ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Island Health

Victoria, BC

On-site survey dates: April 6, 2014 - April 11, 2014

Report issued: May 2, 2014

ACCREDITATION CANADA
AGRÉMENT CANADA

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

Accredited by ISQua

About the Accreditation Report

Island Health (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 April 2014. 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

Table of Contents

Section 1 Executive Summary

Island Health (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

Island Health'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: April 6, 2014 to April 11, 2014**

- **Locations**

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

1 Aberdeen
2 Cairnsmore Place
3 Campbell River Home Health Unit
4 Campbell River Hospital
5 Clearview Detox Centre
6 Coastal Health Unit (Courtenay)
7 Comox Valley Seniors Health Team
8 Cowichan District Hospital
9 Cowichan Lodge
10 Duncan Home Health Unit
11 Duncan Mental Health Building (SORT)
12 Family Place (Parksville)
13 Gateway Village (Victoria)
14 Glengarry
15 Gorge Road Hospital
16 Hillside Seniors Health Centre
17 Lady Minto/Gulf Islands Hospital
18 Ladysmith Community Health Centre
19 Mount Tolmie
20 Nanaimo Mental Health - Discovery Unit
21 NRGH (including Dufferin Place)
22 Oceanside Health Centre
23 Port Alice Health Centre
24 Port Hardy Hospital (including Eagle Ridge Manor)
25 Port McNeill Hospital
26 Priory (Hiscock & Heritage Woods)
27 Queen Alexandra Centre for Children's Health (includes Ledger House & Pearkes)
28 Royal Jubilee Hospital (including Memorial Pavilion & Begbie Hall)
29 Saanich Peninsula Hospital
30 Tofino General Hospital
31 Trillium Lodge
32 Victoria General Hospital

33 Victoria Mental Health - AOT Unit
34 Victoria Mental Health - USTAT
35 Victoria/Oak Bay Health Unit
36 West Coast General Hospital (including Westhaven Lodge)

- **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 Child and Youth Populations
5 Mental Health Populations
6 Public Health Services
7 Senior Populations

Service Excellence Standards

8 Operating Rooms
9 Developmental Disabilities Services
10 Primary Care Services
11 Surgical Care Services
12 Critical Care
13 Emergency Department
14 Home Care Services
15 Ambulatory Care Services
16 Community Health Services
17 Hospice, Palliative, and End-of-Life Services
18 Long-Term Care Services
19 Medicine Services
20 Rehabilitation Services
21 Substance Abuse and Problem Gambling Services
22 Telehealth Services
23 Community-Based Mental Health Services and Supports Standards
24 Obstetrics Services
25 Mental Health Services
26 Medication Management Standards

27 Infection Prevention and Control
28 Reprocessing and Sterilization of Reusable Medical Devices

- **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)	200	4	1	205
 Accessibility (Providing timely and equitable services)	164	4	0	168
 Safety (Keeping people safe)	587	26	17	630
 Worklife (Supporting wellness in the work environment)	239	2	0	241
 Client-centred Services (Putting clients and families first)	370	2	3	375
 Continuity of Services (Experiencing coordinated and seamless services)	121	1	0	122
 Effectiveness (Doing the right thing to achieve the best possible results)	957	44	13	1014
 Efficiency (Making the best use of resources)	89	4	1	94
Total	**2727**	**87**	**35**	**2849**

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	44 (100.0%)	0 (0.0%)	0	34 (100.0%)	0 (0.0%)	0	78 (100.0%)	0 (0.0%)	0
Leadership	46 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	131 (100.0%)	0 (0.0%)	0
Child and Youth Populations	4 (100.0%)	0 (0.0%)	0	29 (100.0%)	0 (0.0%)	0	33 (100.0%)	0 (0.0%)	0
Mental Health Populations	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Populations with Chronic Conditions	4 (100.0%)	0 (0.0%)	0	30 (96.8%)	1 (3.2%)	4	34 (97.1%)	1 (2.9%)	4
Public Health Services	47 (100.0%)	0 (0.0%)	0	66 (97.1%)	2 (2.9%)	0	113 (98.3%)	2 (1.7%)	0
Senior Populations	26 (100.0%)	0 (0.0%)	0	42 (100.0%)	0 (0.0%)	0	68 (100.0%)	0 (0.0%)	0
Infection Prevention and Control	50 (98.0%)	1 (2.0%)	2	43 (100.0%)	0 (0.0%)	1	93 (98.9%)	1 (1.1%)	3
Medication Management Standards	66 (90.4%)	7 (9.6%)	5	55 (87.3%)	8 (12.7%)	1	121 (89.0%)	15 (11.0%)	6

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Ambulatory Care Services	31 (91.2%)	3 (8.8%)	4	70 (97.2%)	2 (2.8%)	3	101 (95.3%)	5 (4.7%)	7
Community Health Services	13 (100.0%)	0 (0.0%)	0	53 (96.4%)	2 (3.6%)	0	66 (97.1%)	2 (2.9%)	0
Community-Based Mental Health Services and Supports Standards	18 (100.0%)	0 (0.0%)	0	111 (99.1%)	1 (0.9%)	0	129 (99.2%)	1 (0.8%)	0
Critical Care	30 (100.0%)	0 (0.0%)	0	88 (97.8%)	2 (2.2%)	3	118 (98.3%)	2 (1.7%)	3
Developmental Disabilities Services	34 (100.0%)	0 (0.0%)	1	74 (100.0%)	0 (0.0%)	2	108 (100.0%)	0 (0.0%)	3
Emergency Department	28 (90.3%)	3 (9.7%)	0	89 (93.7%)	6 (6.3%)	0	117 (92.9%)	9 (7.1%)	0
Home Care Services	39 (97.5%)	1 (2.5%)	1	49 (94.2%)	3 (5.8%)	0	88 (95.7%)	4 (4.3%)	1
Hospice, Palliative, and End-of-Life Services	29 (100.0%)	0 (0.0%)	0	104 (100.0%)	0 (0.0%)	1	133 (100.0%)	0 (0.0%)	1
Long-Term Care Services	24 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	1	95 (100.0%)	0 (0.0%)	1
Medicine Services	26 (96.3%)	1 (3.7%)	0	58 (84.1%)	11 (15.9%)	0	84 (87.5%)	12 (12.5%)	0
Mental Health Services	32 (100.0%)	0 (0.0%)	0	86 (97.7%)	2 (2.3%)	0	118 (98.3%)	2 (1.7%)	0
Obstetrics Services	61 (100.0%)	0 (0.0%)	2	72 (96.0%)	3 (4.0%)	0	133 (97.8%)	3 (2.2%)	2
Operating Rooms	69 (100.0%)	0 (0.0%)	0	28 (93.3%)	2 (6.7%)	0	97 (98.0%)	2 (2.0%)	0
Primary Care Services	32 (97.0%)	1 (3.0%)	1	61 (92.4%)	5 (7.6%)	0	93 (93.9%)	6 (6.1%)	1
Rehabilitation Services	27 (100.0%)	0 (0.0%)	0	67 (98.5%)	1 (1.5%)	0	94 (98.9%)	1 (1.1%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Reprocessing and Sterilization of Reusable Medical Devices	38 (100.0%)	0 (0.0%)	2	57 (96.6%)	2 (3.4%)	0	95 (97.9%)	2 (2.1%)	2
Substance Abuse and Problem Gambling Services	27 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0	98 (100.0%)	0 (0.0%)	0
Surgical Care Services	30 (100.0%)	0 (0.0%)	0	62 (95.4%)	3 (4.6%)	0	92 (96.8%)	3 (3.2%)	0
Telehealth Services	29 (96.7%)	1 (3.3%)	0	37 (100.0%)	0 (0.0%)	0	66 (98.5%)	1 (1.5%)	0
Total	**908 (98.1%)**	18 (1.9%)	18	1727 (96.9%)	56 (3.1%)	16	2635 (97.3%)	74 (2.7%)	34

* 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 (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Home Care 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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 (Obstetrics 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 (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 (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care 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 (Home Care Services)	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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 (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Information Transfer (Surgical Care Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Unmet	3 of 7	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care)	Unmet	2 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	2 of 5	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Unmet	3 of 4	0 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Hospice, Palliative, and End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Unmet	2 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	2 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling Services)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Surgical Care Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Operating Rooms)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Home Care Services)	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 (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Operating Rooms)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Substance Abuse and Problem Gambling Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Surgical Care Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Concentrated Electrolytes (Medication Management Standards)	Unmet	2 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Home Care Services)	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 (Medicine Services)	Unmet	0 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 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 (Surgical Care Services)	Met	1 of 1	0 of 0
Narcotics Safety (Medication Management Standards)	Unmet	2 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (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
Reprocessing (Infection Prevention and Control)	Unmet	0 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Unmet	2 of 3	0 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Medicine Services)	Unmet	3 of 3	0 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Surgical Care Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 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
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Surgical Care Services)	Met	3 of 3	2 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports Standards)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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	1 of 3	1 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.

Island Health is commended for participating in the accreditation program and demonstrating its dedication to ongoing quality improvement.

Activities of Island Health are guided by an established vision and purpose augmented by a core set of organizational values and strategic priorities. The organization has taken a values-based approach to the development of the strategic plan with the organizational values used as the “foundation and moral compass.” Organizational values were previously determined using an interactive engagement process and a broad campaign, “Living Our Values,” was employed to solidify the values into the organizational culture. There is evidence that the values of the organization are regularly referenced in discussions and used in decision-making processes.

The strategic plan was refreshed in 2011 using a broad engagement strategy. Directors and senior leaders visited communities and health care sites doing “walkabouts” over a period of approximately six weeks. This strategy was used again in 2012 for the “Living Our Values" campaign, and was broadened in 2013 to include engagement of the public and municipal leaders in discussion of strategic priorities.

A number of organizational and structural changes are underway to align operations with strategic priorities. These include restructuring and reorganization of leadership functions and responsibilities and care model redesign. A learning and professional support framework has been adopted within the last several months in response to the organizational articulation of continuous learning as a strategic priority. This recognizes continuous learning as a foundational vehicle to achievement of other Island Health strategic priorities.

The organization is commended for its comprehensive workplace violence prevention and safer workplaces strategies. Policies address risk assessment, violence prevention, domestic violence, patient belongings and weapons, working alone, and transporting clients. The strategies have been implemented through information sessions in partnership with professional learning and development through the safety hub, using a provincial curriculum.

The organization is commended for its attention to volunteers with more than 6,000 active volunteers registered at present. A volunteer management database is in place. Consistent strategies and processes are in place for the recruitment, orientation and performance evaluation of volunteers. The mandatory orientation for all volunteers includes a number of instructional videos including dealing with aggressive behaviour. The general volunteer orientation is augmented by a workplace-specific orientation provided by local management. An informative volunteer handbook is also in place.

The organization is commended for its robust Aboriginal recruitment and retention strategy. An Aboriginal employment advisor is in place and a vision and strategy have been articulated. Currently, the board of directors includes a First Nations member who is instrumental in guiding board discussions through "how we work across the differences." Currently the board is developing its relationship with the recently formed First Nations Health Authority.

Internal and external stakeholders report a sense of optimistic enthusiasm for the more collaborative, consultative and interactive engagement and decision-making approach of the organization, which has been evident recently. The organization has conducted an audit of its community relations activities and their

effectiveness and has established a community relations plan. This includes relationship building with regional hospital districts and the formation of community partner networks to discuss determinants of health and the means to impact determinants of health. For example, community partners identified transportation as a barrier in some areas and the organization has responded with the establishment of a bus, which is now self-sustaining, to enhance access to services. Other initiatives include strategies to address identified issues with youth housing and emergency housing.

Board of directors meetings are located in communities throughout the island and each meeting includes a public segment with question period. The board also uses the time for outreach to communities, organizations and municipal leaders. A comprehensive internal and external communications plan has been developed and implemented to improve stakeholder engagement.

The organization has in place a draft strategic quality plan for 2012 through 2015, which was driven by the World Class Quality by 2014 initiative. This comprehensive strategy document is built around a set of promises to patients. The organization takes a comprehensive approach to quality which balances strategic, data-driven quality monitoring and identification of improvement initiatives with local level grassroots initiatives. The organization is commended for its implementation of an interactive electronic dashboard of performance measures and indicators which is available and used at all levels of the organization including by the board of directors. The dashboard provides an easily accessed visual representation of organizational performance. Opportunities for improvement are easily recognized and actions taken. Furthermore, enhanced analysis of measures includes area specific breakdowns by location and program. In-depth analysis of specific measures is conducted by local experts and provided to area and department leadership in brief reports. Visual, graphic performance data is augmented by brief interpretation descriptions of the data to assist the more visually inclined as well as textually inclined observers. The organization is commended for the dashboard itself as well as for its efforts to make the data and findings real and usable by a variety of staff and leaders.

A patient centred approach is used to assist the organization in identifying areas in which to focus quality improvement efforts and resources. For instance, the use of patient journey mapping has assisted in identifying service improvements for mental health clients. In another example, trained patients and volunteers are being used as part of a new hand hygiene initiative. Trained volunteers educate patients on the use of a scorecard to collect observations and comments regarding hand hygiene, which are then displayed on the unit. The team is commended for this innovative approach which has proven successful in pilot testing and is now being spread to other areas.

The organization is moving toward more integrated models of community health with closer integration of primary care, community care and public health. The Oceanside Health Centre is a pilot project for the island and province. The organization is undergoing care delivery model rRedesign, which has been fully implemented at some sites. Staff express a desire for enhanced support during transition to the new model.

Client safety is promoted through a number of mechanisms including safety huddles, bedside white boards, newsletters, and a number of safety related campaigns, including hand hygiene, influenza immunization, and the 6/48 campaign which promotes assessment of each client in six key areas and the development of care plans within 48 hours. Orientation for new employees includes client safety training and participation is audited.

A comprehensive ethics strategy is in place which includes both research and clinical ethics consultation, education, and a tool to guide decision-making. In addition to the ethics framework is a code of conduct for all staff which is built on a foundation of the organization’s values and includes an amalgamation of policies and procedures anchored by a statement on social responsibility. All is augmented by an anonymous, third-party whistle blower service through risk management.

The communication team (including communication, information stewardship, access and privacy) is a newly configured multidisciplinary team. The team is highly focused and knowledgeable about the challenges they face in the complex stewardship of digital information. While the team is fairly new in its current configuration, it demonstrates a high degree of synergy and is very interactive. The team is to be commended for its major focus on health promotion and health literacy. The team is committed to face-to-face engagement across the entire region.

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 care transitions With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	· Home Care Services 6.8 · Medicine Services 7.6 · Critical Care 7.7 · Emergency Department 8.4 · Ambulatory Care Services 8.4 · Obstetrics Services 9.6
Patient Safety Goal Area: Medication Use	
Concentrated Electrolytes The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 12.9
Infusion Pumps Training Staff and service providers receive ongoing, effective training on infusion pumps.	· Medicine Services 4.4
Narcotics Safety The organization evaluates and limits the availability of narcotic (opioid) products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.	· Medication Management Standards 9.4
Patient Safety Goal Area: Infection Control	
Reprocessing The organization monitors its processes for reprocessing equipment, and makes improvements as appropriate.	· Infection Prevention and Control 12.22

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.	· Medicine Services 15.2 · Ambulatory Care Services 17.2
Patient Safety Goal Area: Risk Assessment	
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		
5.5	The organization regularly assesses the effectiveness of its communication strategy and uses this information to make improvements.	
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)

The organization has taken a values based approach to the development of the strategic plan with the organizational values used as the “foundation and moral compass.” Organizational values were previously determined using an interactive engagement process and a broad campaign, “Living Our Values,” was employed to solidify the values in organizational culture. There is evidence that the values of the organization are regularly referenced in discussions and used in decision-making processes.

The strategic plan was refreshed in 2011 using a broad engagement strategy. Directors and senior leaders visited communities and health care sites doing “walkabouts” over a period of approximately six weeks. This strategy was used again in 2012 for the Living Our Values campaign, and was broadened in 2013 to include engagement of the public and municipal leaders. A consensus building approach was employed at the executive level to distil findings from the broad consultation. Throughout the engagement process, particular attention was paid to engaging physicians, including the use of focus groups. Currently the organization is in the process of transitioning local medical advisory committees to a more interprofessional approach.

