**MAJOR**
4.10	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
10.5	The team has a process to evaluate client requests to bring in or self-administer their own medication.		
11.5	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
16.1	The team identifies and monitors process and outcome measures for its mental health services.		
Surveyor comments on the priority process(es)			
Priority Process: Clinical Leadership			

The Mental Health services in Capital District Health Authority (CDHA) focus on acute care, facility-based services inclusive of a comprehensive day treatment program, psychiatry emergency, mobile crisis, community mental health, Forensic Services and Offender Health. Speciality programs include early psychosis, eating disorders, mood disorders, seniors' mental health, sleep disorders, electro convulsive therapy (ECT) and dual diagnosis services.

The team has collected information from the organizations' community consultation process and Canadian Institute for Health Information (CIHI) data however, an opportunity exists to collect information about the

clients serviced specific to the community and population health. This would better inform service delivery and planning. For example, staff members and teams are not aware of the community profile information with demographics/other key data to review and plan service delivery changes required. The East Coast Forensic Psychiatry Hospital has also identified the need to address more complex care clients.

Some excellent partnerships exist: the Canadian Mental Health Association (CMHA); Schizophrenia Society of Nova Scotia; Mobile Outreach Housing (MOSH); police for crisis intervention; corrections; the Healthy Minds Co-operative of clients and families; Direction 180 (Methadone program). In addition, there are several other partnerships focused on community care and supports and transition services.

The service is embarking on service change with the new direction to integrate addiction and mental health services in the CDHA in alignment with the recently completed Addiction and Mental Health Strategy. This program is in the early stages of development to begin planning and to introduce service changes. The quality teams and service teams and staff are keen to become more involved to support this new direction and incorporate evidence-informed service delivery models and processes. The team for example are keen to become involved in concurrent capability training and education, screening and assessment tools, service delivery models of care such a co-location of addiction and mental health staff.

Staff members convey good support to their teams by the organization specific to professional development opportunities, training, students, interdisciplinary team composition, position advancement, work-life balance, academic support, and employee assistance programs.

Priority Process: Competency

There is excellent team representation inclusive of educator support and professional practice roles. There were strong clinical and administrative dyad teams in all service areas visited. One focus of the seniors' mental health (MH) service is the outreach program that consists of relationship building and knowledge translation to the 19 long-term care (LTC) facilities in the catchment area. This includes educational programs provided to staff members working in LTC, and in particular for the smaller LTC homes that lack their own educators, which is considered an excellent model. The other outreach focus is support to the acute mental health services across the Capital District Health Authority on the treatment of dementia in this patient population.

Staff members report orientation processes are comprehensive and inclusive of key information, including for infection prevention and control.

Teams work to enhance their service delivery within specific service areas. An example is the Day Treatment program, which has incorporated many changes based on client feedback with group scheduling and program orientation. Opportunity exists in the program however, to examine consistency and standardization with protocols and processes. For example, with screening and assessment tools, referral processes and transition protocols to better coordinate services.

Staff members report excellent support for education and training opportunities including non-violent crisis intervention, ongoing education and supervision with mental health education on illnesses and treatment modalities, amongst several others.

Opportunity for improvement exists with the recently formed Addictions and Mental Health program to ensure staff competencies are addressed, with concurrent capability training and education.

Priority Process: Episode of Care

Mental health services has some good examples with suicide assessment processes, and documentation in addition to the client/patient and family information provided. Opportunity exists in the program however, to examine consistency and standardization with protocols and processes. Screening tools, referral processes and transition protocols are being looked at to enhance coordination of care.

There is excellent access and coordination of emergency/crisis services by the mobile crisis team, emergency services, and short stay unit for acute care. The team is commended on the approach in the community to permit direct acute care admissions to acute care. This is facilitated by the use of hospitalists in the admission/assessment process in order to bypass emergency services. Client feedback is positive for this service access, and is complimentary to all mental health services offered in the Capital District Health Authority overall.

Good processes exist for clients that are waiting for services, including use of the short stay unit as required. There are outpatient single session therapies, orientation and engagement while waiting for access. There is the day treatment program and mobile crisis services. The program is commended on their regular review of wait-lists, wait-times and monitoring of clients accessing services, Monitoring is consistent with the Canadian Psychiatric Association target definitions of urgent (7 days), semi-urgent (28 days) and regular (90 days), which reflect good access times for community teams/outpatient services.

The team coordinates the needs of clients by way of accessing community treatment and supports across the organization. There is consistent application of assessment of clients for risk of suicide with the Nova Scotia assessment tool for suicide prevention. There are excellent examples of review and consideration of client needs and expectations for care, including goal setting.

The team has access to services and results and advice to complete a proper assessment however this is significantly delayed in the rural areas of Eastern Shore, with limited access to mental health, addiction and psychiatric resources. This is presenting difficulties for clients requiring expert consultation for assessing competency and is at times, delaying discharge from acute care beds in the Nova Scotia hospitals. Additional access to prevention and promotion programs for addiction and mental health with children, youth and adults and addiction expertise is limited.

Teams have a good understanding of medication reconciliation and are adhering to practice standards on admission and discharge and transition between services. Client feedback is positive across the CDHA. Clients report they feel listened to and respected and are understanding of expectations and goals of care and reources/services available.

Strong, skilled interdisciplinary teams exist throughout these services provided by CDHA. Opportunity exists to incorporate recovery based models of care and an enhanced primary care community and outreach focus in both the urban and rural centres.

Priority Process: Decision Support

Good communication processes amongst team members can be seen in the admission review, case conferencing, case management models used, and team interactions. Some excellent examples of incorporating evidence-based guidelines exist, with the new focus on the program as an integrated addiction and mental health program overall. It is acknowledged the teams are at an early stage in terms of clinical integration. Other examples include the early psychosis program, the day treatment program with a focus on

intensive group psychotherapy and the core therapeutic components, electro-convulsive therapy (ECT), and others.

Priority Process: Impact on Outcomes

The team is very advanced in its use and identification of resources required for example, recognition of the need for enhanced primary and community service models of care including shared care, outreach services, prevention and promotion, and rural service delivery.

There are good links to academic partners such as Dalhousie University programs and Child and Youth programs to ensure best practice information is shared. An example is transition protocols for youth. Opportunity for improvement exists however, to benchmark with other like programs and organizations such as the Forensic Services and sites in other provinces by way of existing committee and network structures and mechanisms.

There is good use of written and verbal information for clients and families specific to safety. This includes: infection prevention and control; suicide prevention and supports/services available; patient rights with a CDHA patient representative; rights under the Involuntary Psychiatric Act; a comprehensive guide published for family and friends as a partnership with the Mental Health Foundation; the CDHA addictions and mental health program and the healthy minds co-operative.

The team has achieved many notable successes. A fellow recently completed a research study on the impact of replacing the lights on the inpatient unit and patients' behaviour and experience. Patients were studied for three months prior to the change in the lighting and afterwards. The depression and agitation scores and mediations were monitored before and after the change. There was significant improvement in patients after the installation of higher intensity lighting, with a demonstrated reduction in the use benzodiazepines. Plus, the unit was painted a warm yellow and doors, nursing units and other key areas were outlined in a contrasting colour which enhanced the environment.

In the seniors' mental health program, a clinical team leader role was recently created to provide staff education, research best practices for particular situations and enhance communication with the staff. This individual is now auditing the charts for completion and providing timely feedback to staff members on changes as well as conducting hand-hygiene audits. The response from the staff members has been extremely positive.

All services identify information to collect and monitor indicators and have been creative in establishing their own evaluation tracking and systems. As there is inconsistent identification of performance measures to report and monitor across the program to reflect client outcomes, an opportunity for improvement exists to enhance performance measurement overall to assist the program to continue to make improvements in services and care.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

While organ and tissue donation is not a part of the organization's strategic priorities, it is an important program for the Capital District Health Authority (CDHA) as it is a tertiary and a quaternary service for the region.

The program's participants take an active role in local, Atlantic region and Canadian transplant committees and working groups to ensure services are coordinated, are respectful of the donor families and their needs as well as ensuring the safety for all potential recipients.

The program reviews its utilization data monthly, doing case reviews of all donations as well as reviews of all possible donations to understand whether there were missed opportunities and areas for improvement. Areas for improvement are acted on and results are monitored. The team collaborates with partners in the region to identify and develop further opportunity for recruitment of possible donors. They are also working to ensure processes are in place to address the proposed changes in legislation.

A source of pride for the team members is their close working relationships with one another and their partners, as well as knowing that they make a difference in the lives of the families with whom they work.