Internal and external stakeholders report a sense of optimistic enthusiasm for the more collaborative, consultative and interactive engagement and decision-making approach of the organization which has been evident recently. Board meetings are located in communities throughout the island and each meeting includes a public segment with question period. The board also uses the time for outreach to communities, organizations and municipal leaders. A comprehensive internal and external communications plan has been developed and implemented to improve stakeholder engagement. This is a result of board self-evaluation which identified internal and external relations as an area for improvement.

The organization has conducted an audit of its community relations activities and effectiveness and has established a community relations plan. This included relationship building with regional hospital districts and the formation of community partner networks to discuss determinants of health and means to impacting determinants of health. For example, community partners identified transportation as a barrier in some areas and the organization has responded with the establishment of a bus, which is now self-sustaining, to enhance access to services. Other initiative include strategies to address identified issues with youth housing and emergency housing.

The organization works in collaborative partnership with local health areas at the community level. Community assessments which capture population need, current and projected service utilization, and other measures form the foundation of the conversations.

The organization works in partnership with other BC health authorities. A partnership accord has been established with the recently formed First Nations Health Authority. The organization partners with the Provincial Services Health Authority (PHSA) on a number of initiatives including integrated structures to plan and monitor services through service level agreements, and active partnership on provincial emergency planning and leadership development.

Community and population needs assessments are developed by compiling a variety of vital statistics mixed with admission/discharge/transfer and utilization data. The community needs assessment forms the foundation for planning and for engagement of internal and external partners. Based on the organizational values, strategic themes and the government letter of expectations, programs develop three-year operational plans complete with monitoring mechanisms. Interactive dashboards are available displaying organizational performance indicators and patient safety reports. The organization is commended for its implementation of an interactive electronic dashboard of performance measures and indicators which is available and used at all levels of the organization including the board of directors. The dashboard provides an easily accessed visual representation of organizational performance. Opportunities for improvement are easily recognized and actions taken. Furthermore, enhanced analysis of measures including area specific breakdown by location and program, and in depth (deep-dive) analysis of specific measures is conducted by local experts and provided to area and department leadership in brief reports. Visual, graphic performance data is augmented by brief description of interpretation of the data to assist the more visually inclined as well as more textually inclined observers. The organization is commended for the dashboard itself as well as for its efforts to make the data and findings real and usable by a variety of staff and leaders.

The organization has employed a number of change management strategies and frequently uses the management forum as a mechanism for communicating and supporting organization wide change.
The organization is commended for its use of advanced analytics expertise for data interpretation and planning. The organization is also commended for its development of a human resources forecasting model which allows for simulation of various scenarios. The model has been built based on the foundation of previous learnings and experience, and was augmented by focus groups, key informants, and an expert panel. The team is commended for its use of advanced analytical expertise in the development and testing of the model.

3.1.2 Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The ten-member board of directors is supported by a board liaison officer and executive assistant. Members serve a fixed term to a six-year maximum. The skill-set, geographic location, culture and gender mix of the board is assessed regularly using a skills matrix. New potential members are attracted through advertising and a thorough selection process supported by the board resourcing agency and new members appointed by the Ministry of Health. Currently the board includes a First Nations member who is instrumental in guiding board discussions through "how we work across the differences." The board dedicated efforts to attracting a First Nations member and finds that such membership facilitates community connection and adds credibility to the work of the board. Currently the board is developing its relationship with the recently formed First Nations Health Authority.

New board members receive a thorough orientation guided by a checklist contained in the board manual. New board members are formally mentored by an experienced member and are educated regarding their fiduciary duties, and the roles and responsibilities of the board. Representation of the organization and island as a whole rather than specific jurisdictions is assessed during the selection process and addressed as part of the orientation.

The board manual is a comprehensive document that includes terms for the board and various board positions. The board manual also contains a declaration through which board members identify, acknowledge and sign any conflicts as well as the director responsibilities. A transition committee was established to facilitate continuity when changing to a new board chair.

A professional development policy is in place for board members and a variety of educational opportunities are available. Most recently, board members attended cultural sensitivity training.

The board has adopted an ethical framework which guides decision-making. The framework includes a decision-making tool which has been used to guide difficult decisions including the location of a single hospital midway between two communities. Conflict of interest policies and practices are in place. In addition, the board serves in an approving capacity regarding clinical research as part of the clinical research ethics review process.

The board has identified the implementation of the electronic health record (one patient, one record) as a strategic priority and, as such, reviews progress at each board meeting.

The board evaluates its own performance regularly including a formal annual review. There is evidence that opportunities for improvement are identified and action is taken. The board has adopted a 360 degree peer evaluation tool for evaluation of individual board member performance for use on a go-forward basis. Accomplishment of the stipulations of the Ministry of Health letter of expectations is monitored and also forms a component of the board’s self-evaluation.

The board played an active leadership role in the articulation of organizational values and purpose, and the development of strategic themes through to 2018 using a highly interactive process of internal and external

consultations. Internal and external stakeholders report a sense of optimistic enthusiasm to the more collaborative, consultative and interactive engagement and decision-making approach of the organization which has been evident recently.

The board deployed a thorough process using two external consultants and a partnership with the Minister of Health for the recruitment and selection of the chief executive officer (CEO). The board is also involved in the selection of key executive positions such as the senior medical officer. A succession plan is in place and the board oversees the talent management process of the organization. Financial support for the professional development of the CEO and executive leaders is available

The board demonstrates its accountability for organizational quality and safety, receives regular reports, and demonstrates action taken in areas identified as requiring improvement. Examples include the development of strategies to enhance workplace safety and reduce workplace violence, monitoring activities around falls prevention, and reducing the ratio of alternate level of care patients.

Interactive dashboards are available to the board displaying organizational performance indicators and patient safety reports. The board has identified a need to improve its recognition of the quality and safety improvement activities of staff and as such has begun to formally recognize areas receiving awards for their efforts.

Board meetings are located in communities throughout the island and each meeting includes a public segment with question period. The board also uses the time for outreach to communities, organizations and municipal leaders. A comprehensive internal and external communications plan has been developed and implemented to improve stakeholder engagement. This is a result of board self-evaluation which identified internal and external relations as an area for improvement.

The organization has conducted an audit of it community relations activity and effectiveness and has established a community relations plan. This includes relationship building with regional hospital districts and the formation of community partner networks to discuss determinants of health and means to impacting determinants of health. As an example, community partners identified transportation as a barrier in some areas and the organization has responded with the establishment of a bus, which is now self-sustaining, to enhance access to services. Other initiatives include strategies to address identified issues with youth housing and emergency housing.

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)

Sound budgeting and accounting practices are in place. The organization has experienced a diminishing rate of growth in budget allocation with a 2% increase anticipated in contrast to a 5-6% increase typical in previous years. Financial and business analyst resources are embedded into teams and functional areas. Advanced analytics are available

The annual budget cycle includes standardized mechanisms to assess pressures. A standard set of instructions and a toolkit are provided to all areas annually and include mechanisms to identify cost and risk profiles and articulate implications.

A program budget marginal analysis (PBMA) process is used to identify areas of savings and prioritize areas of reinvestment. Dependant on the fiscal climate of the year, reinvestment of resources may be done organization-wide or may be program-based. Resource allocation decisions are driven by the programs with support of financial services personnel.

The organization has mechanisms in place to identify areas of risk and pressure. Prioritization mechanisms are in place to assist in the allocation of resources to capital equipment and capital projects. An expert choice process is used which is validated and supported by weight-based criteria to rank order projects. A provincial assessment of capital infrastructure informs decisions on capital upgrades. A well-established process with timelines is in place to analyze budget variance for each period. This rigorous process includes analysis of workload and utilization data and includes assessment of risk and opportunity.

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 executive leadership of human capital functions has changed recently. Transactional human resources is more closely aligned with finance and resource management. Human capital strategies include streams for employees, physicians, and volunteers; long-term direction drives the organization toward closer alignment and integration of human capital practices for these three groups.

Human resources and finance are now working in a more integrated way. The numerous touch points or processes requiring handoffs between finance and human resources functions have been used to identify opportunities for improvement in the overall process and flow of information.

A learning and professional support framework has been adopted within the last several months in response to the organizational articulation of continuous learning as a strategic priority. This recognizes continuous learning as a foundational vehicle to achievement of other Island Health strategic priorities.

The organization delivers client safety training and education available to staff. While client safety training is an integral and mandatory component of the online orientation process for new staff and client safety knowledge is enhanced through the use of safety huddles and learning opportunities during daily work, some organizational leaders are challenged to articulate the client safety training and education in which they or their teams have participated. A learning management system (LMS) has been implemented which will assist in monitoring staff attendance at various client safety related training sessions.

Physician privileging and credentialing has been standardized and is centralized at three locations for the island (south, central and north). An initiative is underway to harmonize the process provincially.

Exit surveys are conducted regularly for all staff using a standardized tool. Strategies are in place to ensure that electronic and hardcopy exit surveys are provided at the time of departure, and employees are given the option of a face-to-face or telephone interview.

The organization is commended for its comprehensive workplace violence prevention and safer workplaces strategies. Policies address risk assessment, violence prevention, domestic violence, patient belongings and weapons, working alone, and transporting clients. Strategies have been implemented through information sessions in partnership with professional learning and development through the safety hub, using a provincial curriculum. To date, more than 6,000 staff have attended the mandatory education.

The organization is commended for its development of a human resources forecasting model which allows for simulation of various scenarios. The model has been built based on the foundation of previous learnings and experience, augmented by focus groups, key informants and an expert panel. The team is commended for its use of advanced analytical expertise in the development and testing of the model.

The organization is commended for its attention to volunteers. A volunteer management database is in place.

Consistent strategies and processes are in place for the recruitment, orientation and performance evaluation of volunteers. The mandatory orientation for all volunteers includes a number of instructional videos including dealing with aggressive behaviour. The general volunteer orientation is augmented by a workplace-specific orientation provided by the local management. An informative volunteer handbook is also in place. Performance feedback for volunteers is primarily provided in the area in which they complete their volunteer assignment; the organization is commended for its recent implementation of an annual 360 degree evaluation tool for volunteers. Currently, volunteers report incidents or adverse events through a paper-based system unique to volunteer services. The organization is encouraged to consider strategies to integrate incident reporting by volunteers into the data generated through staff adverse event reporting. The organization is also encouraged to continue its work toward development of a quality council for volunteers with a focus on risk management.

Client safety is promoted through a number of mechanisms including safety huddles, bedside white boards, newsletters and a number of safety related campaigns, including hand hygiene, influenza immunization, and the 6/48 campaign which promotes assessment of each client in six key areas and the development of care plans within 48 hours. Orientation for new employees includes client safety training and participation is audited.

A Gallup survey strategy is used regularly to assess staff worklife. Results are used to identify themes for improvement, and action plans are developed and implemented to address areas for improvement. Action plans include new publications and newsletters to improve internal communications and improved scheduling mechanisms. One item identified for improvement relates to providing timely performance feedback. Compliance with completion has been low and the organization is monitoring compliance rates as the performance development review deadline approaches. The organization is encouraged to develop and explicitly articulate action strategies and defined targets to both drive and sustain improvements in this area.

The organization is commended for its robust Aboriginal recruitment and retention strategy. An Aboriginal employment advisor is in place and a vision and strategy have been articulated.

The organization has worked in partnership with unions on early and safe return to work as a component of the disability management strategy. This has resulted in a 50% reduction in grievances related to disability management.

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 has in place a draft strategic quality plan for 2012 through 2015, which was driven by the World Class Quality by 2014 initiative. This comprehensive strategy document is built around a set of promises to patients.

The organization takes a comprehensive approach to quality which balances strategic, data-driven quality monitoring and identification of improvement initiatives with local level grassroots initiatives. The organization is commended for its implementation of an interactive electronic dashboard of performance measures and indicators which is available and used at all levels of the organization including the board of directors. The dashboard provides an easily accessed visual representation of organizational performance. Opportunities for improvement are easily recognized and actions taken. Furthermore, enhanced analysis of measures including area-specific breakdowns by location and program, and in-depth (deep dive) analysis of specific measures is conducted by local experts and provided to area and department leadership in brief reports. Visual, graphic performance data is augmented by brief description of interpretation of the data to assist the more visually inclined as well as more textually inclined observers. The organization is commended for the dashboard itself as well as for its efforts to make the data and findings real and usable by a variety of staff and leaders.

The organization has a number of tools available to facilitate quality improvement activity, and duality and safety consultants are available for support. The organization uses a number of Lean methodologies including PDSA cycles, rapid process improvement workshops (RPIW) and 5S as examples. More than 500 staff have been trained in Lean and the organization has attracted a number of new employees with black belts.

An adverse events incident reporting system, the Patient Safety Learning System (PSLS), is in place and its use is promoted. There is evidence that the system is well understood and regularly used to report events including no harm events. The organization is encouraged to provide clarity for staff of the difference between no-harm incidents and near misses, and is encouraged to consider strategies to promote enhanced reporting of near misses.

The team reports that incident reporting provides physicians with an opportunity to reflect on practices at the division or department level, though the pragmatic use of incident reporting data is inconsistent across departments and at the discretion of the division head or department head. The organization is encouraged to consider strategies to ensure all physicians are aware of the potential data available through adverse event reports and the subsequent potential for enhanced patient safety.

The organization has used a quality improvement approach to the implementation of policies and procedures relating to Required Organizational Practices, such as the policy on dangerous abbreviations.

There is good evidence that sentinel events are consistently reported and investigated in a timely manner and findings presented to the executive management team and board of directors regularly. There is also

evidence that sentinel event investigations are used to identify areas for improvement with action plans developed, implemented and monitored.

Policies and procedures are in place for disclosure to patients and/or families; disclosure is the organizational expectation and both training and support regarding disclosure are available to clinicians.

A risk management structure is in place and aligns closely with both the quality improvement and ethical decision-making functions of the organization.

A team is in place which effectively liaises with patients and clients to bring patient complaints to resolution.

A patient centred approach is used to assist the organization in identifying areas in which to focus quality improvement efforts and resources. For instance, the use of patient journey mapping has assisted in identifying service improvements for mental health clients. In another example, trained patients and volunteers are being used as part of a new hand hygiene initiative. Trained volunteers educate patients on the use of a scorecard to collect observations and comments regarding hand hygiene, which are then displayed on the unit. The team is commended for this innovative approach which has proven successful in pilot testing and is now being spread to other areas.

The organization has completed prospective analysis using FMEA regarding implementation of procedures for a new implantable device as identified by the heart health program.

The organization has recognized a need to better recognize the quality improvement efforts of staff and teams. Recently the board and senior executives have begun to publicly recognize employees receiving provincial or national awards and have begun to nominate individuals and teams for such awards. Island Health team members have been recognized in provincial quality forums and in management forums. The organization is encouraged to consider additional strategies to promote spread of quality improvement initiatives and recognized the successful quality improvement achievements of staff.

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)

A comprehensive ethics strategy is in place which includes both research and clinical ethics consultation, education and a tool to guide decision-making. In addition to the ethics framework, a code of conduct for all staff is built on a foundation of the organization's values and includes an amalgamation of policies and procedures anchored by a statement on social responsibility. These are augmented by an anonymous, third-party whistle blower service through risk management. The ethics service supports staff through a telephone helpline, email inbox, website and facilitated discussions based on unit or staff request.
Most staff were aware of the existence and supports from the ethics committee but many areas indicated it was not a support that was "top of mind " to use.
Encouragement is given to the organization to bring the ethics process to every day practice. Additional workshops and events would assist with understanding and awareness.

The ethics framework and support was rolled out to all staff as part of a campaign on "Living our Values – ETHICS everyday for everyone." Fourteen educational workshops have been held on request from various areas. Physicians participate in ethics training as part of their clinical teams, however report a barrier to attending training as it typically takes place during practice hours. The organization is encouraged to explore other opportunities to gain additional physician participation.

The organization has physicians with graduate level training in bioethics locally available as well as access to qualified ethicists through the BC ethics harmonization project, in which the organization participates.

The organization monitors and evaluates ethics services primarily through post-workshop questionnaires and anecdotal feedback following ethics consultations. The team is encouraged for consider a formal evaluation of ethics services with an aim towards identifying and understanding any areas for improvement.

Staff indicate that ethics tools and resource information should be more visible on the units and in patient areas to increase everyone's awareness, both staff and public.

Several examples of ethical dilemmas were discussed with staff to understand the function of the ethics process. Many staff feel comfortable working to resolve issues within their respective teams and units but are aware of and indicated they would feel comfortable connecting with the ethics team if they couldn't reach resolution on their own.
The newly introduced structured team reporting process on the inpatient units might be an opportunity for periodic attendance by ethics committee members to glean insight into day-to-day clinical needs as well as to increase visibility and awareness of the ethics support.

A comprehensive research ethics review process is in place. Education, guidance and support is provided to new researchers and students as to the process and to appropriately identifying research versus quality improvement versus program evaluation. Two streams of research ethics review are available, one for clinical research such as clinical trials and another for health research such as creating a registry of data or conducting clinical file reviews. In all cases, client consent forms include a research integrity strategy process for expressing participant complaints or concerns.

The research ethics review process is guided by legislation and developed in partnership with other organizations such as other BC health authorities and the University of Victoria in order to reduce the need for research projects to require multiple reviews. Teams that have used the ethics research process indicate it is both comprehensive and accessible.

There is evidence that the research ethics review process is regularly reviewed and quality improvement initiatives have been implemented to address opportunities for improvement.

3.1.7 Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Telehealth Services		
11.4	The team's research activities for medicine services meet applicable research and ethics protocols and standards.	!

Surveyor comments on the priority process(es)

The senior leadership team (SLT) at Island Health is to be commended for the extensive consultation strategies used to inform the development of values, the strategic plan and the communications plan. Leaders consulted stakeholders, internal and external, across the entire region in some cases over a two-year period. The SLT might consider a more formal link to the communication team as the link was not evident during the team discussion.

The communication team (including communication, information stewardship, access and privacy) is a newly configured multidisciplinary team. The team is highly focused and knowledgeable about the challenges they face in the complex stewardship of digital information. While the team is fairly new in its current configuration, it demonstrates a high degree of synergy and is very interactive.
The team is to be commended for its major focus on health promotion and health literacy. The team is committed to face-to-face engagement across the entire region.

The team is encouraged to complete the review of its retention policy for both corporate and clinical records.

The team is to be commended for the plan to link credential information to the telehealth service. Physicians will be privileged to take part in the telehealth service. This is a very important initiative given the extensive use of the telehealth system throughout the region.

The team is to be commended for the development of an Island Health information steward toolkit. The toolkit is a very comprehensive document that is a very complete summary of information stewardship in its broadest sense. It is a very good quick reference for all staff throughout the region. The digital document contains links to all supporting documentation should more in-depth information be required and is an excellent reference.

The team is encouraged to work with their public health and community health teams to investigate the use of social media and texting to reach high-risk populations.

3.1.8 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Tours in both RJH in Victoria and Cairsmore Place in Duncan verify applicable laws and codes are followed related to building safety such as fire doors, sprinklers, accessible egress, staff awareness of safety procedures, and redundancy support for power outage.

RJH has built in redundancy systems for power failure with two generators.
These generators are tested weekly and each one is able to maintain all power.
Data closets are locked and the servers are backed up daily.

There is a culture of safety at Oceanside Health Centre. The building is new and client/staff safety was considered in the design and build. For example, clinical areas can be viewed broadly in the building, and flooring is anti-slip with no shine/gloss to flooring. Other examples of safety snow removal, ice safety to ensure parking lot safety, mats outside and inside to prevent slips/falls, responsive housekeeping to spills, an alarm system in clinical areas, Vigil pendants, hand-wash stations located throughout the building, and closed circuit TV.

Hoarding was noted in areas where there were renovations occurring. The organization was able to produce analysis of risk to areas that was completed before the renovations started to ensure risk is mitigated.

The leadership team partners with the municipalities from various communities within the island to support clean drinking water, power and communication systems as required to meet the patient needs during a loss of service.
Excellent generators and redundancy systems are in place.
The leaders are concerned with the age of the boilers at RJH but they are currently working well. Preventive maintenance is completed on them regularly

3.1.9 Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Island Health has an Emergency Management Team (EMT) including authority staff and membership from Health Emergency Management BC (HEM BC). This is a relatively small but nonetheless a very high functioning team. There are several levels of planning in BC; health authorities and HEM BC coordinate a provincial response where necessary. The EMT coordinates all planning for the region including facilities and unit planning.

There are five emergency operations centres (EOCs) developed across the island with RJH as the designated regional site. The building is designed to withstand a level 8.0 earthquake and has surge capacity to management 1,000 patients in the event of an emergency. The EOC is extremely well-equipped with primary and secondary communications equipment available in the event of primary equipment failure. Roles are well defined and documentation is exceptional.

The team is to be commended for its work with the amateur radio network in BC and the western USA. This demonstrates exceptional thinking and prudent preparation in the event of an island-wide event. The team is also piloting sending email through the amateur radio system; it is encouraged to continue this work.

Staff have been trained across the region using a train the trainer model. There is an e-learning module available for code training. In the last year, 6,300 staff have received fire training. The team conducts alarmed fire drills and silent drills on a regular basis.

The EMT has identified patient evacuation as a deficiency in their disaster readiness preparation and plans are underway to investigate ways to conduct an evacuation. The EMT has identified dependence on technology as a major concern in the event of a disaster. On March 7, 2014, a code grey was called as the result of the following incident. Network services were interrupted for a period of eight minutes; however, there was an issue during the recovery process where all calls were routed to switchboard as five-digit dialling was not functional. There is discrepancy on the length of time that clinical areas experienced a disruption – estimates range from 30 to 60 minutes. The team conducted a comprehensive after-action debriefing and review. As result of the review, the team has developed an extensive lessons learned action plan and is encouraged to move forward with implementation. The team also plans to review technology dependence and look at opportunities to reduce dependence where possible.

The EMT plans on doing a risk assessment of all facilities and will focus on those facilities of highest risk. It was noted during the discussion that two facilities did not have a fire suppression system. The team is encouraged to review those facilities and mitigate risk as much as possible.

Non-clinical staff is largely contracted staff and their contracts require compliance with the pandemic plan, however there are no performance penalties for non-compliance. It is the responsibility of the unit managers to ensure compliance. The EMT may wish to ask the Shared Service Organization to consider non-compliance language in future contracts.

The region has access to a provincial mobile medical unit (PMMU) that is deployed once a year for educational purposes and can be deployed as needed. The PMMU is essentially a hospital on wheels and is an excellent educational tool.

The team participates in emergency preparedness fairs which are very useful in helping educate the public. They are also invited to First Nation communities to provide emergency preparedness education.

3.1.10 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The patient flow team is a diverse multidisciplinary team that is engaged, focused and knowledgeable about the challenges to improve patient flow. Island Health is facing the same challenges as many, if not all organizations across Canada. However, the response to this challenge is aggressive, thoughtful and encapsulated in a discussion paper entitled “The Road to 85%.” The flow team understands that the factors which affect flow are complex and diverse; consequently, the response must address these factors across the entire health continuum.

The team has proposed the following strategies to address flow. First, reduce admissions by providing responsive enhanced primary care. Second, reduce length of stay through a number of innovative initiatives including IHealth and care plans with specific physician data, readmission reviews, physician and executive discharge committee, primary care professional staff available seven days a week, create specialized areas of care for specific patient populations, and improvements in discharge. Third, reduce both alternate level of care patient numbers and their respective lengths of stay. The goal is to improve efficiency in the residential care sector and develop at residential care facilities a physician team of care. The team is encouraged to proceed with this complex project and study the pre- and post-metrics to gage success and make adjustments to the plan as maybe necessary

A number of specialty areas have reported very significant challenges with respect to patient flow. They would benefit from the creation of specialized areas of care. This underscores the utility in proceeding with a comprehensive response.

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: Reprocessing and Sterilization of Reusable Medical Devices		
2.5	The organization conducts baseline and annual competency evaluations of staff members involved in reprocessing and sterilization.	
4.2	When establishing or updating the team's infection prevention and control policies, the team works closely with the organization's IPAC staff, team, or committee.	

Surveyor comments on the priority process(es)

The leadership team for medical devices and reprocessing is fully engaged and knowledgeable about the medical standards and legislation concerning the management of medical equipment.
There is evidence of a strong preventive maintenance program with corresponding appropriate processes for prioritizing new equipment purchases, replacement of existing equipment and contingency purchasing for immediate replacement.

Tracking and tracing of inventory items is in place and there are plans to do this electronically in the future.
Some of the larger sites are responsible for the reprocessing from smaller sites; this consolidation is to be commended. Where this occurs, there are appropriate transport mechanisms in place and continued dialogue with the participants is ongoing.

All sites visited had good flow regarding separation of clean and contaminated areas; however,the endoscopy suite at NRGH has only a virtual separation. In addition, the doors to this area are always open for practical purposes.
At the NRGH site, liquid materials (suction bottle contents) from the OR are transported to the reprocessing area for disposal. There is a distinct probability of contamination and risk to workers as at times these materials are not well contained. It is recommended that efforts be made to discontinue this practice and look for an alternative solution, which was a recommendation in the 2011 accreditation report.

The actual reprocessing cycle is well documented and there is an ability to trace all steps via recorded information. Mechanization with automated timing devices has improved performance and made the area safer and more employee-friendly.

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: Child and Youth Populations

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

The child, youth and family health team demonstrates a strong commitment and passion for providing quality, seamless care and responsiveness to the disparate communities served by Island Health. The team is a partnership between the child, youth and family program, the child and youth mental health program, public health and Aboriginal liaisons with the First Nations Health Authority. The team also partners with external agencies providing support and health services within specific communities. There are strong linkages with the Ministry of Children and Family Development. VGH has a strong partnership with Jeneece Place which provides accommodation to families from island communities whose children require outpatient or inpatient care offered at VGH.

The team is in the process of engaging communities across Vancouver Island in developing a three-year service plan to guide their work for the foreseeable future. Community engagement includes bringing the relevant data (including community specific determinants of health information), community profiles and partners to the table to ensure that specific community needs can be identified and plans put in place to address those needs. A primary focus of the work with communities is to identify vulnerable segments of the population and then work with partners to provide “wrap around” services to the child and family.

Several innovative programs and services have been implemented with the support of the child, youth and family team. "Her Way Home" is funded by donations from the foundation. A partnership between public health, mental health and child and family programs is designed to support substance abusers through pregnancy, delivery and postpartum with the desired outcome keeping the newborn with its birth mother . "Returning Home" provides a coordination service for Aboriginal families with children with complex medical needs to transition them back to their home communities. It includes liaison, coordination and referrals to community and Island Health services through a supportive, culturally sensitive approach.

Other innovative models of care are in the planning phase such as completion of a business plan to create a collaborative maternity centre that would operate in a shared-care model with family physicians, midwives and obstetricians who would act in a consultant role. The target population for services through the centre would be the unattached pregnant woman through self-referral or community agency referral, the patient without a primary care physician who comes in through ED and delivers in labour and delivery, and the medically and/or socially at-risk woman. The centre would continue follow-up care six to eight weeks postpartum and then transition care to a permanent primary care provider. The vision is to have the centre open in late 2015 if approved.

Island Health members of the team work closely with Perinatal BC, an arm of the Provincial Health Services Authority, to develop and implement standards for perinatal care, and BC Transitioning On-track which supports youth moving through the health system as they age. The director of child, youth and family health identified that an enabler of this team is that strategic leadership for child, youth and family programming which is provided by one individual. A potential barrier is that operational ownership for services to the population is distributed between tertiary and community/rural leadership. However, the team is collaborative and committed which mitigates much of the risk.

3.2.2 Standards Set: Mental Health Populations

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 mental health and substance abuse teams continue to engage with community partners and those with lived experience in identifying needs and decision-making on the services offered. The ability to set region-wide goals, yet allow the communities to have input into the way the goals will be met in their areas is applauded.

The initial integration of mental health and substance abuse programs is noted. Teams have plans for further integration and cross education of the teams.

Cross-program community partner training and education on topics such as suicide risk assessment build capacity within the region and are seen as very positive. There is evidence of good relationships with the primary care sites. The addition of a physician to support the area of substance abuse across the region is an excellent addition to the portfolio.

It is noted that there has been great effort in identifying gaps and reallocating resources across the age continuum. Inpatient as well as outpatient services report that the reduction of acute beds have resulted in significant pressures on the system. Increased wait lists and wait times for inpatient services have resulted. Full to overcapacity situations have increased. Outpatient services feel stretched to provide services to those who would have previously been admitted. These concerns should be monitored and further action taken to address these concerns.

The continuing efforts to refine the information system to provide further data are supported.
The initial integration of mental health and substance abuse programs is noted in the programs surveyed. Teams have plans for further integration and cross education of the team.

3.2.3 Standards Set: Populations with Chronic Conditions

Unmet Criteria	High Priority Criteria
Priority Process: Chronic Disease Management	
6.1 The organization maintains a clinical information system and longitudinal client records.	
Surveyor comments on the priority process(es)	
Priority Process: Chronic Disease Management	

There is an integrated team of passionate staff and management delivering chronic disease care. The organization uses multiple modes to collect information about the services needs of the population. They use client satisfaction surveys, focus groups, NGOs and partner groups, the Patient Voice Group (HIV), and in the past have used needs assessments. Other sources include demographic trends/data, and incidence and prevalence data. At the director/executive level, there are yearly meetings to review the data. The blue matrix has been used by the provincial ministry to identify frequent and high cost users of the health system.

The team sets goals and objectives. Some of the specific goals include reducing CTAS 4/5 visits to the ED; reducing HgbA1C in individuals living with diabetes; improving the outcomes for individuals living with diabetes (decreasing the need for amputation by 85% and decreasing the need for eye surgery by 45%); and, bringing down systolic and diastolic blood pressures.

The organization uses the expanded chronic care model (ECCM) as a framework and self-management is one of the elements of that model. One of those elements is an emphasis on self-management. Examples include Living Well with COPD (seven week program) and chronic pain (mindfulness, stress management). Frontline staff were unable to articulate any of the elements of the ECCM. An area for improvement for the team would be to assist staff to bring life to these elements.

An area of strength for the team is the passion of the staff for the work they do. Staff are current in their research and they critically appraise the research. Twice in recent years they have challenged research that did not appear to match the outcomes they were seeing in their clients. For example, for HIV clients in the north end of the island, the team collected and presented data that challenged the findings of researchers who re-examined their research findings.

3.2.4 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

The public health services team covers the population health and wellness supports and services across the island. Each public health unit works with their respective community partners to understand community needs and priorities both for services and health promotion and prevention activities. Community partners feedback is generally positive and provides examples of collaborative planning and programming. They indicate that relationships are improving and look forward to more collaborative work in their communities.

The team indicates that previously they felt their programs were very structured and directed with little ability to adapt. Recent planning is involving an increased focus on community needs and flexibility to provide services in a different way. They feel the new administration is supportive of the population health approach and is striving to "walk the talk" about prevention and promotion.
The organization is encouraged to include public health in the more strategic planning to ensure they are strongly recognized as a vital part of the continuum.

One successful project involved the hard to reach population which included engagement from Island Health, the police and the municipality, in addition to other agencies. The team is hoping to use this model of collaborative work and planning moving forward with other joint programs.

There are also examples of health promotion activities and programs in place. The successful intersectoral work with education involving the healthy schools initiative is in multiple sites across the island. The pre- and post-natal risk screens used in public health are all validated provincial tools. Under the "Right from the Start" umbrella there are several interventions designed to target populations at risk. The "nurse family partnership" is a researched intervention looking at the effectiveness of intensive home visiting.

The public health team expressed some concern about the new BC core programs requirement and felt it impacted their capacity abilities both for core programs and other community program needs identified. The organization is encouraged to review program delivery in relation to this core document and identify priorities for public health to ensure capacity for effective program delivery is maintained with a continued focus on prevention and promotion in addition to the required core programs.

There are increased legislated requirements around inspections of a variety of facilities such as residential care, day care, restaurants and tattoo parlours, with some public reporting required. As the number of inspections increases, capacity may be an issue. The organization is encouraged to monitor utilization and staffing requirements to maintain this expanding service and retain the key focus of prevention promotion

The program has well-documented processes and examples in managing communicable disease incidents.

There is a close working relationship with the BC Centre for Disease Control and the Capital Regional District labs provide timely access for lab support. Effective communication strategies are in place to alert facilities and/or the public in the event of an outbreak.

Programs and services are monitored and outcomes are used to monitor effective of programming. The triple AIM methodology is used to monitor outcomes including impacts in other programs such as decreased ED visits and decreased admissions based on public health programs and interventions.