One suggestion for the team to consider is to link its program goals and objectives to CDHA's goals and objectives and to ensure that goals are measurable. Another area for the team to consider relates to succession planning given that a few people 'hold' a considerable amount of knowledge and experience.

Priority Process: Competency

There are committed and experienced team members and they are clearly proud of their work and their commitment to ensuring safety for recipients of donated organs and tissues. The team has good processes in place for reviewing their cases and related data every month.

The team is made up of intensivists and registered nurses. Social workers and pastoral care are available to support families and staff members that also have good access to the Capital District Health Authority ethics team.

A valuable addition to the team is a former intensive care (ICU) nurse who is retired but available on a casual basis to relieve then when the workload demands it, or for breaks from work, or on-call coverage. This provided a good opportunity for the team to update their orientation materials and processes. There are comprehensive descriptions of the competencies required for this work, which have recently been updated. The team is encouraged to consider other opportunities for succession planning to ensure continuity of services.

Staff members reported that they feel valued by their clients and partners and also their manager, and their passion and enthusiasm for their work is clearly evident. This section would be even stronger if regular performance reviews were performed.

Priority Process: Episode of Care

This is an area of noted strength for this program, as the team works closely with their partners across the Capital District Health Authority to ensure the information is appropriate, accurate and up to date.

Priority Process: Decision Support

The team follows Canadian Standards Association (CSA) standards and recently participated in a CSA review process. They are actively engaged with partner organizations in the Atlantic region and nationally, sitting on and or leading committees to develop and coordinate best practices.

This service is highly regulated and the team is dedicated to following the regulations. The team is also proactive in responding to new regulations. While team members are obviously committed to the regulations, an area of frustration is determining what is expected by new regulations, as the language could be clearer. The team takes a proactive stance in following up with Health Canada when they have questions or concerns.

Priority Process: Impact on Outcomes

The team is cognizant of the impact of their decisions and ensuring that the recipients are safe. Team members monitor their outcomes, including family experiences. They also ensure that their donor families are aware of where their gifts are in the donor process.

Letters and other family written communications were informed by an active donor families group.

The program hosts an annual Gift of Life celebration which is attended by recipients and donors. This is reported to be a meaningful event for all participants, including the program staff.

Priority Process: Organ and Tissue Donation

As noted in previous report sections for this service, the team is committed to following standard procedures, documenting how it follows and documents the procedures, ensuring that the donor families are treated with compassion and that the safety and quality of life for recipients are always considered. The team has developed good relationships with the medical examiner's office which has benefited both organizations.

This team has met all the standards.

3.3.20 Standards Set: Organ and Tissue Transplant Standards

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

Surveyor comments on the priority process(es)

Priority Process: Organ and Tissue Transplant

This team has met all of the standards. The team is conscientious about ensuring that they provide safe, compassionate care. Team members follow standardized processes and regularly review their cases to identify opportunities for improvement. Actions undertaken are also evaluated. The tissue bank staff members worked with a process engineer to map patients from referral through to discharge, including at satellite clinics. This led to streamlining their processes, reductions in documentation, and increased capacity. Automation will support further improvements in efficiency.

The team is also conscientious about ensuring that their patients are well informed about their medical condition, the implications of the decisions they make, and the status for their position on the wait-list. The team provides the information in different ways realizing that people do not always "take in" all of the information.

Priority Process: Clinical Leadership

This service, as with the other teams in the transplant services program are conscientious about ensuring their standard operating procedures (SOPs) are followed to ensure safe, competent and compassionate care for their patients. There are good relationships and communication with other teams and partners in care such as the operating rooms (ORs) and intensive care units (ICUs). The statement: "we just make it work" was the response to the question about access to the ORs. The team also has good quality improvement processes in place to identify and follow-up on issues.

One suggestion for the team to consider is to ensure its goals and objectives link more closely to Capital Health District Health Authority strategies and that the objectives are measurable and achievable.

Priority Process: Competency

The inter-professional team is made up of well-qualified members that take pride in staying in the forefront of best practices in their respective fields. Several of the team members participate in and/or lead committees provincially, regionally and nationally. Competencies are well-described and kept up to date.

It was evident that the staff members interviewed during the survey loved their work, and many of the team members have been on the team or program for several years. A topic for the team to consider is succession planning to ensure sustainability of the program.

Priority Process: Decision Support

The teams are conscientious about their record keeping to ensure the safety of organs and tissues and their recipients. The record keeping system in the tissue laboratory in particular is manual and labour intensive. Efficiency of that service would be improved with the implementation of an electronic record keeping system.

Priority Process: Impact on Outcomes

All the teams surveyed had many examples of improvements they were making based on case reviews and audits of their processes. The teams were also able to compare themselves to industry benchmarks which they shard with partner organizations provincially, regionally and nationally.

3.3.21 Standards Set: Organ Donation Standards for Living Donors

Unmet Criteria	High Priority Criteria
Priority Process: Organ Donation (Living)	
The organization has met all criteria for this priority process.	
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Organ Donation (Living)

The teams that comprise the organ donation program for living donors also meet all of the standards. As with the other teams that make up the full organ donation and transplant service, these teams underwent a review by Health Canada in the last year, in which they did well.

The teams are conscientious about ensuring that they understand and meet the standards and regulations. The team is inter-professional and includes social work, psychology, occupational therapy and physiotherapy, dietetics in addition to medical specialists, surgeons and nurses. There are good processes in place to ensure that living donors are screened, assessed and make informed consents. The team also has sound ethical processes in place to assist people with making their decisions, including instances where they may be feeling coerced.

Priority Process: Clinical Leadership

As noted earlier, there is sound clinical leadership in this program. As with other teams in the transplant and organ donation program, several team members lead and/or are active participants in provincial, regional and national committees and are focused on ensuring that the standards set result in high quality care for their donors and recipients. The medical director has set goals for increasing the number of transplants available from the various jurisdictions in the Capital District Health Authority and the team has developed plans for achieving that goal.

The quality team for the service also includes a patient representative. This is another noted strength of this program.

Priority Process: Competency

This team has well-documented competencies for their team members. All team members surveyed reported that they had good access to education about new process, procedures and technologies. Several team members reported that they had also had a performance evaluation within the last two years.

Priority Process: Decision Support

The team has good processes in place for tracking both donors and recipients.

Priority Process: Impact on Outcomes

The program has several committees and working groups in place to measure, monitor, report and follow up on their findings. This includes professional practice teams, primarily of the care unit staff members that are working on self-identified projects such as improving their care planning and documentation to their inter-professional quality team, which as noted earlier, has a patient representative.

3.3.22 Standards Set: Point-of-Care Testing

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
1.7	The organization has a standard operating procedure (SOP) that clearly defines the roles and responsibilities of all health care professionals delivering POCT. CSA Reference: Z22870:07, 5.1.4.	
3.1	The organization orients and trains all health care professionals delivering POCT on the standard operating procedures (SOPs) for POCT.	
3.2	Health care professionals delivering POCT receive ongoing training and development. CSA Reference: Z22870:07, 5.15.	
3.3	The organization evaluates the performance of health care professionals delivering POCT annually. CSA Reference: Z22870:07, 5.1.5.	
3.4	As part of their performance evaluation, health care professionals delivering POCT must routinely demonstrate their competence. CSA Reference: Z22870:07, 5.1.5.	
3.5	The organization documents performance evaluation results in the personnel files of health care professionals delivering POCT.	
4.8	The organization has a policy on POCT client self-testing.	
6.1	The organization maintains an accurate and up-to-date inventory for all POCT supplies, reagents, and media.	!
6.2	The organization has a person who is responsible for inventory control of POCT supplies, reagents and media.	
6.3	The organization follows a documented process for testing all new POCT supplies, reagents and media.	!
6.4	The organization periodically verifies that POCT reagents currently being used are working properly, not expired or deteriorated and appropriate for use. CSA Reference: 22870:07, 5.3.2.	!
7.5	Immediately prior to performing the point-of-care test, the health care professional verifies that the POCT equipment is in proper working order by means of a quality control check.	

8.10	The health care professional delivering POCT documents the date and time of the test, the individual carrying out the test and the results of the test on the result form.	!
9.1	The organization has a standardized written or electronic policy or procedure on how to report and disclose all POCT results. CSA Reference: Z22870:07, 5.8.2.	
9.5	When the health care professional verbally reports POCT results to clinicians, the results and methods used to obtain those results must later be documented in a written format and identified as POCT results.	!
9.6	The health care professional delivering POCT completes a comprehensive and accurate report for every point-of-care test carried out that is distinct from clinician notes in the record.	
9.7	The health care professional delivering POCT legibly writes the report using language and vocabulary that complies with recommendations from international, national, or regional professional organizations.	
9.8	When completing the POCT report and filing it in the client record, the health care professional delivering POCT clearly labels the results as "POCT".	
10.7	Health professionals delivering POCT record quality control data in a daily a log.	!

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

The point of care testing (POCT) program has made significant progress over the past three years and is on the right track. The organization as a whole is encouraged to recognize the importance and risk associated with POCT. In particular, the clinical areas need further education and understanding of the requirements for POCT. While the standards for POCT equipment such as glucometers and blood gas machines are being met for the most part, there are manual testing procedures being performed at multiple sites that are not yet included in the POCT program such as urine dipsticks, occult blood tests pregnancy test kits and so on.

It is recognized that training, competency evaluation and education in a large organization and across sites is a difficult task to accomplish and requires adequate resources to develop and maintain. The collaboration between laboratory and clinical personnel is essential to succeed in this regard. Any test on any patient sample must follow the same requirements and standards whether or not it is performed in a laboratory.

The practice of manually transcribing POCT results onto the patient chart by nursing staff should be discouraged. Reference ranges, identity of the person performing the test, date and time of test and indication that the test was performed at POCT is a requirement for the patient medical record.

3.3.23 Standards Set: Rehabilitation Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.1	The team works together to develop goals and objectives.		
2.2	The team's goals and objectives for rehabilitation services are measurable and specific.		
2.4	The team has access to the supplies and equipment needed to deliver rehabilitation services.		
Priority Process: Competency			
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
11.3	The team reconciles the client's medications with the involvement of the client, family or caregiver at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).		ROP
	11.3.1	There is a demonstrated, formal process to reconcile client medications at transition points where medication orders are changed or rewritten (i.e. internal transfer, and/or discharge).	**MAJOR**
	11.3.3	The team documents that the BPMH, the active medication orders, and the transfer or discharge medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	**MAJOR**
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 rehabilitation quality team has been in place for some time. It is an interdisciplinary team that meets regularly, with a goal to improve the quality of service provided to the patients it serves. The team has a good understanding of the clients and community it serves from across Nova Scotia and other Maritime provinces, and can speak well to how the profile of the program is shared with multiple referral sources.

While the work of the team is consistent with Capital District Health Authority strategic directions, the team has yet to undertake a formal process to determine what the corporate strategy means for rehabilitation.

The team does not have specific goals and objectives. However, it clearly states that improving patient safety is a major focus, and highlights initiatives such as reduction of pressure ulcers, medication reconciliation, and fall reduction as priorities. There is a team scorecard organized by corporate strategic objectives, although it is still in template form and was developed centrally. The team understands that it has the opportunity to customize the scorecard by determining content that is most appropriate for rehabilitation.

The team is early in its quality journey and is encouraged to take time to identify its top few priorities, ensure that it has clearly defined outcome targets and metrics that show progress towards these goals. Focusing on these critical few priorities will help the team achieve its highest priorities and mitigate the risk of being distracted by too much data or too many simultaneous initiatives.

Priority Process: Competency

This is a strong interdisciplinary team, with evidence that the team works well together to deliver quality services. Patient tracers confirmed this by way of documentation in the patient record, and conversations with patients and families.

Team members, for the most part, have had a recent performance appraisal, at least within two years, although there are some exceptions. These seem to be related to staff members transferring to positions and missing the appraisal cycle.

There are opportunities for staff members to partake in professional development activities. However, while a wide range of development or education was referenced, there does not appear to be a clear process to target such opportunities.

While the team generally has sufficient workspace, the overall building status is variable in that some areas have recently been upgraded while others are in need of renovation. The team is commended for its passionate support of the: "Revitalizing Rehab" campaign, and determination to make building improvements. By identifying priorities and working with pertinent departments across the organization, some issues of longstanding have been addressed, and others are on the radar.

Priority Process: Episode of Care

The team has developed an admission form that has been helpful for referral sources to use. Telehealth has also become a significant tool used to aid the team in making admission decisions. Both approaches have proved helpful in making admission decisions without unnecessarily requiring patients to be present on site at Capital District Health Authority. A telemedicine consultation during a patient tracer demonstrated how the interdisciplinary team can do its work in a virtual environment.

Newly admitted patients experience a standardized intake process. There is risk of repetition in that the patient will be asked history questions by various team members. The team is encouraged to consider integrating the admission process to make it more multidisciplinary.

The team is commended for its work to incorporate medication reconciliation as part of the standardized admission and discharge processes. The team is proud of what it has accomplished, and recognizes that it has come a long way from the days when there was no clarity on what medication reconciliation really was, or how it would benefit patients. The team particularly notes the discharge information that is provided to the patient's family practitioner, free of dangerous abbreviations with a clear flag on all medication changes during the hospital stay. The team was an enthusiastic volunteer to become an early adopter for medication reconciliation at internal transfer. This work is in the early stages, with some development remaining. The team is encouraged by its earlier successes and will press on to make this work as well.

Following admission and assessment, an individualized care plan is developed for every patient. Every care plan is reviewed at the weekly team conferences, and progress is assessed against each of the goals. Updates are made as necessary, with immediate communication to the patient and family.

Priority Process: Decision Support

The client record is paper-based and easily accessible. While there is access to some electronic health information, this information is often printed and then included in the paper chart. The charts reviewed during the survey were relatively easy to navigate, although the volume of paper not being securely fastened in the binder is sometimes an issue.

Priority Process: Impact on Outcomes

The team uses a risk reporting system to record adverse events and other critical incidents.

At the time of admission, patients are assessed for falls risk and mitigating strategies are put in place, as necessary. Patients and families are also given an informational brochure about their role in patient safety at that time, and the team is working to expand this approach to include outpatient care as well Both of these initiatives address suggestions from the previous accreditation survey, and the team is commended for taking action in this regard.

The team has also instituted regular safety rounds. Team huddles on every shift are used to share critical information, and use standardized categories to prompt team members to identify new safety risks.

3.3.24 Standards Set: Spinal Cord Injury Acute Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.6	The team has sufficient space to accommodate patients and provide safe and effective services, including private space for patients and families.		
Priority Process: Competency			
3.6	Sufficient workspace is available to support team functioning and interaction.		
5.11	Team leaders regularly evaluate and document each team member's performance and competence in an objective, interactive, and constructive way.		
Priority Process: Episode of Care			
8.2	With the involvement of the patient, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile patient medications at transitions of care.		ROP
	8.2.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
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 clinical and administrative leadership of the neurosurgery unit at the Halifax Infirmary site presented as a strong, committed team. Leaders and clinicians actively advocate for the needs of the complex patient population served on this unit. The unit is the only neurosurgical service for Nova Scotia and PEI, and a referral centre for all the Atlantic provinces, seeing on average 20 or more acute spinal cord injured patients per year, with more than 700 spine-related admissions and 600 plus patients requiring neurosurgeries.
An excellent working relationship with the physiatrists from the Nova Scotia Rehab Centre (NSRC) facilitates early and efficient transfer of patients that require long-term rehabilitation. The NSRC director has recently assumed accountability for acute spinal cord injury services at the Halifax Infirmary in addition to her leadership role at the NSRC. This cross-site accountability is expected to further strengthen already strong processes for continuity and transition of services from acute care to rehabilitation services.

There are formal processes for accepting referrals and admitting clients for neurosurgery services. Criteria are in place to determine appropriateness for admission and the urgency and priority for the required admission. Admission assessments are thorough, and all patient charts reviewed during the tracer had a safety and falls risk assessment screening completed. Pain and symptom assessment, as well as attention to pressure sore development were also noted on review of the health record during tracers. Fall- risk stickers were observed at the bedside, on armbands, and in the health record. Care plans and goals were found to be individualized according to every patient's unique needs and personal goals.

The organization and the team are commended for their progress in formalizing and standardizing the approach to medication reconciliation. Medication reconciliation was evident on admission and at transfer from the unit to the intermediate care unit (IMCU) and back, as well as on discharge. Locked medication cabinets in every patient room seen and the use of two client identifiers were consistently noted during the tracer.

Blackberry devices for wireless paging of porters for efficient and timely transport of patients were noted during the tracer. Staff members in the diagnostic areas that were visited during the neurosurgery unit tracer all used two client identifiers to identify the patient.

The team does not have sufficient space in patient rooms to accommodate patient needs and to provide safe and effective care for servicing the complex patient population with heavy care needs. The patient rooms are too small to accommodate the needs of patients requiring isolation precautions and those requiring mechanical lifting devices because rooms are not equipped with ceiling tracks. Rooms are also inadequate for patients using mobility devices/wheelchairs, and for patients requiring bed extensions. The lack of ceiling tracks for lifting, repositioning, and transferring patients is a significant limitation on this unit. There is senior leadership support for plans put forward by the clinical leadership team to create a consolidated spine program with expanded IMCU capacity. It is anticipated that this plan will address many issues, including space constraints, outdated furnishing, patient and staff flow issues, and provide a more efficient and effective use of clinical and administrative resources.