Immunizations are delivered in a variety of ways and the program is flexible in terms of delivery, based on individual community needs. Evening, weekends and alternate location clinics ensure immunization rates are high. Staff are to be commended on developing an internal award for highest immunization rates. This creative approach keeps the focus on the delivery of service while also recognizing staff for good work done.

Sexually transmitted infections and communicable diseases are followed by three dedicated hubs of nursing supports. This ensures focused follow-up and tracings are managed in conjunction with the primary care physician. Youth clinics and targeted education are offered to support this population.

The organization is to be commended in supporting additional linkages between public health and acute care. Joint participation in infant mortality clinics and public health nurses rounding in acute care provides more comprehensive care and support to patients and families. Encouragement is given to continue to explore further linkages across the continuum.

3.2.5 Standards Set: Senior Populations

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

The organization is committed to seniors' health and wellness with a focus on the determinants of health. The organization has developed a seniors service excellence strategy. The organization has supported a strong interdisciplinary team committed to excellence in seniors' care and programs. Innovative programs and services are developed that seek to promote the participation of seniors and caregivers. This innovation has extended to reducing geographical barriers through providing funding for a bus to enable transportation. Additionally, the use of telehealth and home health monitoring for heart failure have reduced the burden of travel for seniors.

The organization works with a wide array of partners to further the reach of their programs and services. Healthy public policy for the senior population is evident including advocating for senior-friendly facilities with the implementation of the building design guidelines. The input of seniors and caregivers is valued including participation on health networks, patient voices network, and client advisory committees. The organization has promoted intergenerational programs such as "Trust Us." There is a strong commitment to providing education for staff, seniors and caregivers. A variety of forums are used to provide education and events are well attended. The organization has received recognition for their use of least restraints processes and the development of a video on delirium. "Understanding and Managing Loss and Grief," a workbook for dementia caregivers, has been developed.

The organization is committed to evidence-informed practice and is encouraged to continue to seek opportunities to share the results of their work through conferences and publication. The organization is to be commended for their work with senior populations and commitment to a population health approach. They are encouraged to continue to plan to meet the needs of the senior population which is anticipated to increase.

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:

Primary Care Clinical Encounter

- Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services

Clinical Leadership - Primary Care

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

Competency - Primary Care

- Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Infection Prevention and Control - Primary Care

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

Impact on Outcomes - Primary Care

- The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Decision Support - Primary Care

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

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

3.3.1 Standards Set: Ambulatory 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			
8.4		With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at ambulatory care visits where the client is at risk of potential adverse drug events*. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and the how often medication reconciliation is repeated. *Ambulatory care clients are at risk of potential adverse drug events when their care is highly dependent on medication management OR the medications typically used are known to be associated with potential adverse drug events (based on available literature and internal data).	ROP
	8.4.2	For ambulatory care visits where medication reconciliation is required, the organization identifies and documents how frequently medication reconciliation should occur.	**MAJOR**
	8.4.3	During or prior to the initial ambulatory care visit, the team generates and documents the Best Possible Medication History (BPMH), with the involvement of the client, family, caregiver (as appropriate).	**MAJOR**

	8.4.4	During or prior to subsequent ambulatory care visits, the team compares the Best Possible Medication History (BPMH) with the current medication list and identifies and documents any medication discrepancies. This is done as per the frequency documented by the organizational.	**MAJOR**
	8.4.6	When medication discrepancies are resolved, the team updates the current medication list and retains it in the client record.	**MAJOR**
11.7		The team records, stores, handles, and disposes of medication samples and experimental medications in the same manner as any other medications.	!
Priority Process: Decision Support			
14.4		Staff and service providers have timely access to the client record.	
Priority Process: Impact on Outcomes			
5.4		The team has a process for identifying and reducing risks to team members while delivering ambulatory care services.	!
17.1		The team is trained to identify, reduce, and manage risks to client and staff safety.	!
17.2		The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
	17.2.1	The team implements a falls prevention strategy.	**MAJOR**
	17.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
	17.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
19.3		The team compares its results with other similar interventions, programs, or organizations.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Ambulatory clinics and sites across the region provide a diverse range of services and supports to clients and families. Service planning and goals of each program are developed in alignment with the overarching vision and values of the organization and with a priority on more client-specific population needs.

Client and family satisfaction surveys are completed and the results are used to inform improvements where resources allow.
Ambulatory care programs are using the LEAN methodology in a number of areas to ensure opportunities like improved patient flow, access and wait times are addressed.

The pain clinic within ambulatory care has been growing since 2006. This Interdisciplinary team has developed a program involving a three-pronged approach including intervention, rehab and neuromodulation implants. This comprehensive approach best addresses client needs, and a strong and passionate interdisciplinary team is evident. Referrals and program linkages occur with palliative care, neurology, orthopedics and other programs requiring assistance for clients who need more extensive pain management support. Planning for service delivery in this program follows guidelines and best practices recognized internationally from the International Association for the Study of Pain.

The atrial fibrillation clinic at RJH began in 2009 and has been through a few model changes, where staff have looked at efficiencies. The schematic model is available. Indicators are set by Heart Health BC. The team regularly reviews indicators and looks for improvement opportunities, for example, efficiencies on intake. This is one of three atrial fibrillation clinics in BC. This program currently supports interior BC through a shared physician model.
The atrial fibrillation team is a nurse-led multi-team approach with a clinical pharmacist and a collaborative set up with Western cardiology (Island Health EP physician group). They work collaboratively with standard intake criterion, triage patients according to pre-set criteria, and arrange pre-physician work-ups and post-EP physician follow-up. The team uses a text approach in accessing EP physicians when required, which is an innovation achieved as a part of their LEAN strategies. They have access to the clinical parameters for the patient and use this information to develop the care plan with physicians.
Program outcomes such as wait times are benchmarked and monitored to ensure improvements are made. Client feedback is sought to ensure QI processes are targeted at what is important to clients. Program adjustments are made based on indicators to ensure improvements in care and service are achieved.

Priority Process: Competency

The ambulatory care team has a strong interdisciplinary approach with respect and collegiality which is evident throughout the program. It is evident that the team works collaboratively with a clear focus on client outcomes and has the client as part of the care team throughout the process.

The staff communicates regularly both face-to-face and through the single chart process within the RJH site. Complex client care rounds occur once a week for the team to discuss and plan appropriate interdisciplinary care plans.

Formal orientation occurs for new staff with a skills checklist to ensure appropriate training occurs. A buddy/mentoring approach is provided for new staff to ease their transition into a new team.
Infusion pump training is provided both scheduled and just-in-time for those care sites that use this support. Additional training and support is also available through monthly videolink rounds with St. Paul's and telehealth is used for additional training opportunities.

Staff training is well documented and monitored to ensure staff competency across the Ambulatory care locations.

Staff in the atrial fibrillation clinic at RJH have been encouraged to pursue nursing specialty training. They also participate in life-long learning and see continued learning as important. Certifications are achieved and the electronic learning management system is applied as applicable.

Priority Process: Episode of Care

Ambulatory care programs use client information and identified needs when planning specific programming.

Client and family feedback is gathered and reviewed to ensure the service offered most appropriately fits the specific clients within each service.

There is coordination across disciplines and other programs to ensure client needs are met. Assessments are done through a team approach in most areas, and information is gathered and shared through a mix of paper and electronic charting. The transition between paper charts and some electronic charting is underway with varying levels of implementation. The program is encouraged to ensure information is accurate, timely and available to providers despite this transition time. This may require more diligence on organization of paper charts and a communication process to ensure all information is available.

There are effective assessment tools that appear standardized. Each program has varying ability to prioritize patients based on acuity and urgency, but is done well in the more acute areas of ambulatory care.

Outcome indicators are used to monitor wait times, access and client satisfaction. The results are used to implement improvements within the service.
Medication reconciliation processes need to be formalized to ensure information is accurately shared across transition points of care. This is of critical importance when clients may be on multiple medications as in the pain clinic. Accurate documentation needs to occur at all points of transition to ensure safety and organized in a way on the charts that information is readily accessible and easy to find, based on chart organization.

The ambulatory care pain clinic provides an exceptional patient education and support program. This innovative program provides a full complement of education and social supports with activities for clients throughout the program. Clients have taken an active interest and personal ownership of the program with many clients presenting or leading sessions for the entire group. There is a variety of educational sessions complementing the physical and emotional support areas, many of which are lead by clients within the program. This innovative approach allows the clients to feel more in charge of their pain management and more confident. It is suggested that this program be considered for submission for a Leading Practice through Accreditation Canada.

Priority Process: Decision Support

Ambulatory care areas have a blended system to charting. The organization is transitioning to electronic charting across the organization. This has resulted in a mixed system of power charts and paper charting for these areas.

Chart access is adequate in most ambulatory care areas but staff express concern about locating the paper chart at times due to multiple staff requiring access. Each program is encouraged to develop and use a process to ensure chart location is known and providers can readily access charts as need.

The organization is encouraged to follow a standardized charting arrangement through dividers or tabs to clearly delineate the various sections within each respective chart while the paper chart is being maintained. There are some concerns that paper charts in some areas are not organized making it very challenging to locate anything specific. This could potential be a risk situation if critical information was needed urgently.

Guidelines in ambulatory care areas follow specific best practice standards. LEAN methodology with staff engagement is used to ensure processes are efficient and well-functioning. Improvements in wait times, access and intake processes have gone through LEAN methodology to highlight and subsequently implement improvements. Research activities meet ethical standards and protocols.

Priority Process: Impact on Outcomes

The falls prevention strategy is in the early stages of implementation across the various areas. There are individual assessment done on a case-by-case basis. The program is encouraged to roll out the falls prevention strategy across ambulatory care and include evaluation as a key area. Although falls prevention is in the early stages of implementation, there is a focus on patient safety within these areas. Pamphlets and information are available to patients and visible on site.

Two identifiers are used consistently across ambulatory sites that were visited. There is a significant risk potential for patients and staff within the pain clinic. The location of this clinic presents challenges and a potential risk that need to be addressed. The team does have expert staff that would be able to manage a code if there is no code team available through Island Health. As well, any emergent incident would require a 911 call and an ambulance dispatched to transport clients across the parking lot.
Staff have indicated at times they have wheeled a patient in a wheelchair across the parking lot themselves to access emergency services.
Oxygen and suction needs to be considered in areas where interventions are occurring to ensure patient safety. Based on the physical structure of the clinic, call buttons are not available nor is access to an Island Health code team. This presents a potential risk situation particularly within the intervention area of the pain clinic. This needs prompt discussion and resolution to ensure client safety.

3.3.2 Standards Set: Community Health 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.	
4.7	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 teams welcome students and learners. The volunteers that work in the maternal infant child team are seen as invaluable to the smooth running of the vaccination clinic.

The teams are to be commended on the effective use of multiple community partners in solving complex cases and trying to help clients navigate socio-economic issues. The teams are commended for their holistic approach to health.

Priority Process: Competency

The maternal infant child team is well-trained in lactation and breastfeeding. Of note was the emphasis on motivational interviewing where all nurses have had level one and some have advanced training.

The Aboriginal health team incorporates skills in partnership and relationship building for all its members. This enables the trusting relationship between the health services and the First Nations population to be fostered to ensure services are accessible.
Due to the complexity of working with First Nations in federal, local and provincial services, clarity about roles and responsibilities are key in delivering services in a consistent manner from community to community.

Priority Process: Episode of Care

Three teams were reviewed under this standard - public health nursing at Coastal Health Unit (Courtenay), Family Place Parksville Health Unit and the Aboriginal Health Program at RJH. The surveyors were impressed with the overall compassionate and person-centred approach of the staff and volunteers. Programs have been designed with flexibility and focused on a harm reduction model.

Cultural safety education for Aboriginal health is available widely within the organization for all staff and the Aboriginal team encourages staff to take it. There is a spiritual room available in a convenient location at RJH which is used by all staff and clients as needed. This was built through a collaborative process with local artists and community input.

The team is commended on the recent decision to hold daily team huddles at Family Place.
The public health maternal child team instituted evening clinics which has allowed more fathers to participate

Surveyors commented that the teams took complaints seriously, followed-up and made improvements as required.

Priority Process: Decision Support

Public health staff do regular community education sessions and provide written material for members of the public.

Privacy and confidentiality is important to the teams and records of all clients are secure

Priority Process: Impact on Outcomes

The teams use population health data from a variety of sources to tailor their services to the general public and those at highest risk. Most of the programs offered are designed around provincial and health authority standards. The teams are encouraged to evaluate the effectiveness of the implementation of these programs and services at their local level to get input on service design and to provide regular feedback to the communities they serve.

The community health teams do quarterly chart audits on ROPs and this information is provided to the teams broken down by geography.

3.3.3 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	
8.5 The organization's hours of operation are flexible and address the needs of the individuals and families it serves.	
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 teams are responsive to the communities they serve. There have well-developed goals for service and community partnerships. The teams are cohesive and well-integrated at the sites. Leadership has well-developed orientation to the sites and provides appropriate ongoing education. Performance appraisals are up-to-date and are used as a discussion tool to outline personal goals for staff.

Priority Process: Competency

The community-based mental health programs have processes in place to review their programs on an ongoing basis. Best practice and evidence-based guidelines are reviewed and implemented as appropriate. It should be noted that the team members feel that they have the opportunity and encouragement to bring forward ideas or information regarding best practice to the team for discussion.

Priority Process: Episode of Care

Clients feel very welcomed and respected at the adult outpatient location. The staff support and open caring relationships with the clients are evident. One client commented that "this felt like coming home." Community-based mental health services clients at USTAT also report feeling well-respected in their interactions with their team. The adult outpatient program at the downtown location had some flexibility for programming. Intakes were accommodated seven days a week and evening programming is available once a week. There is review based on client feedback and the evening group is appreciated by clients unable to attend day sessions. USTAT has set hours of operation. Clients are made aware of available services in the region if an emergency arises. There are plans to review the hours of service in the future.

Team members along with clients, discuss transitioning and end of service planning. The expectation of the USTAT service is for approximately 8-10 sessions although this is noted to be a guideline as the needs of the client take precedence.

Priority Process: Decision Support

The community-based mental health programs uses evidence-based practice in all facilities. It is noted that certain specialty services such as dialectical behaviour therapy (DBT) are offered in the community setting. This program is well developed and is a best practice, evidence-based program.

The scope of services outlined for the urgent treatment program are well-defined. It has been noted that there has been a change in both the numbers and acuity of the referrals. The program is applauded for being proactive in developing proposals to address these issues.

Priority Process: Impact on Outcomes

The community-based mental health programs have training in safety programs and are involved in the joint occupational health and safety committees.

3.3.4 Standards Set: Critical Care

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.8	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.		
Priority Process: Episode of Care			
7.7	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	7.7.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	7.7.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	7.7.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
12.7	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			
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

Adult Intensive Care Unit (ICU):

There is a strong leadership team and good collaboration among the tertiary critical care units in Island Health. Leadership identified that collaboration and integration with community hospital ICUs could be improved to support improved standardization of policies, procedures and guidelines. Having said that, the clinical nurse educators in critical care across the organization have a solid network that they use to develop and review policies and procedures. The intensivist group also networks across Island Health. Critical care leadership also participates in the provincial critical care working group to develop standards and guidelines as well as to manage the provincial database that collects information for benchmarking and research in ICUs across the province.

The team has access to organization and provincial data to benchmark against and use for setting goals and objectives. Services and planning are aligned with the Island Health and the Ministry of Health. Based on needs of patients on-site and across the organization, the team has recently revised admission criteria to expand the types of patients that are to be admitted to the ICU to provide improved, appropriate care to a greater number of patients. The leadership team has identified that the number of critical care beds within Island Health is below national benchmarks and is in the process of developing an action plan to provide to senior Island Health leadership.

A sound surge capacity and over-capacity plan is in place that includes the use of the PACU. The plan was tested real-time during flu season this year. Protocols for managing transfers of critically ill patients across the organization to ensure right bed and right level of care are in place and effective.

The units have solid interdisciplinary teams that work collaboratively with the patient and families to provide quality patient care. They are a committed and engaged team who provide input into unit operations, plans and quality improvement projects.

Neonatal Intensive Care Unit (NICU):

The NICU operates within an interdisciplinary team model of care. The manager has joined the team in the past year and, in that short time frame, has effectively engaged the team to participate in unit planning and QI projects.