Priority Process: Competency

There is a strong interdisciplinary team in place on this unit. The allied staff members reported significant job satisfaction with obvious commitment and passion for their work with "neuro" patients. A matrix reporting relationship exists for clinical staff members in that they report to both program and discipline/practice leadership.

The neurosurgery unit has experienced high nursing staff turnover. The challenge for this unit is that it is a 'feeder' unit for nurses that wish to pursue careers in intensive care, post-anesthetic care, emergency care and outpost nursing. The leadership team is commended for the efforts to recruit highly specialized nursing personnel to address the recent shortage and for providing excellent orientation and mentorship to newly hired and newly graduated nurses hired to work on the unit. The development of a nurse resource team is an example of the use of information on labour distribution, qualifications, and so on to inform a new approach to staffing and an alternative to the use of agency staffing. Lunch and learn sessions take place and topics include anatomy of the spine, spine surgery, and so on.

The flow of work on the neurosurgery unit is compromised by the lack of adequate workspace for the team, as there is no charting space other than the nursing station.

Clinicians questioned during tracers reported they have not received regular, formal, documented evaluation of their performance.

Priority Process: Episode of Care

There is a strong interdisciplinary focus on the care of patients on the neurosurgery unit.

The organization and the team are commended for their progress in formalizing and standardizing the approach to medication reconciliation at admission and discharge. Locked medication cabinets in every patient room and the use of two client identifiers were consistently noted during the tracer.

The focus of the entire team on pressure sore prevention and skill and attention in managing wounds/wound care is commendable. Patient health records showed that the Braden scale is consistently used to conduct an initial pressure ulcer risk assessment on admission to the neurosurgery unit or the intermediate care unit (IMCU), and from transfer from the IMCU to the unit. Daily flow sheets showed vigilance related to daily reassessment of every patient at shift change and during care routines. A nurse educator with a wound care focus is a resource to the team.

The unit's team leaders indicated that the age of patients treated on the unit is typically 16 years of age and older. Children and youth with spinal cord related conditions are treated at the provincial children's hospital, the IWK. On occasion, a youth patient is accepted, and an exception is made for young adults below the age threshold of the admission criteria, when it is deemed that for transition and follow-up purposes, the interests of the young person would be best served by the unit.

A comprehensive discharge checklist has been developed with team input. There is a strong relationship with the Nova Scotia Rehabilitation Centre for transition of patients requiring long-term rehabilitation services.

The transfer of accountability (TOA) check list ensures that critical information about patients is effectively transferred at transition points. This is done at transfer between units, at shift change, and when a patient leaves a unit for a procedure. A checklist ensures that the exchange of information is documented. The TOA check list was completed on all charts reviewed during the tracer.

The unit staff members are commended for their focus on infection prevention and control (IPAC). This is particularly important, as transmission rates on the unit for methicillin resistant staphylococcus aureus (MRSA) and vancomycin resistant enterococci (VRE) were problematic. The vigilance in addressing this issue is commendable. Housekeeping, nursing, allied health, and the patient are all now viewed as playing an important role in keeping patients safe by ensuring a clean environment. Staff members that were questioned during the tracers were aware of the unit's hand-hygiene audit rates. Personal protective equipment (PPE) is placed outside the room of patients on isolation precautions in wall-mounted or door-hanging units to provide ease of access to the required PPE.

Patients acknowledged that they experienced a high quality of care on this unit. The unit is commended for its focus on a person-centred model of care. All patients seen during the episode of care tracer were asked to rate their overall satisfaction with the quality of care and services provided on a 10 point scale and ratings ranged from eight to a perfect 10. In all cases the patient and/or family member reported being active participants, as much as they wished, in the care provided by staff.

Priority Process: Decision Support

Several new information technology systems have been implemented since the previous Accreditation survey, with a new scheduling system, a new patient safety reporting system, and a new workload measurement

system. The focus to date has been on training/learning with little to no opportunity thus far to synthesize the information capability of the systems to provide information to inform decision support at the unit level.

The unit is actively involved in both basic and clinical research activities with funding for research coming from the Capital District Health Authority (CDHA) research ethics board (REB) and the Dalhousie University REB. Quality teams have implemented changes that have resulted in improved outcomes for patients, including a project related to infection prevention and control (IPAC) related to the spread of methicillin resistant staphylococcus aureus (MRSA) and vancomycin resistant enterococci (VRE). The unit is commended for its focused efforts and attention to addressing this important patient and staff safety issue. The leadership commitment to allocating resources for new equipment needed to address this issue is commendable.

Note is made of a neurosurgeon's participation in a national committee with Accreditation Canada and the Rick Hansen Institute to develop national standards for the acute inpatient care of spinal cord injury patients.

Priority Process: Impact on Outcomes

The leaders of the neurosurgery unit have been challenged with issues outside of their control that have had an impact on their ability to manage within the existing budget. Issues that have all contributed to the unit's deficit position are: use of agency personnel to provide augmented staffing levels for complex patients (requiring sitters); one-time purchases to address aging equipment that was linked to increased transmission and risk of MRSA/VRE; one-time purchase of wall/door mounted personal protective equipment (PPE) cabinets; slings for mechanical lifting devices; cleanable chairs for visitors, commodes, and blood pressure cuffs.

The organization and the team are commended on their progress with implementing a corporate falls prevention strategy. The focus of the entire neurosurgery team on use of the Morse falls risk assessment tool to assess risk of falls is commendable. A review of patient health records showed that the Morse scale is consistently used to conduct an initial risk assessment on admission. Patients at risk are identified with falls-risk stickers at the bedside and on their armbands, and fall prevention precautions are implemented.

A quality and patient safety team is in place. A team scorecard tracks corporate indicators with targets. A goal to reduce the number of MRSA/VRE transmissions on the unit has been actively pursued with education on infection control cleaning for housekeeping staff. There has been the replacement of furniture with new cleanable items, close monitoring of hand hygiene, and monthly MRSA sweeps. The unit staff members are commended for their vigilance in addressing this issue.

A quality and patient safety team scorecard has been developed to align operational related team goals with CDHA's 2013 milestones and 2016 strategic goals and to track trends in improvement in the SCI unit. Most of the indicators on the scorecard are rate based, and although compliance is tracked, no targets were apparent.

Patient satisfaction survey results are tracked for the unit however, no evidence could be found during the tracer of how the results/data are interpreted, or translated into actions to improve the experience and satisfaction of patients was provided. Open text comments were transcribed, but not linked to any key themes arising from the quantitative data. Long-term trend reports of incidents on the SCI unit were provided to the surveyor that showed numbers of incidents over time, but little to no interpretation of the data was noted.

3.3.25 Standards Set: Spinal Cord Injury Rehabilitation Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.4 The team has access to the necessary supplies, equipment, and technologies to deliver spinal cord injury rehabilitation services.	
Priority Process: Competency	
5.11 Team leaders regularly evaluate and document each team member's performance and competency in an objective, interactive, and constructive way.	
Priority Process: Episode of Care	
8.2 With the involvement of the patient, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile patient medications at transitions of care.	ROP
8.2.4 The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
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 Nova Scotia Rehabilitation Centre (NSRC) provides inpatient and outpatient rehabilitation services for patients over the age of 16 years with spinal cord injury (SCI). Patients served come from the entire province of Nova Scotia, as well as the other maritime provinces. Approximately, 50 to 60 new patients are seen per year, including 25 to 35 traumatic SCI patients. Some patients are readmissions for seating reassessment and wound care.

The team is commended for its foray into the use of telehealth services to ensure a smooth transition of care from the NSRC to the patient's home community, and also to build capacity in local communities by supporting local therapists, other professionals, and care providers. Telehealth services are also playing an important and emerging role in reassessment and triaging of patients referred for service.

There is a strong interdisciplinary team on this unit, committed to meeting the needs of their patients and families. Team members interviewed during tracers expressed a passion for their work and for being a part of

the NSRC. There was clear evidence of collaborative practice and a desire to evaluate and improve the effectiveness of interventions. The interdisciplinary team functions within a program management model. Allied professionals have the support of practice leaders, as well as program leaders. The NSRC director has recently assumed accountability for acute spinal cord Injury services at the Halifax Infirmary site in addition to her leadership role at the NSRC. This cross-site accountability is expected to further strengthen already strong processes for continuity and transition of services from acute care to rehabilitation services.

Quality and patient safety is included as a standing agenda item at program and team meetings. Communications take place using a variety of methods, including the fun and innovative Bathroom Blitz cartoons. These were provided to staff members in the NSRC relative to Accreditation Canada's required organizational practices (ROPS) specific to falls risk, medication reconciliation, and hand hygiene. Patients interviewed during tracers had received information in writing and verbally about safety awareness. Hand hygiene and infection rates were visibly posted on staff communication boards. The corporate patient safety reporting system (PSRS) for reporting of patient safety incidents is used for reporting of errors and safety related incidents. Reporting of near misses seems to have increased over time.

The physical space and equipment available to the team to deliver spinal cord injury rehabilitation services is antiquated. For example, the therapeutic pool has been out of service for more than two years because of problems with leaking pipes. Treatment plinths in the gym are not height adjustable, and there are other deficiencies as well.The lack of necessary equipment and technology limits the ability of the team to accommodate patient needs and to provide efficient and effective care and treatment options for this complex patient population. It was indicated that there is senior leadership support for plans put forward for: "Revitalizing Rehab". This includes a renovation plan for the Nova Scotia Rehabilitation Centre that is expected to address many issues, including repair/replacement of the pool, outdated treatment furnishings, patient and staff flow issues, and promote a more efficient and effective use of clinical and administrative resources.

Priority Process: Competency

There is a strong interdisciplinary team in place on this unit. The team presented as capable and passionate about working with this complex patient population. A matrix reporting relationship exists for clinical staff members that report to both program and discipline/practice leadership.

There is strong support to the clinical team from the physiatrist that works with the team members. Changes have been tested and implemented and have led to improvements to patient care and patient flow from the acute neurosurgery unit to the rehabilitation centre. A specific example are the weekly rounds with the nurosurgery unit at the Halifax Infirmary and the twice-weekly team huddles.

Clinicians questioned during tracers reported they have not received regular, formal, documented evaluation of their performance. Clinicians also reported high workloads and caseloads. Patients reported a desire for more frequent therapy sessions. In discussions with the team about the mix of team members to serve the spinal cord injury (SCI Rehab) population on the unit, it was reported that psychology and recreation therapy services were deemed insufficient.

Priority Process: Episode of Care

Feedback from all three patients interviewed during the tracers, when asked to rate the quality of the care received on the spinal cord injury (SCI) rehabilitation unit on a scale of one to five, where five is excellent, and all rated their care as a perfect five. There are clear admission guidelines in place for the SCI unit and a pre-transfer checklist. Once admitted, patients and families receive an excellent patient/family guide

entitled: "Welcome to the Nova Scotia Rehabilitation Centre", which includes a section on medicine safety that introduces medication reconciliation. Patients and families are asked to bring a list of current medicines, including drugs their doctor did not order and under the heading: "Self Medication" one of the goals during their rehabilitation stay may be to learn how to take their own medicines. The importance of hand hygiene is also covered in a section on hand cleaning.

The Morse falls risk assessment tool is used on admission with all patients. Patients at risk are identified with falls risk stickers at the bedside, on their identification arm bands and on their medical record. Fall prevention precautions are implemented and included on the transfer of accountability (TOA) check list and daily shift report.

Risk of pressure ulcers are a priority for the SCI patient population. Initial pressure ulcer risk assessment is conducted on admission using the Braden scale assessment tool, and then weekly. Individualized care plans are developed based on the Braden scores and daily shift change and visual inspections.

A best possible medication history (BPMH) is completed on all admitted patients and this is for patients admitted from the community or from another facility, on the admission medication reconciliation form. At discharge, the list of all medications to be taken by the patient is noted on the discharge medication reconciliation form. Reconciliation is done against the admission BPMH and the medication administration record (MAR). Two identifiers were routinely used to identify patients receiving medications. The Pyxis medication system is in place on the unit to dispense medications. There is also a robust, staged/phased self-medication program for patients. Medications are dispensed from the Pyxis medication system and then taken to the patient and the blister packages are opened and administered on location. Nurses report only taking the medications for one patient at a time, returning to the Pyxis machine for the medication for the next patient.

A face sheet has been created for nursing staff to track patient safety related information. This includes code status, allergies, fall risk and so on. Interdisciplinary team huddles have been implemented as another patient safety focused initiative. An excellent patient safety initiative, the transfer of accountability (TOA) checklist ensures that critical information about patients is effectively transferred at transition points such as transfer between units, at shift change, and when a patient leaves a unit for a procedure. The TOA checklist ensures that the exchange of information is documented.

The physical space in the rehabilitation centre requires updating. The therapeutic pool has not been usable for more than two years and the therapy gym spaces, while large, are badly in need of updated equipment. For instance, some plinths are not height adjustable. A body weight supported treadmill was donated as an alternative to a pool in an attempt to replicate the outcomes in the absence of access to the therapeutic pool however, this is not seen as an adequate alternative. Use of the local Canada Games pool is also not an alternative, as the pool is unheated and the time to transport patients to and from the pool is prohibitive.

New accessible washrooms have been installed in the outpatient areas, and plans are in place with the: Revitalizing Rehab initiative to partner with the Capital District Health Foundation to raise funds for badly needed renovations and capital equipment.

Priority Process: Decision Support

The Nova Scotia Research Centre (NSRC's) wheelchair skills training program has been recognized by the World Health Organization (WHO) and the Rick Hansen Institute's rehabilitation environmental scan atlas as a leading practice. The spinal cord injury (SCI) rehabilitation team was also recognized for excellence in the management of neuropathic pain. Note is made of the physiatrist with the SCI Rehab program that

participated in a national committee with Accreditation Canada and the Rick Hansen Institute to develop accreditation standards for rehabilitation of persons with SCI.

The inpatient and outpatient areas are actively involved in ongoing basic and clinical research projects. Staff members and physicians are seen as national experts and called upon for teaching at conferences. The team is proud of implementing a new SCI pathway.

There are formal processes for accepting referrals and admitting patients. Criteria are in place to determine who is appropriate for admission and the urgency and priority for the required admission. Admission assessments are thorough, and all new patients have a safety and falls-risk assessment screening completed. The assessment is enhanced over time, as the new patient settles into a routine and a more complete picture of strengths and limitations becomes known.

There are numerous examples of written materials for clients and families relative to safety, risk, program options, and other educational content.

There is a good consolidated, interdisciplinary assessment and goal-setting framework in the clinical documentation.

Priority Process: Impact on Outcomes

The SCI unit participates in the National Rehabilitation Data Set recording project via the Canadian Institute for Health Information. Some benchmarking with similar rehabilitation centres is possible, and is pursued as appropriate. Data on referrals, health status, and goal categories are monitored along with the National Rehabilitation Data Set findings and other data sources. A review of data from the national data set showed higher readmission rates for the SCI Rehab unit than others in the data set. A lack of community services in Nova Scotia was referenced as the reason for the need to readmit patients to the SCI Rehab unit. In addition in-house data on wait-lists is collected and priorities are constantly reviewed to help manage wait-lists for admission.

A quality and patient safety team scorecard has been developed to align operational related team goals with CDHA's 2013 milestones and 2016 strategic goals, and to track trends in improvement in the SCI unit a monthly audit of charts and kardex is completed. Most of the audit item indicators on the scorecard are rate based, and although compliance is tracked, no targets were apparent to the surveyor.

Patient satisfaction scores are reported on a fiscal year basis, but no translation of scores into information for action or targets were noted during the survey. Open text comments were transcribed, but not linked to any key themes arising from the quantitative data. Long-term trend reports of incidents on the SCI unit were provided that show numbers of incidents over time. Root cause analysis appears to be carried out at the incident level, but little interpretation of the data over time was noted. Run-charts with trend lines may be a more effective way to display these results, with annotations to explain trends or changes over time and to prompt selection and monitoring of improvement efforts.

Quality initiatives of note include a new SCI pathway implemented in August, and implementation of the use of spinal cord independence measure (SCIM) as an assessment tool. Large television (TV) monitors on the unit floor appear to be an effective way to display patient safety information for patients and staff.

3.3.26 Standards Set: Substance Abuse and Problem Gambling Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.6	The interdisciplinary team communicates regularly to coordinate services, roles, and responsibilities.	!
4.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
6.9	If the team is unable to meet the needs of potential clients or referring organizations, the team explains the reasons why, facilitates access to services offered by other organizations, and records the information for use in service planning.	
8.2	The team verifies that the client and family understand the service information provided.	!
9.5	The team adheres to applicable legislation, organizational policies, accepted standards of practice, and codes of ethical practice when delivering services to clients and families.	!
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support		
12.1	The team maintains an accurate and up-to-date record for each client.	
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
Substance abuse and gambling services comprise intensive treatment services, the Opiate treatment program (Methadone), inpatient program and day program. In addition, there are several community-based services across the organization that offer intake, recovery, counselling and specialized targeted programs such as the stop smoking services and driving while impaired program, amongst others.