Leadership at the unit and program level is strong and works collaboratively with other NICUs in the organization. Given that the NICU at VGH is the only tertiary level unit in the organization, robust processes for transport of mom and baby are in place. The unit participates in daily provincial bed calls to support appropriate level of care for babies and moms across the province. A provincial transport team is used when transfer needs to occur between communities and health authorities.

The NICU is divided into three subunits for Level 3 and 2 care. The lowest level NICU is not adjacent to the other two units; this can be an issue when babies in that location deteriorate. Staff rotate through all units.

The NICU inputs data into a national neonate database and has ready access to information for benchmarking, planning and research initiatives.

Priority Process: Competency

Adult ICU:

The interdisciplinary team approach to care planning is robust in the unit. Pharmacy, social work, physiotherapy and dieticians participate in daily rounds with nursing and the intensivist. Allied health staff are dedicated to the unit however do not report to the unit's manager. Patients and families are invited to participate in rounds and are provided with clear communication regarding the plan of care. The unit has 24/7 in-house intensivist coverage. The ICU manager has responsibility for the ICUs at both VGH and RJH.

Staff receive comprehensive orientation and access to ongoing education over the year. Recent budget reductions have limited the extent to which continuing education can be offered. All RNs must have completed an ICU certification course or have previous experience in critical care in order to work within the unit. Staff work between VGH and RJH when required to cover staff shortages and are appropriately orientated to the sites when this occurs. Performance reviews have not been completed however the manager has a plan to correct this.

The team is encouraged to consider implementing strategies to support fuller integration of allied health staff into unit and program planning opportunities since those professionals do not report directly to the manager of the ICU.

Recent renovations have increased family and staff lounge space and have been well-received by families and the team.

NICU:

Care in the unit is provided by an interdisciplinary team that rounds daily in the unit. Neonatologists provide coverage in the Level 3 unit while a mix of pediatricians and neonatologists supports Level 2. Pediatricians provide evening and night medical coverage with neonatologist backup. The medical leadership in the unit is very engaged with the staff and quality improvement initiatives.
Unit staff are committed to providing high quality care and participate readily in quality improvement work. The clinical nurse educator networks with her colleagues across the organization in development of policies, procedures and guidelines.

Performance reviews have not been completed however the manager has put a plan in place to correct this and has completed 25% of the performance reviews for staff in the NICU.

Priority Process: Episode of Care

Adult ICU:

The VGH ICU provides tertiary trauma and neurology care within Island Health. As such, patients are transported from across the island for care. Transport protocols and processes are in place and work effectively.

The ICU does not provide outreach services to the site however the team is looking at the development of a "ramp-up" model for outreach. During the development, the team might consider using the ramp up outreach team to provide follow-up for ICU patients post-transfer to the inpatient units.

The majority of patients are admitted through the emergency department. Solid processes are in place for transition of care between the ED and the ICU. ICU staff will attend in the ED to support care of trauma patients as required. Transition processes upon transfer out to inpatient units are also well-developed and meet requirements.

Processes for DVT prophylaxis, pressure ulcer prevention, VAP, central line infections, delirium management and falls prevention are well-developed with “cheat sheets” available at every bedside to remind staff and patients daily. Required processes for pain and sedation are also established.

Medication Reconciliation is not in place in a formal process, however the unit pharmacist plays a role in reviewing PharmNet and other information sources to develop a BPMH. High-risk medications are clearly labelled and kept in a secure area within the medication area.

Patients and families interviewed were pleased with the care they received on the unit and felt they were participants in care planning.

NICU:

The NICU at VGH provides tertiary level care for the population served by Island Health. Transport protocols are sound and based on provincial standards. Admissions come from a variety of sources including in-house labour and delivery and other obstetrical units across the province. Transitions out include discharge home with parents or back to lower level NICUs in the parents' communities. The team provides comprehensive education to parents prior to discharge and encourages increasing levels of care by parent opportunities. A care by parent room is made available as appropriate in the final two to five days prior to baby discharge home. All babies are brought back for follow-up in the neonatal clinic.

Care planning occurs at least daily through a process of interdisciplinary rounds that include parents are available. Care plans are reviewed and updated during this process. Respiratory therapists play a significant role in the care team in the NICU.

Space constraints related to physician dictation areas have been resolved by provision of drop-down team space allocated for this purpose.
The NICU team offers outreach services to the labour and delivery and post-partum areas through a resuscitation team that includes an RN, RT and physician. There are several levels of call to this team that defines urgency and required team members.

The lowest level NICU unit is physically and electronically separated from the main NICU space resulting in some concerns expressed related to safety for patients when deterioration occurs. All staff rotates through all NICU areas therefore the risks are mitigated to a certain extent. Time to move from one unit to the other is less that one minute. All of the units are open-concept which makes management of babies who require isolation somewhat difficult. There is one isolation room available for the team to use.

Required protocols for VAP, CLI and pressure ulcer prevention are all in place and modified for the neonate population. DVT protocols are not required for this population.

As with medication reconciliation in the adult ICU, the NICU does not have a formal mechanism in place at this time.

Priority Process: Decision Support

Adult ICU:

The ICU is a closed unit with 24/7 in-house coverage by an intensivist.

Evidence-based guidelines are in use. Leadership and CNEs work closely with their counterparts at RJH and Nanaimo ICUs to develop standard policies, procedures and guidelines and these are shared with the ICUs in rural communities. The team also works with the provincial critical care working group to develop and implement provincial guidelines and policies. Consideration should be given that some policies have not been reviewed and updated for over three years; a plan should be developed to correct this.

The team participates in research activities and follows organization guidelines. Research and data are shared with the team. There is a program quality improvement committee that uses data and research to inform and evaluate improvement initiatives.

The team participates in daily bed calls when capacity is tight.

NICU:

The unit is managed by a team of neonatologists and pediatricians 24/7 with neonatologists available for consultation 24/7.

Evidence-based guidelines and policies are in place and standardized across the NICUs in the organization. The team works through the provincial neonatal network to enter data and use reports to benchmark and evaluate activities and compliance.

The team participates in daily provincial bed calls to support management of capacity within the organization and provincial NICUs. Charting is current and complete with daily updates to the care plan through the rounding process.

Priority Process: Impact on Outcomes

Adult ICU:

The care team has access to the equipment and supplies they require to do their work.

Safer Healthcare Now protocols for VAP, DVT prophylaxis and CLI are implemented fully.

The leadership team is committed to quality improvement and works with the frontline team to implement changes they identify as well as to work on organization and provincial initiatives. Provincial critical care databases allow the team to collect robust information to identify areas for improvement and then to evaluate the outcome of changes made. Results are shared through internal, organization and provincial working groups and networks.

NICU:

The care team has access to the equipment and supplies needed to carry out there work.
Safer Healthcare Now protocols, modified for the neonate population, are in place for VAP and CLI. The team is to be commended in having only one central line infection in the past year.

The team has access to data through the provincial neonatology network for benchmarking and trending to identify areas for quality improvement. The information is also used to evaluate implementation of initiatives. NICU CNEs across the organization meet regularly to review policies, processes and guidelines and to work collaboratively to implement changes and updates. The same is true of clinical nurse leaders and managers.

Priority Process: Organ and Tissue Donation

In the adult ICU and NICU
, the policies, processes and practices follow the required standards. The BC Transplant program has provided an organ donation coordinator on-site to assist the team in assessment of potential donor patients, communication with families and access to the provincial organ donation database. The coordinator manages all aspects of procurement and transport of donor organs to the organ transplant site. Organ transplant occurs at RJH however VGH is the site the cares for the adult donor prior organ retrieval.

3.3.5 Standards Set: Developmental Disabilities Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team has done extensive community consultations with both internal and external partners. The program is reviewed on a regular basis. The team works very well together and team members feel supported in their work. Clients also report feeling very well respected and informed. There are numerous examples where this team is involved successfully with their community. In response to the families and the identified needs, various educational activities and self-help groups are being offered

Priority Process: Competency

This team uses an interdisciplinary approach and has a variety of professional clinicians to provide clinical service. There is a matrix management approach to provide clinicians administrative as well as clinical support. The majority of clinical service is provided either in the home or day care setting and there is adequate storage space for needed equipment. This team supports a variety of student placements.

Priority Process: Episode of Care

The team has a well-developed assessment protocol which gathers information from families, as well as any involved community partners, with the appropriate consents. Families report that they feel very respected in the treatment process. They feel that they are provided with information and support in making informed decisions regarding their child's care. The team involves the ethics committee when they feel it is necessary.

Priority Process: Decision Support

The team shows leadership in pursuing best practices and shares this with its community partners and with the families of their clients. There are weekly case conferences to review clients and address any issues that have arisen.

Priority Process: Impact on Outcomes

The team is very well aware of risk management issues and takes appropriate steps to mitigate them. The team is very engaging with its clients and families and encourages feedback regarding the services received.

3.3.6 Standards Set: Emergency Department

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 are linked to benchmarking of bed availability in the Emergency Department, time to admission, client diversion to other facilities, and wait times.		
2.9	The team has the workspace needed to deliver effective services in the Emergency Department.		
Priority Process: Competency			
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			
6.11	The team sets, tracks, and benchmarks data related to waiting times for services and information, and the length of stay (LOS) in the Emergency Department.		
8.4	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	8.4.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	8.4.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	8.4.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
8.8	The team follows a process for staff and service providers to communicate and validate client diagnoses when there is discrepancy between the initial diagnosis and diagnostic imaging or laboratory results.		!
Priority Process: Decision Support			

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
14.5	The team shares benchmark and best practice information with its partners and other organizations.	
16.1	The team identifies and monitors process and outcome measures for its Emergency Department services.	!
16.3	The team compares its results with other similar interventions, programs, or organizations.	!
Priority Process: Organ and Tissue Donation		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency department (ED) corporate leadership structure and processes are a strength for Island Health overall. The emergency services and trauma care regional quality council appears to be a high functioning body across the island with great potential. As the council continues to evolve, the team is encouraged to strengthen the rural/community input and output. It was noted during the survey that there was less integration of overall strategic goals, objectives and outcome measures embedded into the local (rural/community) sites.

Aside from evidence-informed practice standards, the leaders have been working to transform the ED culture into a "welcoming environment" for patients.
The philosophy of visual leadership is also an important element of Island Health's quality journey.

At Campbell River Hospital, space limitations were highlighted during the survey visit. The team is providing excellent care despite their physical set-up. There are solid plans in place to construct a new facility. It will be important to fully engage staff in the next phases of design, to ensure their input into and support of the new design.

Priority Process: Competency

The care processes, although challenged by volume demand and flow, are safe and of high quality. The work by the ED and Island Health corporate leaders around flow is helping. Innovations around staff mix and composition, alternate physician extender roles and staff practices for interdisciplinary, coordinated rounds and huddles have been instrumental to ongoing improvement.

Strong leadership and vision is very evident and the teams are commended for their passion and successes and encouraged to continue to support staff to embed quality and safety into their day-to-day practices.

Training using the LMS system is highlighted by staff and leaders as a strength.

Although staff report that training for infusion pumps is in place, there was not consistent documentation available for review during the survey visit. The accreditation coordinator was able to produce the records of training prior to completion of the report. As the LMS system evolves, this ability will be important for documentation.

As well, finalizing and implementing a process to ensure consistent performance management is currently being developed. This will be important as a low rate of completed performance appraisals was noted at all sites.

Priority Process: Episode of Care

The ED corporate leaders and clinical teams have been working through areas of patient access, intake, quality/safety and customer service with success. The use of data to drive improvement is evident in the urban sites, less so in the rural/community sites. Leaders express a "cautious optimism" regarding organizational flow momentum.

NRGH received a 2014 WEDOC award for patient flow for success with throughput and output.

The clinical care and patient experience were noted to be positive in all locations.

One of the areas impacting flow from the urban EDs is the lack of intermediate care beds. This may be an area to investigate to further improve flow.

Medication reconciliation is in various stages of implementation across the EDs and has been highlighted by the organization as an area of focus for the coming year as IHealth is fully implemented.

In relation to validating client diagnosis, at Campbell River Hospital, there is a solid process in place for diagnostics but not for laboratory results.There can be a delay in reviewing laboratory results if the physician who saw the patient in the ED is away.

Priority Process: Decision Support

The use of data to drive evidence informed care and processes is obvious in dialogue with corporate ED leads and in the urban sites. There was less integration noted in the rural/community departments and is likely an area the regional emergency services and trauma care regional quality committee can work to improve in the future.

Another area of strength is the work around emergency preparedness. The urban sites have held regular tabletop and disaster exercises and trained staff in disaster kits. Including rural/community sites in the preparation and exercises is an area that is encouraged in the coming cycle.

Priority Process: Impact on Outcomes

An area of strength for the EDs is the focus on preventing and managing violence. All staff receive training and express comfort implementing the training concepts into their day-to-day practice. This proactive approach enables less of a presence of security services in the departments. There has also been a mandatory training program entitled "Strangers in Crisis" which further supports the overall environment of welcoming and respect for patients and families.

All departments proactively manage patient experience and satisfaction, and expedite investigation into concerns and adverse events. Leaders respond to concerns in 48 hours or less and are focused on positive resolution for patients and learning for clinician teams.

The FirstNet system is instrumental in monitoring care segments as patients progress through the ED as well as provide data around admission rates, return rates, tests and procedures ordered.

An area the team has highlighted for future work is discharge processes when patients are sent home from the ED. The survey team supports this activity.

Also the rural/community sites are not monitoring, sharing or benchmarking measures, outcomes and results. This likely is an area the regional quality and safety council can address.

Priority Process: Organ and Tissue Donation

Emergency department clinical teams meet standards around organ and tissue donation. They have a strong collaborative relationship with BC Transplant and have been working to provide education to clinicians. They have appropriate processes and policies for clinical referral, approaching families, neurological determination of death and coordination with the organ procurement organization.

3.3.7 Standards Set: Home Care Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
14.3	The organization's guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.		
Priority Process: Competency			
4.10	The organization regularly evaluates and documents each staff member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
6.8	When medication management is a component of care (or deemed appropriate through clinician assessment), and with the involvement of the client, family, or caregiver (as appropriate), the organization generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications.		ROP
	6.8.3	The organization works with the client to resolve medication discrepancies OR communicates medication discrepancies to the client's most responsible prescriber and documents actions taken to resolve medication discrepancies.	**MAJOR**
	6.8.4	When medication discrepancies are resolved, the organization updates the current medication list and provides this to the client or family (or primary care provider, as appropriate) along with clear information about the changes.	**MINOR**
7.6	The organization facilitates access to emotional support and counselling for clients and families.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
10.8	The organization documents any incidents involving medications, and uses this information to improve its medication services.		!
Surveyor comments on the priority process(es)			
Priority Process: Clinical Leadership			
Home care services provide the centralized intake hub for beds throughout the system including day programs, residential options, self-care management programs and intensive home care programs. There is			

daily collaboration and communication between home care and acute care facilitated by a liaison nurse within each acute care facility. There is a HCC work plan for 2013/14 which encompasses the values of the organization (C.A.R.E.), the Island Health goals and objectives, the CHS WIGs, the HCC service model redesign and sustainability/quality and safety. This is in a pyramid that is posted in work areas across the organization.

Service planning is done with a clear focus on meeting the needs of clients. The staff meet regularly as a team providing joint planning for care. Home care provides central intake services and does not have the ability to turn clients away needing services. This model of care and service for all is to be commended; however, the organization is encouraged to monitor resources in order to ensure delivery of care. The team uses RAI-HC (home care version). From this tool. the team can run reports on attributes such as pain rating, depression and cognitive issues in order to understand characteristics.

The team leader and manager support interdisciplinary daily huddles at the beginning of every day to review travel plans, patients being seen and specific issues to be addressed.

The organization is to be commended for implementing innovative programs to better meet the high needs of clients remaining at home. The Home First program and the quick response team are innovations that better support clients in their own homes, thereby deferring residential or acute care admissions. There is recognition that these specialized programs are only available in the major city and encouragement is given to explore expanding this service elsewhere.

The organization uses contracted services through both affiliate organizations and for home support workers. There is a formal RFP process in place. Rigor and expectations around quality and care are required and align with Island Health standards. Regular indicators are monitored regarding access, wait times, occupancy and placement, and internal adjustments are made where possible.