The services collect several indicators to reflect the substance profiles of clients served. Indicators for mental health issues are: self-reported; percentage of concurrent disorders clients; continuity of care; length of stay and several utilization indicators. The team demonstrates several excellent examples where the service has been adjusted based on data collected and monitored. One example is adjusting the former 28-day residential treatment program and the three to seven day detoxification program into one 21-day inpatient service. This has significantly affected the drop out rates, and improved the transition to after care rates. In addition, a psychiatrist was added to the team introducing a stronger focus on the co-morbidity of mental illness in the population served with more appropriate assessment and treatment services. The interdisciplinary team members also report improved coordination and flow for patients between the services, based on a recovery oriented model of care.

This team is strongly aligned with the strategic directions of the organization, and is making significant advances to integrate addictions and mental health into the new Capital District Health Authority Addictions and Mental Health program model of care. Examples include introducing mental health supports to the program with some excellent examples in education, training, and quality improvement initiatives. New interdisciplinary team members have been introduced in psychiatry medicine, psychology, recreation therapy and discharge planning,

Several good examples of the programs efforts to raise awareness are in place including education groups. However, an opportunity exists to enhance services aimed at prevention and promotion, in addition to community outreach services in the rural areas. Client and family feedback suggest the services offered in more rural/remote areas are minimal, including any access to Methadone replacement therapy. Community teams identify enhancement of service delivery as an overall opportunity for improvement across the organization.

The team is excited with the new directions and see advancement in their service over the last year in addressing standards of care and consistent, standardized practices. Examples concern client record development, medication management, suicide risk assessments, falls prevention strategy, amongst others. Several plans are in place to redesign service models with medication management such as the medication nursing role, the physical layout from a safety perspective with the medication dispensing in the outpatient program, and regulatory changes with the operation of the inpatient program.

Good student support is evident in medicine and nursing disciplines.

Priority Process: Competency

Obvious significant enhancements have been made with this team. An example is introducing a much stronger mental health and concurrent disorder service which is commendable. There is psychiatry and general medicine involvement with client assessments and treatment. There is enhanced interdisciplinary team functioning with the addition of a psychologist and recreation therapist. There is a discharge planning coordinator role. There are team meetings, and a quality team focus on key initiatives for change, with access to a psychologist, general practitioners and other supports.

Many examples exist around skill development for staff members, including introducing standardized assessment processes with suicide prevention, medication reconciliation and concurrent disorders development. Encouragement is offered to continue efforts at ensuring education/training is completed, monitored and tracked.

There are some excellent examples of staffing review and changes being implemented to ensure improvements are made, One example is the addition of the psychiatrist, recreation therapist, and volunteers with evening music programming.

Priority Process: Episode of Care

There are good examples of standardized processes, which have recently been introduced in suicide assessment, along with falls prevention assessments completed on admission, and the use of the team record of care. The team is encouraged to continue with its implementation of this work, including with all team members and staff. The team is also encouraged to develop capacity for their auditing processes as a quality improvement initiative for the Capital District Health Authority (CDHA).

There is excellent centralized intake for access to addiction services, including a web site for self-referral. An opportunity for improvement exists to further develop this centralized intake process with mental health services, with the integration of these areas as a district-wide program.

As the services are voluntary, the team has discovered that additional wait-list management information is required to more clearly identify actual service needs, based on the high number of no-shows and cancellation rates. This is an area the team is working on to be better able to track and monitor, as the service is expanding, particularly for methadone treatment.

With the more recent introduction of the interdisciplinary team assessment record, staff members are beginning to document client needs and expectations. Practice evidence and audits indicate this is not completed in a consistent manner by all disciplines.

The team is currently addressing a number of regulatory requirements for methadone treatment to improve compliance with CDHA policy and has demonstrated significant progress since January 2013. Enhancements have been made with the interdisciplinary team representation and in securing physician and pharmacy coverage. New policy and protocol development is a work in progress to address quality and safety. The current practice of pouring methadone doses from a stock supply is not consistent with the CDHA policy for the administration of methadone. Work is underway to effect a change so that methadone is provided to the addictions program staff members as unit doses. Until such time as this in place, or an alternate policy is developed, an exception to the policy will be required. Current nursing practice of addictions staff preparing methadone doses, complete with the necessary safety check and physician order, will need to be authorized to continue.

Day treatment and outpatient services develop a plan of care for service. The team is working to further advance/enhance discharge planning with a new discharge planning role specific to the needs and with a focus on housing and financial supports.

Good safety and security precautions are noted across the program with staffing models, security on site, staff reporting, client reporting, use of safety wrist alert bands, locked medication rooms, and processes introduced for medication dispensing.

Priority Process: Decision Support

Documentation is inconsistent amongst the interdisciplinary team members however, staff members and educators and the quality team are working hard to introduce all of the new assessment forms and documentation requirements. Support for information advancements with documentation is encouraged to address the quality and accuracy of information for the team.

Good use of evidence-based practices are emerging with the team expansion and advanced skill sets. Examples are the integration of addiction and mental services as a program, a focus on the recovery model of care for this population, and the group therapy model. The team is encouraged to continue to advance its work and planning, focused on concurrent capability education and training to develop staff competencies, and introduce best practices as these relate to assessment and treatment.

Priority Process: Impact on Outcomes

The quality team is actively addressing the current services and developing and implementing a plan to address service changes that are in alignment with the strategic directions of the organization. Areas of risk as they relates to the quality of care are being addressed with new client flow processes in place, new staffing models, policy development, and screening and assessment tools, amongst others. The team is encouraged to continue these efforts to introduce the changes planned with mental health and addiction programming, education, competency development, data collection, and evaluation.

The team has developed some good utilization/process indicators that will continue to assist in making service adjustments. A focus on client functioning and outcome measurement is encouraged to address effectiveness of services and interventions provided.

3.3.27 Standards Set: Telehealth Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	The organization has a comprehensive written agreement with each organization when two or more organizations are involved in delivering telehealth services.	
2.1	The organization has policies and procedures in place to govern the delivery of telehealth services.	!
2.2	The organization sets measurable goals and objectives for telehealth services to guide day-to-day telehealth activities.	
5.14	The organization's leaders follow a plan for maintaining, upgrading, and replacing telehealth equipment.	
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		
13.1	The team identifies and monitors process and outcome measures for its telehealth services.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Capital District Health Authority has developed a clear vision for how telemedicine services should fit into an integrated model of clinical service delivery. Rather than leading with technology, the organization is asking clinical programs to first determine the care needs of the patient population served and then consider service delivery options.

Fitting with the provincial mantra of: "better care sooner", programs are supported to determine how technology, including telemedicine can be best used. Rather than planning for telemedicine in isolation, this is included as one aspect of clinical service planning, as programs envision how care will be provided in the future. The organization is commended for taking an approach that is broader than telemedicine and

appropriately identifying that there is now many different enabling technologies. The language it is using is: "connected health" rather than "telehealth."

Use of telemedicine as an enabler is currently limited to a few clinical programs namely, renal, rehabilitation, dermatology, cardiovascular and mental health. At this time, there are 26 different geographical sites at CDHA with access to telehealth.

There have been longstanding issues between CDHA and the Department of Health and Wellness about how the shared-accountability model for telemedicine is defined and will practically work. In recent years, the program has been challenged with resource and technology issues. A 2012 review of the program by the Department of Health and Wellness has resulted in a series of recommendations, including refocusing efforts to support clinical services versus education or administrative uses to close the gap between demand and current capacity.

It will be important for CDHA to continue its efforts to provide leadership to establish the provincial direction, and to clearly define how the collaborative relationship between the organization and the province will work.

It will also be important for the organization to clearly identify measurable goals/priorities to ensure the expectation of each of the programs is clear about determining how enabling technology will be used.

Priority Process: Competency

While there is some central coordination and support, the organization's philosophy is to embed telemedicine expertise in each of the program areas. There are processes in place to ensure that every team member with telemedicine responsibilities receives technical training.

Priority Process: Episode of Care

The use of telemedicine has increased the contact some patients have with the clinical team, particularly physicians, and has reduced travel time for patients, families, and clinicians.

Members of the care team give careful consideration to which clients are appropriate to receive services via telemedicine. This includes consideration to the type of information that may be shared during the clinical encounter, as well as the patient's ability to receive information via this mode, considering their hearing, sight and language abilities.

Patients are given the option of telemedicine or an in-person consultation. The experience of the care team is that the telemedicine option is almost always accepted. The care team explains to patients that telemedicine is part of the care provided, and are asked to sign a consent.

The patient record and care plan is available to the clinical team prior to the consult, and both are appropriately updated with new information or orders resulting from the consult. Regardless of the sites involved, there is a single patient record and new information is consolidated in that single location. There is heavy use of protocols, which fit well with an interdisciplinary team approach.

Patient tracer activities provided the opportunity to see the telemedicine service in action. In all cases, the interdisciplinary team was able to interact with the patient. There was agreement by all involved that any challenge associated with distance was far outweighed by the benefits of easy access, communication, and ability to make decisions about care and treatment options.

Priority Process: Decision Support

The team is well aware of the importance of privacy and confidentiality, and makes great effort to ensure appropriateness of the locations used by patients and providers. While patient tracers did disclose that not all conversations were completely private, this was due to the shared space nature of the direct care setting, and not specific to the use of telemedicine services. The information that is shared during and after the telehealth encounter is well managed.

Priority Process: Impact on Outcomes

Patient satisfaction with the telemedicine option is reported as high, which was validated during the patient tracer. The team however, does not report any particular improvements that have been made as a direct result of patient feedback.

3.3.28 Priority Process: Surgical Procedures

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

Unmet Criteria		High Priority Criteria
Standards Set: Operating Rooms		
1.8	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
2.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
12.6	The organization transports contaminated items separate from clean or sterilized items, away from client service and high-traffic areas.	!
14.4	The team sets performance goals and objectives and measures their achievement.	
Standards Set: Surgical Care Services		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for its surgical care services are measurable and specific.	
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
7.9	The team assesses each client's risk for developing a pressure ulcer and implements interventions to prevent pressure ulcer development.	ROP
	7.9.5 The team has a system in place to measure the effectiveness of pressure ulcer prevention strategies, and uses results to make improvements.	**MINOR**
11.6	Following transition or end of service, the team contacts clients, families, or referral organizations or teams to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
15.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
	15.2.5 The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**

Surveyor comments on the priority process(es)

Three sites were visited during the survey: the Victoria General site's operating room (OR) and unit 6A, the Halifax Infirmary site's OR and unit 4.1 and Dartmouth General Hospital's OR and unit 3A. The general organization of the Capital District Health Authority, with a single department of surgery is proving beneficial to the staff members from the point of view of standardization of policies, procedures and forms. There remains site-specific variation due to local circumstances such as the physical state of each of the facilities. The total acceptance of this organizational structure faces some resistance, which is not unexpected, but is fading. There were comments from medical staff members regarding their ability to be heard and participate in higher level decision making.

At the three sites visited there is a strong atmosphere of teamwork. Staff morale appears positive, with witnessed communications attesting to positive interpersonal relationships. This extends to the medical staff, which is not always evident. Staff members are forthright in dealing with any issues that do arise, usually handling them one-on-one to resolve any conflicts, but able and comfortable to escalate if necessary.

The orientation process is extensive, covering the general hospital part and the focused orientation to the specific working area, be it the OR a patient care unit. The learning management system (LMS) is a useful tool for online training, including for Accreditation Canada's required organizational practices (ROPs), and recording such training. It also points staff members to classroom courses which will subsequently be recorded as completed. Ongoing education is widely supported in many areas, including though donations and fundraising by the staff. The Wednesday morning inservice sessions are well attended. The nurse educators are a valuable resource and much appreciated. It is suggested that Dartmouth General Hospital (DGH) site could use a full-time person versus the current sharing arrangement. The addition of the nurse practitioner role to the surgery units is proving extremely helpful to patient care, particularly in their contribution to patient flow by assuring patients and their documentation are ready for the next step.

The performance appraisal process is not consistent across the three sites visited. In some areas, staff members have difficulty remembering when, and in some areas it is recent occurrence. It is recommended that the organization review its approach to performance appraisals to confirm a system that is practicable. Much of this has to do with the large span of control of some managers.

None of the areas visited set out goals and objectives on a business cycle basis. There is much data collected regarding activities and incidents, including aspects of the ROPs, but there does not appear to be any specific goals set as to what to accomplish locally within the collection of this data. Individual issues are dealt with appropriately, but it seems there is no attempt to summarize overall learning and/or influence outcomes. One notable effort at this approach is the DGH's OR. Here the integration of three commonly collected data sets that is, body temperature, timing of antibiotic administration and surgical site infection rates, in the face of an increasing caseload is yielding information that could support a major shift in patient outcomes.

The patient flow process from pre-admission clinic to day of admission assessments by nursing, anesthesiologist and surgeon, to the OR and then to PACU and either to the unit or discharge is smooth and well done. If issues arise, such as a missing consent in one case or an abnormal laboratory test in another, decision-making processes occur to proceed safely and appropriately. The standardized patient record for day of surgery admission is a boon to safe patient care. There is evidence of the use of dangerous abbreviations in hand written orders. This situation requires review with medical staff.

Medication reconciliation is done on both admission and discharge with the reinstitution of reconciliation on transfer just beginning. The electronic process on discharge is a good example of streamlining however, some medical staff members require reminding of their role and responsibility in the process.

The safe surgical checklist (SSCL) has been implemented and a policy is about to be promulgated. The SSCL is used in all ORs in the CDHA which meets the Accreditation Canada standard. Compliance is monitored and results are posted. The auditing that is currently done does not extend to the itemized level in each of the three phases. It is recommended that the organization undertake such an audit to assure it is meeting the detailed intent of the SSCL for patient safety.

The physical plant of the three sites varies considerably. The ORs and units were designed and built according to standards that existed at the time. The issues with the structures are well known and are actively considered on a recurring basis. The solutions vary from a total new build, capital expansion of existing site, to refurbishment of specific existing areas. In the meantime, staff members must be especially attentive to issues of patient overcrowding and infection prevention and control.

Section 4 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.

4.1 Governance Functioning Tool

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

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

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

- **Data collection period: January 24, 2012 to November 23, 2012**
- **Number of responses: 9**

Governance Functioning Tool Results

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	11	0	89	92
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	96
4 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	93
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	0	0	100	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	93
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	95
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	93
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	90
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	92
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	95
14 Our ongoing education and professional development is encouraged.	0	0	100	86
15 Working relationships among individual members and committees are positive.	0	0	100	96
16 We have a process to set bylaws and corporate policies.	0	11	89	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	96
18 We formally evaluate our own performance on a regular basis.	11	11	78	76
19 We benchmark our performance against other similar organizations and/or national standards.	0	11	89	68
20 Contributions of individual members are reviewed regularly.	11	44	44	66

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	11	33	56	77
22 There is a process for improving individual effectiveness when nonperformance is an issue.	11	44	44	59
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	11	11	78	82
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	0	0	100	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	33	44	22	68
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	94
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	11	11	78	86
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	96
29 As a governing body, we hear stories about clients that experienced harm during care.	0	11	89	83
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	11	89	91
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	13	13	75	91
32 We have explicit criteria to recruit and select new members.	14	14	71	83
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	57	29	14	88

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	92
36	We review our own structure, including size and sub-committee structure.	11	0	89	87
37	We have a process to elect or appoint our chair.	0	0	100	92

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2012 and agreed with the instrument items.