The organization is encouraged to monitor home care resources to ensure adequate funding and flexibility is provided, ensuring client care is maintained with the growing seniors population and the preference of care at home. The new redesign model within home care services should provide enhanced and more efficient service to clients through an interdisciplinary approach. The organization is encouraged to continue to involve staff and clients in the planning and implementation strategy to ensure buy-in and support.

Priority Process: Competency

Staff work within an interdisciplinary approach and are moving to a single client care plan. This new initiative is to be commended and will provide clients with more coordinated and efficient care.
The organization is encouraged to provide additional education on the team approach to care and ensure staff voices are heard as the new model is further implemented.
Co-location where possible will further facilitate the team development particularly if staff are involved in the planning and design. The organization is encouraged to support staff involvement.

Staff receive both scheduled and just-in-time training for infusion pumps. This is recorded and monitored to ensure skills are maintained.

The organization is encouraged to develop a formalized approach to ensuring performance appraisals are completed for all staff on a regular basis. There is recognition of the benefit of these and the target is to have individual appraisals every two years. Encouragement is given to monitor the completion rates and ensure this issue is appropriately managed.

Priority Process: Episode of Care

The recent redesign provides the opportunity for staff to begin to think, plan and work in teams to provide care. This redesign work is in the early stages of implementation and examples of single discipline approach still are evident. The organization is encouraged to continue this team approach to care, ensuring all providers receive training and support to participate in this new model of care. This process should ensure physicians are also involved as training and educational support to team delivery occurs.

The home care programs visited have one single client chart with daily huddles and weekly conferences for more complex clients. This interdisciplinary approach ensures joint planning for the most effective program delivery.
Innovative programs such as Home First and the quick response teams are available in larger centres.

A medication reconciliation plan is in place for the organization and will be functional when IHealth is also in place. Currently home care does a BPMH with periodic medication reconciliation. This practice needs to be consistently done, and medication errors and adjustments need to be accurately documented and communicated to providers and clients as needed.

Clients and families indicate they feel a part of the planning process for care throughout the duration and opinions and wishes are respected. Every effort is made with the family and client involved to provide the type and location of care best suited for the client and in keeping with his/her wishes.
Falls prevention assessments are in place throughout home care and regular reassessment occurs based on client changing needs. Families are well informed as to their role in supporting the client safety initiatives.
Home care routinely uses two client identifiers.

Priority Process: Decision Support

Best practice initiatives and guidelines are considered and implemented where appropriate. The Home First program and the rapid response team are examples of innovative initiatives that follow evidence-based and best practice guidelines.

Priority Process: Impact on Outcomes

Home care indicator development and the quality plan are well done with key indicators measured and monitored. Occupancy, wait times and a variety of clinical quality indicators provide a quality picture of the service. Targets and benchmarks are set, and monitoring and readjustment of service occurs to best achieve targets.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Staff and leaders are passionate about providing quality and safe care to clients and their families. The team is strong and cohesive. They value the contributions of all team members including volunteers who are an integral part of the team. The palliative care unit is viewed as a place that staff want to come to work. A staff member commented, "It is a privilege to work here." Events such as "Wellness Days" are held to support and acknowledge staff.

The team partners with a wide array of organizations including the Victoria Hospice Society and the Nanaimo Community Hospice Society. An example is the partnership with the Eye Bank of BC. The team received recognition from the Eye Bank of BC for their appreciation for their work with the gift of sight through the eye donor program. There is an array of services to meet the needs of clients and their families. This includes the palliative ambulatory care team and the palliative response team.

Priority Process: Competency

The interdisciplinary rounds strengthen the coordination of care across the continuum. Community-based staff attend the interdisciplinary rounds and provide information on the needs of clients who may require the services of the palliative care unit and end-of-life program. There is a psychosocial and spiritual component of the interdisciplinary rounds. Team members speak highly of the value of the interdisciplinary rounds. There is a strong commitment to the orientation and training needs of staff, leaders and volunteers. This includes mentorship and a buddy system. The leaders are encouraged to continue to monitor staff and leader performance to acknowledge their work and performance.

Priority Process: Episode of Care

The palliative care unit at NRGH is welcoming, bright and provides a supportive environment for clients and their families. Clients and their families express satisfaction with the environment of the unit and the quality of the care provided. They view the staff as "exceptional." The team uses "My Story," a biography to personalize care. The palliative care unit at the NRGH was redesigned in 2008 with an emphasis on client safety. Ceiling track lifts are in place. The family areas are welcoming and provide space for family interaction but also quiet space. The centre courtyard is used by clients and families. The commitment of volunteers is commendable. They enhance the services provided to clients and their families and are welcomed by the team. They receive an extensive orientation. Appropriate assessments are completed on clients using standardized measures. The team provides support for clients and families. This extends to support for the team. There is a comprehensive care plan for clients which is updated and re-assessed at regular intervals. The team is strongly committed to pressure ulcer care and proud of the results they achieve.

Priority Process: Decision Support

There is a strong, coordinated approach to care across the service providers. The organization is encouraged to continue with the IHealth strategy. The team is excited regarding the implementation of this strategy and the opportunities for information management. Education and training opportunities are available for the team. The organization is encouraged to continue to support staff education and training.

Priority Process: Impact on Outcomes

The staff and leaders are committed to client safety. This includes implementation of a fall prevention program and educational material that they provide to families. The leaders are committed to staff safety. Education on violence prevention, purple alerts, code whites and alarm buttons are all processes used by the team. The team felt supported by the assistance of security when needed. The leaders are encouraged to continue with the violence prevention initiatives.

The leaders and staff are to be commended for their commitment to providing the highest quality of care for the clients and their families. They truly live the vision and values of Island Health.

3.3.9 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.		!
12.22	The organization monitors its processes for reprocessing equipment, and makes improvements as appropriate.		ROP
	12.22.1	There is evidence that reprocessing processes and systems are effective.	**MAJOR**
Surveyor comments on the priority process(es)			
Priority Process: Infection Prevention and Control			

Infection prevention and control (IPAC) is led by a director and medical director who provide the oversight and strategic management organization for the program. The corporate office is supported by an administrative assistant, epidemiologist, data consultant and two IPAC consultants. Site-specific coverage across Island Health is provided by 17 infection control practitioners (ICPs) who work under the direction of the two operational lead consultants for the south and north/central island. The ICPs carry out surveillance, education, consultation and policy development.

The IPAC team has adopted a progressive robust surveillance system which continues to evolve. There is an emphasis on syndromic surveillance leveraging clinical care electronic health record data in order to detect potential infections in real time. Epidemiologically significant organisms are selected and tracked on a continuous basis. The Centers for Disease Control and Prevention's National Healthcare Safety Network's definitions of infection are used.

Outbreak investigations are carried out with the interdisciplinary team and other relevant departments, with the support of the clinical laboratory and public health department. Recommendations are tracked until fully implemented. A final outbreak report is issued and reviewed with all concerned departments.

Surveillance reports include weekly updates which compare the number of cases to historical averages and are distributed as an email to senior management and the executive; monthly trend reports which are distributed to the IPAC team and quality and patient safety office; quarterly site reports which are sent to all Island Health sites; and, quarterly unit reports which include a graphical display at the unit level that can be posted for communication purposes.

Epidemiological data from internal surveillance and investigations along with community trends and emerging organisms are used to inform the surveillance plan. Surgical site infections are selected based on the morbidity and mortality associated with specific types of surgery and the degree of contamination at the beginning of surgery.

Outbreak investigations are carried out with the interdisciplinary team and other relevant departments with the support of the clinical laboratory and public health department. Recommendations are tracked until fully implemented. A final outbreak report is issued to and reviewed with all concerned departments.

IPAC leadership has a wide community of partners.
External partners include the Provincial Infection Control Network
, Canadian Nosocomial Infection Surveillance Program (CNISP), IPAC Canada
, BC Cancer
, BC Ambulance, the BC Centre for Disease Control, and the Ministry of Health. Other Island Health team partners include public health, heart health, the medical health officer, communicable disease nurses, tuberculosis control and Aboriginal liaison
. Currently the service is exploring the involvement of Aboriginal nursing students as a way of securing ICPs who desire to live in the north island.

The IPAC education program is comprehensive. Staff know their role in infection control. IPAC policies are readily available on the internet.

Hand hygiene is audited in Island Health acute care and long-term care facilities using an audit tool adapted from the Canadian Patient Safety Institute. Health care providers are observed by auditors to determine whether they used proper technique when they wash their hands or use an alcohol-based hand rub product. Those who complete the activity correctly, without wearing barriers such as rings and long sleeves, are considered to be compliant with Island Health guidelines.

3.3.10 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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization is committed to collecting information on the senior population. A family engagement initiative, "What We Heard," was completed in 2013. This information is used to inform programs and services. The team collaboratively works with many partners. Volunteers are an integral component of residential services. A resident/family council or family support group guide has been developed. Resident councils and family councils are supported. There is a strong team-based approach. The leaders are innovative and committed to the highest level of care. A seniors service excellence strategy, "Sharpening the Focus," is developed. The focus is on developing a centre of excellence, supporting caregivers and dementia care. The organization is encouraged to continue to implement this strategy.

Priority Process: Competency

A strong interdisciplinary team is supportive of the needs of clients. Staff and leaders are passionate about their work and seek opportunities to improve care. The team participates in huddles, staff meetings and interdisciplinary rounds. The orientation processes include both an organizational and program component. Staff state that the orientation process prepared them to work in residential services. There are educational opportunities for staff and leaders. The organization is encouraged to continue to provide educational opportunities for staff and leaders. The staff and leaders' performance is evaluated with a plan for ongoing review. Violence prevention is a priority for the team. There is evidence of violence prevention education including code white and purple alerts.

Priority Process: Episode of Care

The team is resident-centred and responsive to the needs of residents and families. The medication reconciliation process is well-established. Pressure ulcer prevention is a priority of residential services and is implemented. Resident care plans are developed and continually updated to reflect the changing care needs of the clients. Residents and their families speak highly of the care received. They identify the care provided as "excellent and exceptional" and responsive to the needs of residents. An array of activities are available to support residents. Families articulate that they feel comfortable in asking questions regarding residential services and are supported by the team. The organization is encouraged to continue to support residents and family members during the transition to residential services. This may include a physical tour of the facility.

Priority Process: Decision Support

The team works from a collaborative model and shares information as appropriate with other members of the care team, partners and service providers. The team is encouraged regarding the development of the IHealth strategy and the opportunities that it will bring to information management. The seniors service excellence strategy, "Sharpening the Focus," has a focus of a centre of excellence based on best practice and evidence-informed decision-making.

Priority Process: Impact on Outcomes

The team is resident focused and committed to safe and quality care. They have identify priorities to meet the needs of residents. Program changes are incorporated based on feedback and best practice information. There is a commitment to falls prevention. The team benchmarks quality indicators. Information is shared during rounds, staff meeting, huddles and in the newsletter, "Between the Lines." Staff participate in safety discussions and use this as an opportunity for improvement. The team monitors residents' perception of the quality of its services. Evaluation results are shared with family councils. The quality council plays an important role in sharing information with team members. The compliments board is an important way to acknowledge team contributions.

3.3.11 Standards Set: Medication Management Standards

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
1.3	The interdisciplinary committee regularly evaluates its roles and responsibilities and makes improvements as needed.		
3.3	The interdisciplinary committee regularly reviews and updates the formulary.		
8.1	The organization has a process for determining the type and level of alerts required by the pharmacy computer system which include, at minimum, alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.		!
9.4	The organization evaluates and limits the availability of narcotic (opioid) products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.		ROP
	9.4.2	The organization avoids stocking the following narcotic (opioid) products in client service areas: • Fentanyl: ampoules or vials with total dose greater than 100 mcg per container • HYDROmorphone: ampoules or vials with total dose greater than 2 mg • Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.	**MAJOR**
12.9	The organization evaluates and limits the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas.		ROP
	12.9.2	The organization avoids stocking the following concentrated electrolytes in client service areas: • Calcium (all salts): concentrations greater than or equal to 10% • Magnesium sulfate: concentrations greater than 20% • Potassium (all salts): concentrations greater than or equal to 2 mmol/mL (2 mEq/mL) • Sodium acetate and sodium phosphate: concentrations greater than or equal to 4 mmol/mL • Sodium chloride: concentrations greater than 0.9%.	**MAJOR**
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.		!
13.4	The organization stores anaesthetic gases and volatile liquid anesthetic agents in an area with adequate ventilation as per the manufacturer's instructions.		!

14.1	Prescribers write or electronically enter complete medication orders, reorders, or reassessments upon admission, end of service, or transfer to another level of care.	!
15.1	The pharmacist reviews prescription and medication orders within the organization prior to administration of the first dose.	!
17.4	Unit dose oral medications remain in the manufacturer's or pharmacy's packaging until they are administered.	!
18.2	The pharmacy team dispenses medications in unit dose packaging.	!
19.1	When the pharmacy is closed, the organization provides designated staff and service providers with controlled access to a night cabinet or automated dispensing cabinets for a limited selection of urgently required medications.	
21.5	Service providers provide clients with written information on whom clients can contact for questions about their medications and their availability at the end of service or transfer of service.	
24.2	Staff and service providers monitor and document in the client record the effects of medications on the client's treatment goals.	
26.2	The organization provides staff and service providers with information on how to detect and report adverse drug reactions to Health Canada Vigilance Program.	
27.4	The interdisciplinary committee regularly completes a comprehensive evaluation of its medication management system.	
27.5	The interdisciplinary committee monitors process and outcome indicators for medication management.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

Island Health has focused tremendous energy to develop a collaborative, interdisciplinary structure to oversee the medication management system within the region. Merging medication safety with quality creates an ideal profile for this responsibility and a visible message that quality is core to the safe use of medications and is an interdisciplinary responsibility. The formal relationship between Island Health pharmacy and therapeutics and medication safety and quality ensures focus on both therapeutics, and quality related to safe medication use and stewardship. Medication safety committees are now also an important resource within the residential care program, providing a forum for discussion amongst homes regarding safety issues and initiatives, and ultimately sharing amongst the region residential teams. A suggestion has been made to align these with the Island Health medication safety and quality council.

The structure of the interdisciplinary team for Island Health is inclusive but complex, with an aggressive scope of responsibility. With the structure now established, and some core activities well under way, the committee must turn some attention to establishing performance indicators to monitor, ensure effectiveness of the medication management system, and communicate progress out to the organization.

A component of medication management effectiveness is the prevention of drug therapy problems (DTPs). In a recent report reflecting the impact of pharmacist services at RJH, almost 20% of identified DTPs if left unresolved, had a likely or almost certain likelihood of causing major or catastrophic outcomes. This reflects an effective clinical pharmacist team, which has been strengthened by pharmacists being released from the pharmacy to be present in patient care areas, supporting clinical teams and patient care. This has been partially facilitating technicians to practice to their full scope.

Leadership of Island Health has strongly supported the allocation of resources and commitment to implement an antimicrobial stewardship program (ASP) co-led by leaders from quality and safety and medical microbiology. The strategy of development and implementation has been unique, and may well be a model for other therapeutic stewardship teams. Considerable advancement in establishing a "data warehouse" is already acknowledged, and early high level reports show encouraging results of continuously increasing resolution of drug related problems primarily involving dosing strategies and addressing unnecessary drug prescriptions. Extension of this result to economics, patient flow and overall stewardship is eagerly anticipated. This team is well aware of the importance of distributing the resources of the program to include localities that otherwise do not have this level of support.

Island Health has continued its efforts with high alert drug restrictions and safe administration strategies. There is clear evidence of the collaborative energy that has been spent on the removal of all medications deemed to be over the limit for ward stock which has been a bold and considerable project. Problem-solving to mitigate the loss of these agents has been creative, collaborative and effective, through providing CIVA-prepared standard concentrated electrolytes, an example of a positive shift in practice. The medication safety quality council is to be commended for the establishment of the "variance" application and approval process; this could be a leading practice.

Moving forward, it is suggested that a safety audit process be incorporated similar to that performed for dangerous abbreviations, including point of care staff (or delegates) to conduct peer review of practice and compliance.

The medication safety and quality council has an extremely aggressive vision for the future of medication management. The medication system for Island Health’s future is envisioned to be a closed loop model, showcased at Oceanside Health Centre. The system will include barcode unit dose characteristics, all enabled through a centralized production facility, automated dispensing cabinets, CIVP production through robotics, electronic health record and computerized physician order entry through IHealth. The team must recognize the importance of keeping staff informed through this project, and carefully consider current and future communication requirements.

The Patient Safety Learning System (PSLS) has a high profile amongst staff and appears to be well used. Medication safety committees and the medication safety and quality council use the information received from the system to learn and make system improvements routinely. Stronger communication lessons learned, and resulting recommendations for change to prevent future occurrence would be a valuable start to increase staff consciousness of the impact of system errors, and safe practices to prevent them, thus creating the expectation of the changes anticipated over the next few years.

3.3.12 Standards Set: Medicine 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 its medicine services are measurable and specific.		
Priority Process: Competency			
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.		
3.7	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
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**
4.8	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**
	7.4.4	The team identifies major orthopaedic surgery clients (hip and knee replacements, hip fracture surgery) who require post-discharge prophylaxis and has a mechanism in place to provide appropriate post-discharge prophylaxis to such clients.	**MAJOR**
	7.4.5	The team provides information to health professionals and clients about the risks of VTE and how to prevent it.	**MINOR**
7.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP

	7.6.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	7.6.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
	7.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
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

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

14.5	The team shares benchmark and best practice information with its partners and other organizations.		
15.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.		ROP
	15.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
	15.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
15.3	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.		!
17.1	The team identifies and monitors process and outcome measures for its medicine services.		
17.3	The team compares its results with other similar interventions, programs, or organizations.		
17.4	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.		
17.5	The team shares evaluation results with staff, clients, and families.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Medicine team members are extremely engaged and dedicated to their roles and responsibilities. It is evident that members of the multidisciplinary team are encouraged to develop and take on additional responsibilities as part of their growth and development. Team leaders across the region are enthusiastic and dedicated to the service of medicine. Leaders demonstrate great pride and support in the work of their teams.

Some of the sites identified with the annual planning cycle of the health authority, and the creation of goals and objectives, while others are not obviously connected to this process. There could be an opportunity to develop goals and objectives for the service as the new strategic plan is released. It is important for all sites delivering medicine services to be connected to the overall plan of Island Health in addition to addressing local objectives.

Collaboration among providers and services is very strongly noted both within and among various sites and services. The needs of the individual patients are seen to be at the centre of this.

Priority Process: Competency

A key strength across the medicine teams is the interdisciplinary teams. The teams are highly skilled and enthusiastic with a high degree of collaboration seen both within and among teams. Team members are provided with thorough orientation and ongoing education.
Team members take on the accountability to ensure that they have the necessary knowledge and skills to competently provide care for complex, highly acute medical patients.

Not all of the sites have formal processes to evaluate the functioning of the interdisciplinary team. Some groups used the team vitality and staff engagement survey instruments. These tools may be appropriate to spread to the remaining teams.

On the medical assessment unit, staff are in the midst of incorporating health care assistants (HCA) into the model of care. Staff are feeling uncertain about the new model and its impact on the care and workload, yet believe that they can work it through as a team with management support.

A number of the sites did not have documentation of their training on infusion pumps, although staff did report that they had access to training when there were new pumps or changes to existing pumps.

Performance evaluations are not consistently provided across medicine services, though a number of leaders articulate that they believe this is important, and are planning to do so.

The physical layout of Lady Minto Hospital and the lack of space in Tofino creates challenges for effective team functioning.

Patient feedback to surveyors during their visit was very positive. Patients state that they are treated as individuals and that the interdisciplinary team works well together to support them.

Priority Process: Episode of Care

The medicine teams surveyed across the region all demonstrate excellent interdisciplinary team work and patient-focused care. Patients are thoroughly assessed, and individualized plans of care are developed and implemented. A number of different collaborative interdisciplinary team meetings occur on a regular basis.

Significant work is occurring to implement the safety practices related to the prevention of VTE and pressure ulcers. The standardized assessments upon admission have been widely spread. The key next step for the teams is to audit and monitor their results and then to make improvements.

A standard process for assessing pain has been put in place, and is being used regularly across the services. Patients report satisfaction with the management of their pain.

Medication reconciliation is not implemented in this service. This is a very important area of work for the teams given the known risks that medicine patients have related to medications. The organization has a plan in place to implement medication reconciliation in other services while implementing IHealth.

Medication incidents are documented through the safety reporting system and are individually followed-up on. A key next step is to use compiled data to determine trends and develop improvement plans.

Excellent tools have been developed and put in place to support the flow of information. Teams have begun to work on improvements related to transition to home. Discharge rounds are in place in many areas and include the input of the interdisciplinary team. Some teams are using "My Ticket Home," which is completed for all discharges and includes current information about the diagnosis and treatments while in hospital and addresses the patient's follow-up questions at the point of discharge. A key next step is for teams to follow-up with patients after discharge in order to learn how successful the transitions are, and to stimulate improvements. One example of work in this area is in the area of pacemaker care where a post follow-up pacemaker care tool has been established.

Priority Process: Decision Support

The medicine teams have implemented good processes to ensure coordinated and thorough flow of information in order to improve patient safety. Excellent tools have been developed and implemented. For example, inter-facility transfers follow a protocol using the transfer checklist, interdisciplinary discharge and transfer summary. A checklist for the repatriation of patients is also in place.

The processes to determine and access clinical practice guidelines is excellent. These guidelines are used well in medicine services and are seen as particularly supportive to units with multiple specialties and complex patients.

Priority Process: Impact on Outcomes

There is a significant variance across the teams in terms of their focus on monitoring and measuring their outcomes. Benchmark information does not appear to be readily available or used by all teams, and will be key to helping teams to move forward in this area.

Teams are in different phases of implementation in terms of the falls strategy. Overall, there is a good process in most teams as part of the standardized assessment process to begin the falls assessment. Once there is full implementation of the strategy, it will be important to audit and monitor whether the strategy is achieving results.

A number of the medicine teams are not yet monitoring process and outcome measures. Some teams are not currently comparing their results with other programs or organizations. There is an opportunity for teams from various sites to work together to compare results and share their practices. It is noted that the teams with a wide variety of patient types and from smaller centres require more support in this area. The more specialized areas, for example, cardiology and renal, have more ready access to this information.

Safety briefings occur on some sites, and it is recommended that this best practice be spread to all of the medicine teams.

3.3.13 Standards Set: Mental Health Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
12.4	The team identifies gaps in the transition plan and implements mitigation strategies to minimize risks at transition.	
12.6	The team follows a process to evaluate the effectiveness of transitions, and uses this information to improve 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		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Staff and leaders strongly support a strengths-based and client-directed approach to mental health services and programs in all surveyed areas.
Clients and their families voice that their care is strengths-based and that they are an intrinsic component of the circle of care.

Mental health teams have a strong focus on recovery and well-being.
Public forums have been held with community partners at some sites. These are also very well attended.

Leaders and staff have developed strategies and plans such as a trauma informed plan and a peer support program.

Changes are made as appropriate in consultation with internal and external stakeholders. This included the establishment of an open crisis counselling clinic based in a local mall. A provincial award was received highlighting this great initiative.

The adult acute unit at Royal Jubilee Hospital is exploring the releasing time to care model to see if this model of care will enhance their service delivery.

A new psychiatric emergency services unit and psychiatric intensive care have enhanced the quality and safety of the service. Staff speak highly of the benefit of the new services.

Leaders and staff are strongly committed to reducing stigma. There is a stigma working group. A public education forum on stigma was recently held with approximately 100 people in attendance.

The nursing students and their instructor are very complementary of the working relationship with staff.

Priority Process: Competency

The team on the adult unit is noticing an increase in medically fragile clients being admitted. They are hoping to expand their team to include physiotherapy as a regular team member to further this area of client care.

There is a strong interdisciplinary focus. Clients and families state that the team is very responsive to their needs.

There is a well-developed interdisciplinary team in place and structured case review process
. An electronic process is used which the leaders and staff state is working well.

Infusion pump initiations are not done by staff on this unit as with the infrequency of clients admitted with these needs, competency would be almost impossible to maintain for all staff. Nursing staff receive training and education regarding maintenance of the infusion pumps so they can be managed while the client is admitted. Team members report a good relationship with other units team who will initiate the infusion pumps. Clients with infusion pumps are not admitted to Ledger House.

There is a restraint policy in Ledger House. It must be noted and applauded that since implementing the trauma informed practice model, the use of restraint and violent incidents have been reduced by 75%. These results continue to be audited.

There is a strong commitment to training. This includes education through the e-learning system. Staff and leaders speak highly of the education and training provided.

Leaders are committed to ensuring that staff performance appraisals are completed. Staff articulate that their performance appraisals are complete. The performance appraisal process included feedback from peers and/or supervisors.

A respectful workplace is strongly supported. There are processes in place to address issues. Staff articulate that they feel supported by Island Health.

Priority Process: Episode of Care

At Ledger House, the team communicates regularly not only within the team but with clients and families regarding treatment goals and progress. Families report this is a very welcome strength of this program.

A comprehensive suicide risk assessment policy is in place and regular training with the tools is documented in all services.
It is seen as very positive that clients and families are included in the development of the safety plan and are made aware of all resources available to them when a client is away from the facility on passes.

Physical activity on the adult unit is encouraged and several options are offered through the day hospital. Ledger House offers a variety of age appropriate activities.

There are comprehensive policies for the use of restraint and seclusion, including guidelines for use and documentation.

The use of the PharmaNet system has allowed for tracking of BPMH throughout the formal health system. Clients' use of alternative medication such as vitamins and over the counter medications are routinely explored. A list of the client medications are entered into the PharmaNet system and sent to community-based providers on discharge. Nursing staff discuss the medications with the clients on discharge and document this in the client record. Clients are given their prescription(s) on discharge and can request a written list of their medications. It would be beneficial to provide a written list of all medication to the client as part of the standard discharge procedure.

Staff connect clients to community-based services, support groups and other services.

Priority Process: Decision Support

The team has identified its needs for technology and information management. They are quite excited about the plan to increase the system's ability to generate further reports.

Priority Process: Impact on Outcomes

The new units support staff safety. There is a strong culture of staff safety using alert systems, violence prevention training and working alone processes.

It is very positive to note that fall prevention information is included on the information pamphlet.

3.3.14 Standards Set: Obstetrics Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.2	The team's goals and objectives for obstetrics services are measurable and specific.		
Priority Process: Competency			
3.9	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
4.9	Team leaders evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
9.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	9.6.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	9.6.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
	9.6.4	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 obstetrics/perinatal program is integrated island-wide with organizational leadership vested at Victoria General Hospital. The department of obstetrics and gynecology is complemented by the department of midwifery with, generally, family practitioners and midwives acting as "most responsible physicians" for all low risk pregnancies. Consultants have well-defined areas for involvement in higher risk cases and any unexpectedly complex cases.

The larger team with representatives from across Island Health meets regularly, usually by teleconference, to discuss higher level issues such as policy development or implementation. All sites feel they have a voice at the table and results from committee work are beneficial to their local work and their clients. The setting of system goals and objectives is done to a large extent by BC Perinatal Services, and local units are working on local goal setting and beginning to work on specific local performance indicators.

Of particular note is the midwifery program at Lady Minto Hospital which is has a solid record of quality outcomes and is an exemplar for obstetrical services in rural areas. This unit is contributing to the literature on such services.

Priority Process: Competency

All sites have an appropriate interdisciplinary team to deliver services. The orientation process to each unit is extensive to ensure competent care delivery. In some sites this becomes complicated where staff must be able to care for a pediatric or adult medicine census as well due to bed configurations or over capacity issues. At the site level there is ongoing review of the staffing to assess effectiveness.

Performance appraisals are not done consistently across the larger team and it is recommended that the team review the organization's policy and ensure it is followed.

Although the team communicates very well and regularly, it is suggested that it develop a formal means to assess its functioning on a yearly basis as a complement to the review of its clinical results/outcomes.

Succession planning in the smaller or rural areas should be a top consideration where the obstetrics program hinges on one or very few personnel.

Priority Process: Episode of Care

The client care processes from prenatal involvement, through admission and delivery to discharge are generally well delivered through a combination of competent staff and excellent support tools, including order sets. Safeguards are in place for escalation of concerns should they arise, including in rural areas. In these areas, clients are regularly reminded of their choices and supported in their decisions for birth location. Education materials and efforts are quite detailed. Specialty support is available centrally on referral including diabetes in pregnancy (multi-disciplinary team including a full-time dietician, RN, endocrinologist and perinatal obstetrician); maternal fetal medicine clinic; mental health in pregnancy team that supports women with known mental health issues; ad, a genetic counselling service.

Medication reconciliation is not yet implemented in the obstetric service. The organization has a plan in place to implement medication reconciliation in other services when implementing the EHR.

In sites where C-sections are preformed, the safe surgery checklist is used. Established mechanisms are used for information transfer when undertaken.

The total focus, post-delivery, is establishing the maternal child bond. Rooming-in is the standard practice with no routine newborn nursery.

Priority Process: Decision Support

The record document set for managing obstetrical care is extensive and thorough; it is being transferred to electronic format over time. Staff receives adequate training as this currently hybrid system of paper and electronic moves forward. There is electronic access to many databases of support for care delivery and care guidelines are kept current with processes including local input.

Priority Process: Impact on Outcomes

Two client identifiers are used consistently. A falls prevention strategy has been implemented. In some areas there has not been enough data to warrant a formal review/evaluation as yet, although each case is looked at to determine corrective actions, if appropriate. There is an intensive effort put into educating clients and families in safety.

The team uses the adverse event reporting system to register errors, including near-misses, and participates, if necessary, in disclosure activities around these events. The team is encouraged to make safety a specific topic in all their regular staff (monthly) meetings. This is meant to help keep a constant focus on safety (both staff and client).

3.3.15 Standards Set: Primary Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership - Primary Care		
3.2	The clinic's funding or payment models create incentives to deliver the best possible primary care services.	
3.3	The clinic's workspace supports interdisciplinary team functioning, interaction, and the timely delivery of primary care services.	
Priority Process: Competency - Primary Care		
5.6	The clinic regularly evaluates and documents each team member's performance in an objective, interactive, and positive way.	
Priority Process: Primary Care Clinical Encounter		
9.14	When prescribing any medication, the team reconciles the client's list of medications.	!
Priority Process: Decision Support - Primary Care		
12.1	The clinic's leaders select systems and technology based on the team's needs and with innovation in mind to support high quality primary care services.	
12.4	The clinic uses information technology to support decisions about client care and services.	
Priority Process: Impact on Outcomes - Primary Care		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Primary Care Clinical Encounter

The organization has been working to integrate their health services and there has been evidence of this in the survey. The organization is building integrated teams, wrapping services around clients. The sites have been increasing access to primary care by using advanced clinical access and extending hours. The staff are committed and leadership engaged. The organization needs to ensure that physicians and nurse NPs are doing only what they can do. It was noted that the physician and/or NP were assisting clients to undress, removing dressings, put on bandages and assisting on/off exam tables. The MOA could be doing these so that the physician or NP is freed up for other appointments.

Priority Process: Clinical Leadership - Primary Care

The organization is continuing to build/enhance their primary care services. Oceanside Health Centre is a new site, less than one year in operation. It houses primary care, urgent care and community services under the same roof. The team is considering submitting a leading practice for primary care services.

For the most part, sites are collecting information on the population they serve and using that information to plan/change services. An example would be the clients of the primary care site at Oceanside. If their patients use the urgent care centre while the clinic is open, they follow-up with the clients and educate them about same-day appointments. Clients of Oceanside identify obtaining timely appointments for non-urgent issues and parking as the main concerns. They do note that if their issue is urgent they can often be seen on the same day. Clients identify they feel very much a partner in their care and have positive experiences in primary care.

The primary care team at Oceanside has developed operating principles and application to Oceanside that spells RELATIONSHIP. Their focus is to have client-centred care where the client is the centre of the hub, with supports wrapped around them. Island Health has a brochure that is used in primary care titled "Simple Steps for a Safe Visit to a Primary Health Care Centre." This is provided to all clients and includes how to prevent infections, falls, information on medication safety, how to keep informed and general tips on a successful visit.

The Hillside Seniors Health Centre may be operating more like a physician office site rather than a primary care health centre.

Priority Process: Competency - Primary Care

The primary care team has the necessary credentials and education/training to do their work. They are working to their scope of practice and are client-focused. Not all staff have had their performance evaluations completed and the organization needs to ensure this. The team at Oceanside is working on an interdisciplinary core competency process and this will assist the team in evaluating not just the individual, but the team.

Priority Process: Impact on Outcomes - Primary Care

The primary care team is looking at a number of metrics to determine effectiveness of their service - the look at hospitalizations of their clients, LOS, ED visits, urgent care visits, time of day and day of week. The team uses the organizational PSLS system for documenting near misses and adverse events. There is quick response to safety issues and the surveyor had the opportunity to discuss an incident with a client. The client fell in the doorway to a health centre due to water on the floor. The client was assisted by staff/volunteers and they received a telephone call from the manager later that day who reported on the action taken. The client was quite satisfied and felt heard.

Priority Process: Decision Support - Primary Care

The organization meets the legislative requirements for privacy and security. The organization is currently in a hybrid state for records with some being electronic and some on paper. The organization is working with Cerner Canada (vendor for the hospital-based system) to build a community electronic record and the team is assisting with this. The surveyor observed a NP and physician sharing the electronic record with clients and the clients were pleased to be viewing the electronic chart. It is quite comprehensive. The team uses clinical practice guidelines to guide care.

3.3.16 Standards Set: Rehabilitation Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
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 acute rehabilitation service spans three sites and supports 93 beds. The team is multidisciplinary and works in a program model. Recently an external review of the service was commissioned; it is dated March 2013. This review will serve as the transformational rehab roadmap for Island Health. To date project co-leads have been assigned, a rehab transformation steering committee has been formed, and a draft project plan including an action plan is being finalized. The rehab transformation roadmap will align with the principles of the proposed strategic plan, focusing on an island approach to rehab services. This will help to set goals and objectives for the services beyond NRS data capture goals.
The rehab team sees a revised vision for rehab services playing a large role in flow issues within the system. The team is already focused on discharge planning and through daily rounding has seen improvements in LOS data according to NRS indicator monitoring.

The demographic profile served is elderly and trending suggests home supports would be of value to patients. The team sees advantages of supports in the community, and recognizes the human resource recruitment challenges that this vision proposes. In January 2014, the rehab team started to implement an innovative amputation program which will support the approximate 88 persons who require this care per annum. This will be a hybrid model between the acute care and outreach outpatient clinics in Victoria and Nanaimo. Progress to date is promising, best evidence care pathways are developed, and inclusion and exclusion criteria established. Hopes of decreasing the current eight day LOS will be monitored.

Priority Process: Competency

Rehab services are multi-team, focused at RJH and VGH. Staff competencies at both sites are monitored by the educator and this data capture is manual. Orientation is a composite of e-learning and staff training. Staff like the e-learning option.

Bed huddles and SRT processes are standardized. These are impressive as staff are empowered and engaged to make changes to staff assignment. From a patient safety perspective, all team members are aware of more acute patients. Students and volunteers are seen as an asset to the service. This has provided opportunity for staff recruitment. Team members are aware of their duties prior to hire. Staff-initiated activities provide opportunities for team celebration and team building; service awards through Island Health are in place.

Priority Process: Episode of Care

Some care pathways are available. Some policies are available, others are required. A formal process for reviewing policies and procedures, including care pathways for the service, is encouraged.

Teams at both RJH and VGH develop comprehensive care plans with goals and target dates. The focus of rounding is discharge. Discussion with multiple external partners is supported at both sites. Patients feel they know their goals of care.

Priority Process: Decision Support

The rehab team believes in best evidence practice. In March 2013, an external review of the service was conducted. International standards were requested through this process in an effort to develop a future vision for the service.
Since 2009/10, NRS data capture has occurred. FIM data capture is part of the program and trending of this data allows improvement in program care. Recently at VGH, an early discharge stroke pilot occurred. There is a pending implementation of the amputation program which is hoped to improve LOS for this patient population.

Priority Process: Impact on Outcomes

Rehab service team members work collectively to support positive outcomes for their patients. Best practice is important to this team. NRS and FIM data have been observed over time and assist with care planning goals. There are strong linkages with external partners.

Innovation through the early discharge stroke program and the amputation program attempts to address improvements in patient outcomes through improved LOS. The team considers the home location of their patients in planning for discharge. They link with other partners in supporting discharge plans. Patient safety is important to this team.

The team looks forward to the e-health record and chart standardization. The team views incident reporting as helpful to their service and an opportunity to improve care. Debriefings have been conducted after critical incidents to support staff.

Patients are complimentary about the care they have received. There is opportunity for follow-up questions to staff post-discharge.

3.3.17 Standards Set: Substance Abuse and Problem Gambling Services

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization is to be commended on their integration of mental health and addictions services. This is the first step in a truly patient-centred approach where clients and patients would receive a common assessment or care plan for comprehensive services. The organization is encouraged to keep this integration as a priority.

It was evident that staff are proud and passionate about their work. The organization is commended for having detox services in a scenic residential neighbourhood thus reducing stigma. At the Discovery Unit, efforts have resulted in increased referrals from schools. The team is to be commended on having flexibility about the age of youth to transfer out of the program by looking at it with a developmental and readmission lens.

There are overall program-specific goals for mental health and addictions but the individual teams are encouraged to continue to work on goals and objectives specific to their sites.

Priority Process: Competency

Interdisciplinary staff are encouraged to ask questions and contribute during individual case management discussions.

There is opportunity within the organization's program to further integrate mental health and addictions knowledge for dual/concurrent disorders.

At the Discovery Unit there is a team review every summer called "Team Day" where goals are set for the team.

Priority Process: Episode of Care

There is flexibility in services and care plans are built around the individual as much as possible. 24/7 medical care is available and physicians are integrated into the team.

Concerns were raised by clients and staff about the lack of recovery programs on the island, particularly for women. The organization is encouraged to look at best practice for recovery following detox and ensure clients have some accessible options.

Clients interviewed express satisfaction with the treatment and particularly mention the positive healing influence of the good food available at Clearview. At the Discovery Unit the philosophy of care is to be commended and there is a seamless process for transition of care between mental health and addictions.

Priority Process: Decision Support

Staff are very conscientious about privacy. Evidence and best practice in the field of addictions is constantly evolving. Leaders and staff have access to provincial, national and international sources of information through their practice collaboratives and professional associations.

Priority Process: Impact on Outcomes

The program has clear information for patients on what to expect during treatment and at discharge. Outcome measures for this population are more difficult, primarily based on self-reporting by clients. As more research evidence becomes available in the field of addictions, the team may be able to incorporate some other measurable and specific outcome indicators. The program at the Discovery Unit has developed outcome criteria that have been recognized as a leading practice and should be used as a program model.

Staff at the Discovery Unit use a motivational interviewing approach with patients and clients. They have excellent response rates to referrals, usually one to two days.

3.3.18 Standards Set: Telehealth Services

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
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 telehealth team has very strong clinical leadership. The leadership understands the importance of this technology to a region as large as Island Health. The leadership is passionate about the use of the service and its future potential. There is a clear understanding of the difference between telehealth and video conferencing. All team members clearly understand their respective roles.

Priority Process: Competency

The telehealth team has well-defined roles and position descriptions. There is evidence that the organization assigns appropriately qualified, licensed and registered service providers to deliver telehealth services. The team has access to appropriate education.

Priority Process: Episode of Care

An episode of care that was conducted via telehealth was observed. It was very clear from those observations that this is a very patient centric team. The providers and patient were very comfortable communicating in this manner and the patient was very supportive of this form of service delivery.

There is evidence that prior to using telehealth, the organization orients service providers about the scope of service, telehealth operational protocols and procedures, and the safe use of equipment when delivering telehealth services. Equipment is standardized and appropriately secured across the entire region.

Scripts are used to ensure consistency of messaging. The information is reinforced when the client arrives.

There are hand hygiene stations in all rooms as well as supplies to clean equipment between patients.

Priority Process: Decision Support

The team protects the privacy and confidentiality of patients and families and is very responsive when concerns are expressed. For example, at the Campbell River site, concerns were expressed by patients in the patient satisfaction survey about a lack of confidentiality; the patient could hear staff outside of the room so assumed the staff could hear them. The organization has since installed sound panels and a white noise machine. These are quite effective.

Priority Process: Impact on Outcomes

There is evidence that the organization identifies the human, financial, structural and informational resources needed to achieve the goals and objectives for telehealth services. The team identifies and monitors process and outcome measures for its telehealth services. For example, within Island Health, the service has prevented the equivalent of 114 trips around the earth. Patients have been empowered to get involved with their care. Results from TeleHome Monitoring show a 67% reduction in hospital admissions, 78% reduction in length of stay and a 65% reduction in ED visits.

The team monitors clients' perspectives on the quality of its telehealth services. For example, 99% of patients say they are satisfied with the telehealth service. The team routinely conducts patient satisfaction surveys.

3.3.19 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		
1.3	The team uses evidence-based client care maps or pathways to guide them through steps in the procedure, promote efficient care and achieve optimal client outcomes.	
2.8	The team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Standards Set: Surgical Care Services		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
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.	

Surveyor comments on the priority process(es)

The surgical services team for Island Health is responsible for providing these services at eight sites within the region. Five of theses sites are "rural communities" and also report administratively through the community program. The three major sites (RJH ,VGH and NRGH) are all managed by the surgical program. However, all sites are expected to adhere to the standards, policies and procedures as developed and implemented by the surgical program.

The surgical team meets regularly to determine and prioritize the needs of all the patient locations and use the data produced to realign and develop services. A new initiative will analyze the surgical services looking at access, sustainability, allocation of resources and financial implications for future development. A pilot project is imminent and will likely have ramifications for the region.
The surgical quality council (SQC) has been very active in developing indicators, bench marking throughout the region and by its involvement with the American College of Surgeons' National Surgical Quality Improvement Plan (NSQIP). The quarterly reports generated through this program have indicated a number of areas where improvements could be made in various regional sites. The SQC has implemented changes in some sites that have brought the indicator levels to or below the benchmarked numbers. There is still and always will be work to be done but the reduction in wait time for hip fracture repair and the ongoing vigilance is to commended. Other indicators such as surgical infection rates, checklist compliance and VTE prophylaxis are showing gradual but steady improvement.

A new "call to care" program has been implemented and should enhance the overall "comfort level" of patients having had a procedure or recently discharged. This program demonstrates the high level of commitment to patient satisfaction and safety.

Overall,the surgical staff appears happy and engaged with the organization. They are all aware of policies and procedures and feel that they have the ability to have some input into the review and development of these. All feel comfortable with the adverse event reporting system and do not feel that there is a "blame" culture. Workplace difficulties are not openly obvious and staff have a general feeling of "well being." There are areas where performance evaluations have not been completed and staff sometimes feel that they are not sure where they stand in the organization. Succession planning and possible realignment will be necessary to ensure that qualified staff are available to provide services in the future. This is particularly true for anaesthetic services. There have been considerable cancellations over the past few months due to retirements and FFS reductions have interfered with the efficient running of the operating room lists. This is more evident in the South island sites. There may be some relief with the proposed recruitment of four new graduates. Consideration should be given to an alternate reimbursement modality so that these shortages do not occur in the future.

Surgical inpatient services are well provided and all aspects of patient safety, including education,monitoring and high risk avoidance, are evident. Charting is timely and complete in a multidisciplinary format. Systems of "flags" are used to alert and expedite interventions when necessary.
A new model of care delivery is being introduced and the organization needs to be aware of staff concerns with the implementation. At present there is good collaboration amongst all caregivers and the "daily report" allows for good planning and continuity of care. These meetings also act as a forum for safety briefings and information exchange.

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: March 1, 2014 to March 27, 2014**
- **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.	0	0	100	89
2 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	93
3 We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	93
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	90
5 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	0	0	100	89

	% 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	92
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	94
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	93
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	92
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	90
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	88
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	89
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	92
14 Our ongoing education and professional development is encouraged.	0	11	89	87
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	0	100	91
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	95
18 We formally evaluate our own performance on a regular basis.	0	0	100	78
19 We benchmark our performance against other similar organizations and/or national standards.	0	13	88	66
20 Contributions of individual members are reviewed regularly.	0	11	89	61

	% 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.	0	0	100	77
22 There is a process for improving individual effectiveness when nonperformance is an issue.	0	11	89	53
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	78
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.	67	33	0	81
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	11	89	64
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	11	89	92
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	11	89	78
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	92
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	81
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	88
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	84
32 We have explicit criteria to recruit and select new members.	0	11	89	79
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	11	89	86

	% 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	22	78	91
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.	0	0	100	86
37 We have a process to elect or appoint our chair.	100	0	0	90

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

4.2 Patient Safety Culture Tool

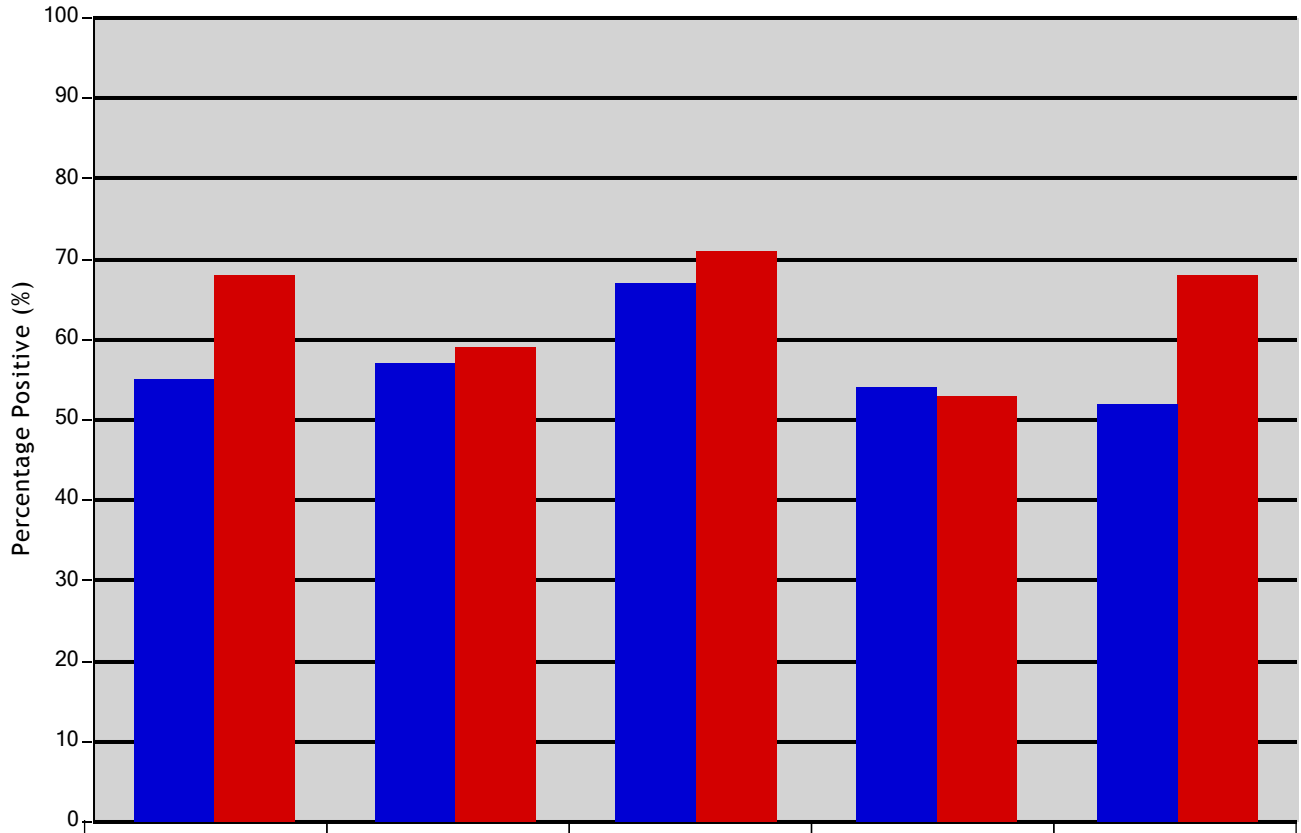
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations 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: October 18, 2013 to November 22, 2013**
- **Minimum responses rate (based on the number of eligible employees): 374**
- **Number of responses: 1365**

Patient Safety Culture Tool: 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
	55%	57%	67%	54%	52%
	68%	59%	71%	53%	68%

Legend

Island Health

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2013 and agreed with the instrument items.

4.3 Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

The organization then had the chance to address opportunities for improvement, and 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

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