4.2 Patient Safety Culture Tool

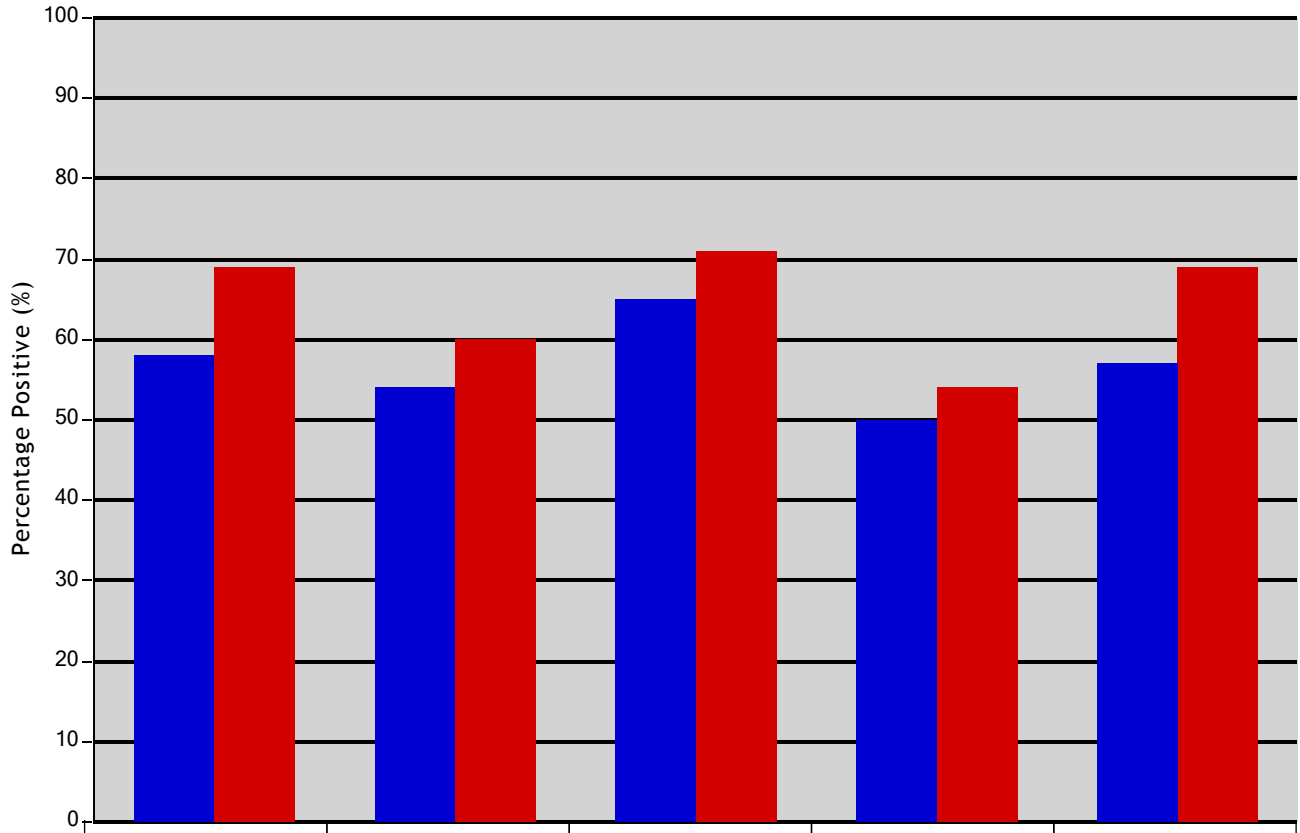
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: January 22, 2012 to June 22, 2012**
- **Minimum responses rate (based on the number of eligible employees): 379**
- **Number of responses: 2525**

Patient Safety Culture: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	58%	54%	65%	50%	57%
	69%	60%	71%	54%	69%

Legend

Capital District Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2012 and agreed with the instrument items.

4.3 Worklife Pulse Tool

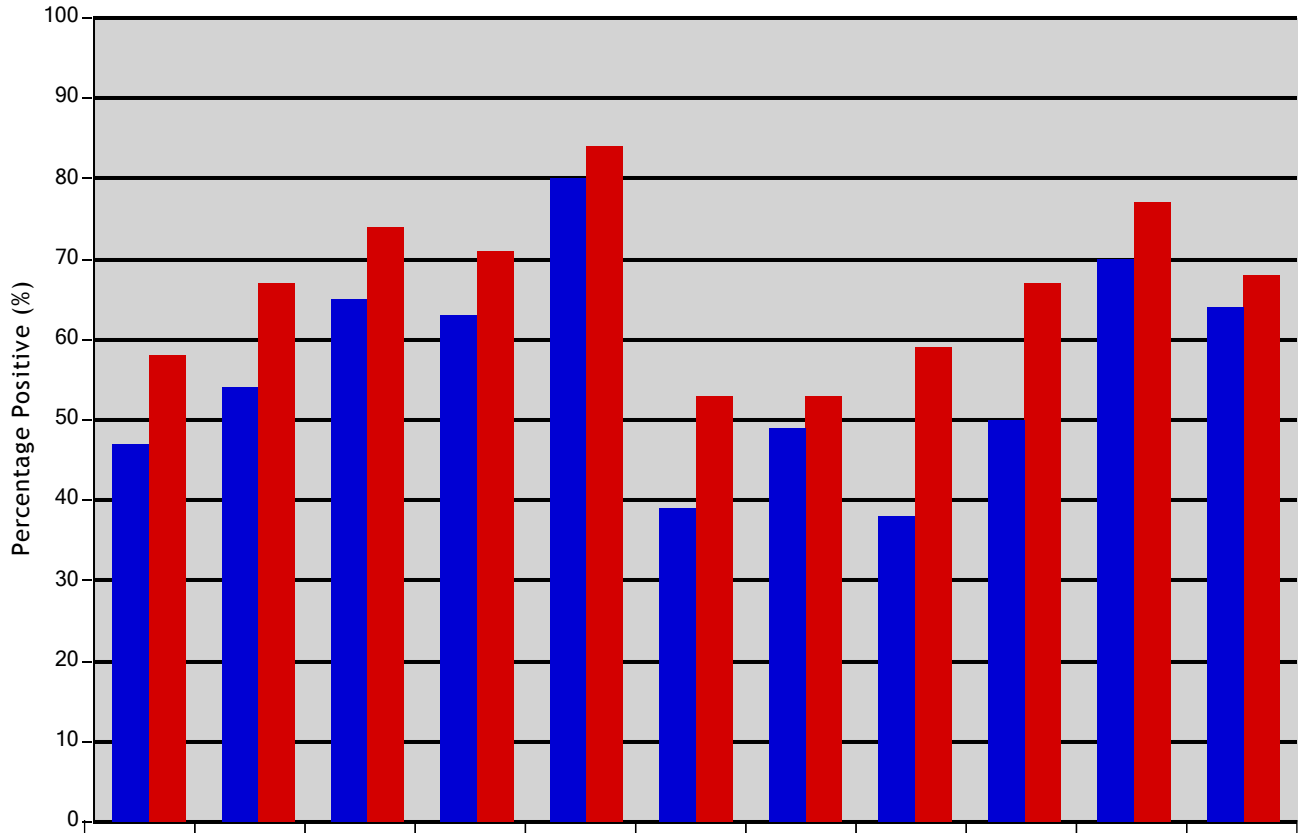
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: January 22, 2012 to June 22, 2012**
- **Minimum responses rate (based on the number of eligible employees): 379**
- **Number of responses: 3178**

Worklife Pulse Tool: Results of Work Environment



	Organizational communication	Work area communication	Supervision	Job control	Role clarity	Decision making involvement	Job demand	Trust	Learning environment	Safe environment	Worklife balance
	47%	54%	65%	63%	80%	39%	49%	38%	50%	70%	64%
	58%	67%	74%	71%	84%	53%	53%	59%	67%	77%	68%

Legend

Capital District Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2012 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

Section 5 Organization's Commentary

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

Capital District Health Authority is pleased to have recently welcomed Accreditation Canada surveyors to the organization and is most appreciative of their findings, which both celebrated areas of success in improving quality and patient safety and provided insight into areas for improvement. The surveyors' visit marked the second time Capital Health has participated in the Qmentum process for accreditation. The Qmentum process is aligned with Our Promise and Our Promise in Action and our results this year clearly showed how the process can enhance attainment of the quality improvement goals of participating health organizations.

Early completion of Standards' questionnaires and relevant surveys supplemented and strengthened the commitment of Capital Health's employees, physicians, volunteers, learners and governing board to continuous quality improvement and to Our Promise and Our Promise in Action strategic planning. The overwhelmingly positive interaction with 12 surveyors, an Accreditation Canada facilitator and an observer during their visit to 23 of our sites was a clear reflection of this commitment. Throughout the district, we embraced the opportunity for the care and services we provide, to be comprehensively evaluated and validated against 34 sets of high quality Standards and 32 Required Organizational Practices.

A significant change since Capital Health's last Accreditation Canada survey was the transition from accreditation teams to more than 60 quality and patient safety teams that worked, and continue to work, to improve the overall quality and patient safety of our care and services. The most recent Accreditation Canada visit allowed these teams to see the excellent results of their dedication and hard work and to learn about the opportunities for improvement, one of many drivers in the quest for further improvement.

We accept the findings in this report and, consistent with the enthusiasm and dedication of our teams, work is already underway to address those criteria that were not met. This includes the tests for compliance of Required Organizational Practices and a focus on business continuity planning as it relates to some of our older buildings.

Capital Health extends a sincere thank-you to the dedicated team of surveyors who were with us between October 27 and November 1, 2013. Their insight, detailed in the onsite report, is valuable to us as we strive toward achieving the mission of Our Promise – to be a world-leading haven of people-centred health, healing and learning.

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 15 business days.

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge