ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:

Horizon Health Network/Réseau de santé Horizon

Miramichi, NB

On-site Survey Dates:

September 19, 2010 - September 24, 2010

October 18, 2010

ACCREDITATION CANADA
AGRÉMENT CANADA

Accredited by ISQua

Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Horizon Health Network/Réseau de santé Horizon.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Horizon Health Network/Réseau de santé Horizon only. Accreditation Canada does not release the Report to any other parties.

In the interests of transparency, Accreditation Canada encourages the dissemination of the information in this Report to staff, board members, clients, the community, and other stakeholders.

Table of Contents

About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

Legend

A number of symbols are used throughout the report. Please refer to the legend below for a description of these symbols.

Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.

Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.

Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.

Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

Horizon Health Network/Réseau de santé Horizon

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

On-site survey dates	September 19 to 24, 2010
Report Issue Date:	October 18, 2010

Accreditation Decision	Accreditation with Condition (Report)

Locations

The following locations were visited during this survey visit:

1 Zone 1 - Albert County Health & Wellness Centre
2 Zone 1 - Extra Mural Program Driscoll Unit
3 Zone 1 - Petitcodiac Health Centre
4 Zone 1 - Sackville Memorial Hospital
5 Zone 1 - The Moncton Hospital
6 Zone 2 - Centracare - Saint John
7 Zone 2 - Charlotte County Hospital
8 Zone 2 - Community Mental Health Saint John
9 Zone 2 - Extra Mural Program Saint John Unit
10 Zone 2 - Extra Mural Program St. Stephen Unit
11 Zone 2 - Public Health Saint John
12 Zone 2 - Ridgewood Addiction Services - Saint John
13 Zone 2 - Ridgewood Veteran's Wing - Saint John
14 Zone 2 - Saint John Regional Hospital
15 Zone 2 - St. Joseph's Community Health Centre (Saint John)
16 Zone 2 - St. Joseph's Hospital
17 Zone 2 - Sussex Health Centre
18 Zone 3 - Addictions Services - Fredericton
19 Zone 3 - Community Mental Health Fredericton
20 Zone 3 - Dr. Everett Chalmers Regional Hospital
21 Zone 3 - McAdam Health Centre
22 Zone 3 - Oromocto Public Hospital
23 Zone 3 - Queens North Community Centre

24 Zone 3 - Stan Cassidy Centre for Rehabilitation
25 Zone 3 - Upper River Valley Hospital
26 Zone 3 - Veterans Health Unit - Fredericton
27 Zone 3- EMP Fredericton
28 Zone 3- EMP Oromocto
29 Zone 7 - Miramichi Regional Hospital
30 Zone 7 - Public Health - Miramichi

Service areas

The following service areas were visited during this survey visit:

1 Addictions/Gambling
2 Ambulatory Care
3 Blood and Transfusion Services
4 Cancer Care
5 Case Management Services
6 Community Health Services
7 Development Disabilities
8 Diagnostic Imaging
9 Emergency Department
10 Home Care
11 Hospice/Palliative Care
12 Intensive Care Unit/Critical Care
13 Laboratory
14 Long Term Care
15 Maternal/Perinatal
16 Medicine
17 Mental Health
18 Operating Room
19 Public Health
20 Rehabilitation
21 Sterilization and Reprocessing of Medical Equipment
22 Surgical Care
23 Telehealth

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Surveyor Comments

Overall Strengths

The following is a summary of the identified strengths of Horizon Health Network.

There is a well-developed telehealth system that is becoming embedded in all facets of the organization.
The Extra Mural Program has 24/7 access with a nurse on call.
There is a Quick Response Program Pilot Program in Emergency that is working well.
There is a pilot program using pharmacists for medication reconciliation in the community and it is working well.
There is a well-established and respected Sexual Assault Nurse Examiner Program at all referral centres on a 24/7 basis.
The Ambulatory Care Services across the network have undergone considerable program development and impact analysis. The Irving Ambulatory Care Clinic is an example of success in program development and has enhanced patient flow.
There is a solid ethics framework and a research ethics board.
The interdisciplinary team approach is evident in the community with a focus on best practice and client self-management.
There has been solid leadership in the development of excellent emergency response plans for the entire Network.
Staff orientation and training, including e-learning is well developed and consistent across the Network in most facilities. There is exceptional support and mentoring of new employees across the organization.
There is a strong commitment at all levels to enhance patient flow, and a variety of initiatives are taking place across the Network, including using referral centres, addressing wait lists, freeing up operating room (OR) time, ambulatory care initiatives, utilization monitoring, commitment to diagnostic imaging and laboratory turnaround times.
There is a well-established Regional Biomedical Program with electronic inventory of all medical equipment and a comprehensive preventative maintenance program.
There is a solid Infection Control Program across the Network with low infection rates and knowledgeable staff at all levels.
There is a commitment by staff to making the organization a great place to work. There are many long service employees and staff consistently say ' this is a great place to work'.
There is security staff at most facilities and it is appreciated by staff. Security staff are knowledgeable of the organization and helpful to staff and the community.
There is a comprehensive tertiary rehabilitation program serving the Network.

The Network is challenged by the following;

- A lack of Alternate Level of Care (ALC) beds
- Staffing shortages in several areas – nursing, diagnostics, family physicians, and some specialists
- Increasing wait times in Emergency Departments
- Escalating demand for a number of services which exceeds available capacity (oncology, orthopaedics, clinics) and pressure and need to launch programs without adequate resources (stem cell transplant)

• Limited management support in some areas, especially small centres making quality and safety monitoring a challenge
• The absence of a provincial medication database resulting in challenges in obtaining patient specific medication history
• The lack of integration and the limitations of the current information management systems both clinical and administrative
• The standardization of equipment across the Network

Successes of Leadership

The Leadership has a number of successes including the following:
• A strong Board of Governors and Executive Management team relationship
• An open and transparent relationship between the Board of Governors and CEO
• A leader and senior team committed to a common vision building on the strengths of the legacy organizations.
• A shared vision of the Network
• The support of excellent foundations and auxiliaries
• A shared commitment to integration at all levels in the interest of patient care
• A shared commitment to quality improvement and patient safety.

Challenges of Leadership

The Leadership has a number of challenges. The primary challenges are:
• An enormous number of competing priorities
• The development of a standardized and consistent framework for management, policy and protocol development, quality management, risk management, and information management across the Network
• Communication across the Network at all levels and to the community and government
• The travel and workload demands on senior staff; the lack of connectivity to the sites and next level of management and staff.

Leadership also needs to leverage the pockets of excellence found throughout the organization

Communication with/among Different Levels of the Organization

There is good communication among the staff at all levels of the organization and there is a sense of visionary leadership evidenced by staff developing goals at all levels that align with the Network strategy. This in turn is evident in the energy of staff to do a good job and make a difference for the patient and community.

The organization lacks the information technology infrastructure required for the sharing of important patient information, electronic charting, cross Network patient registration, scheduling of programs and clinics, and staff scheduling.

Relationship between Organization and Community

The Network has excellent relationships with the community. The following is some of the evidence of this:
• The Regional Infection Control Committee
• There is a strong link with the Provincial Critical Care Program
• There are well-established linkages with schools
• There are linkages with Corrections Services, Police and Victim Services, YMCA, Social Development, and nursing homes

• There is a well established relationship with New Brunswick B Cancer Care and Vitalité (Health Region A)
• There are excellent relationships with educational institutions supporting sustainability of human resources
• There are links to Food Security Programs.

All partners represented in the Community Partners Focus Group spoke in positive terms about their relationship with Horizon Health Network.

Follow up on Previous Accreditation Recommendations

The following is an update with respect to actions to address previous survey recommendations from the legacy organizations.What follows is an identification of the recommendations which have not been addressed. If a recommendation is not identified here then it has been addressed or is no longer relevant.

Atlantic Health Sciences Corporation

No previous recommendations were unmet.

Regional Health Authority #7-Miramichi

Patient Safety Goal Area #2-Communication-Medication Reconciliation
Medication reconciliation is not fully implemented. Medication reconciliation at admission is in place in only some parts of the region.

Leadership and Partnerships6.3
The ethics framework has not been fully operationalized region wide. Comprehensive education has been done.

Human Resources 4.2
Competency based performance appraisals for physicians is under consideration.Chiefs do have performance appraisals. Consider including this is in the re-credentialing process.

Regional Health Authority #2-River Valley Health

Patient Safety Goal Area #2-Communication
Medication reconciliation is not fully implemented. Medication reconciliation at admission is in place in only some parts of the region.

Leadership and Partnerships 5.5
There is no annual Board performance evaluation.

Human Resources 1.6
A comprehensive human resource plan has yet to be developed.

Regional Health Authority #1 - South East-Moncton

Leadership and Partnerships 5.5.
The Board does not have a process to annually evaluate its performance.

Ambulatory Care 11.4.
The organization's ethics framework has not been fully implemented. Education has occurred.

Organization's Commentary

The organization has no comment at this time.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

Leading practices are commendable or exemplary organizational practices that demonstrate high quality leadership and service delivery. Accreditation Canada considers these practices worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue.

Leading Practices
- are creative and innovative
- demonstrate efficiency in practice
- are linked to Accreditation Canada standards
- are adaptable by other organizations

Horizon Health Network/Réseau de santé Horizon is commended for the following:

Suicide Process Review

The implementation of this leading practice was successful because of the commitment between the Addiction & Mental Health Program and the Quality Risk Management Department. Support and education is required for staff to move away from a "punitive" perception of the process toward a supportive approach that focuses on quality improvement and patient safety, and that not only supports their needs and practice but also provides an opportunity for family closure. (Mental Health Services)

Physician Consult

Physician Consult Project

MedContinuum is a Provincial utilization tool used in all acute care New Brunswick hospitals since 2007. This utilization tool is completed by nursing staff on most nursing units at The Moncton Hospital on a daily basis. Length of stay is an indicator used to measure how well the hospital is performing compared to other hospitals across the country of comparable size and similar service. The Canadian Institute for Health Information (CIHI) data indicated that our patients were staying too long in hospital. MedContinuum helped us sort out some of the reasons for this delay in patient discharges.

The data produced by this tool identified wait times for consultations with medical specialists as a factor in the delays and prolonged lengths of stay of our patients. The process used for notification of consults was complex, time consuming, varied for each service, and involved many individuals (nurses, ward clerks, private office staff, ambulatory care clinic staff, phone answering services, and physicians). There was often no record to confirm that the consultant had actually been notified. While direct verbal contact between the attending physician and consultant would have been ideal, it was often impractical, especially surgical and procedure-oriented services.

An analysis was carried out to
- review the ways and means of communicating consult requests for medical and professional services on the in-patient population.

• clearly identify all of the varying requirements of the stakeholders involved
• design a clear, streamlined process for all physician consults
• provide a backup means of communication to ensure that consult requests are transmitted in an acceptable time frame
• ensure there is a feedback loop to communicate the message has been received and acknowledged
• improve patient care by providing efficient communication of consultation requests

This physician driven project resulted in a tremendous amount of creative thinking, consultation, team work, etc. Together, we were able to develop a process that has proven to be very workable, easily managed, and is a giant step towards the Provincial initiative of One Patient One Record. (Medicine Services)

Miramichi Public Health Baby Friendly Initiative

Baby-Friendly Initiative (BFI) is a strategy to increase the health and well-being of children and families through the protection, promotion and support of breastfeeding. The Baby-Friendly designation is a process that is based on evidence-based guidelines associated with breastfeeding. The Miramichi Public Health Division recognizes that breastfeeding is key to the health and well-being of the residents of Zone Miramichi. It is also a population health approach that is necessary to re-establish breastfeeding as a cultural norm. The process to become a BFI designated organization is based on the Breastfeeding Committee for Canada`s 10 steps plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services. The Miramichi BFI Public Team has implemented several initiatives/strategies to ensure that all key steps were met to become a BFI designated workplace. A BFI mock assessment held on May 28, 2010. As part of this activity, a master assessor for the national BFI authority conducted a very thorough assessment based on the 10 steps for designation. The results achieved were very impressive and spoke highly to the strong leadership and dedicated individuals committed to reaching the established goals. Strong collaboration, teaching practices, knowledge and seamless delivery of care were highly commended by the assessor. Miramichi Public Health services is well on its way to become the first BFI designated community health service in the province of New Brunswick. (Public Health Services)

Home Phototherapy

As described above, the Home Phototherapy has had many positive outcomes - shorter length of stay, parent satisfaction, cost effective, ability to empower parents to be involved in their baby's care. (Obstetrics/Perinatal Care Services)

Clinical Guideline Application to Appropriately Determine Who Needs White Blood Cell Growth Factors

The American Society of Clinical Oncology (ASCO) clinical guideline for appropriate use of white blood cell growth factor was adopted by the Horizon Health Network, Zone Fredericton Oncology Service to minimize the incidence of (febrile) neutropenia, to avoid patient hospitalization, and to keep patients on track with their treatment, especially in the adjuvant setting, to give the patient the best possible treatment outcome. ASCO's clinical guideline form was adopted and implemented as a two-part form (a copy for the patient's chart and a copy for Pharmacy). The data captured on the form is entered into a data base. Data are periodically analyzed to capture practice patterns. Findings from the data helped the Oncology Service identify that white blood cell growth factor support was not consistently offered to patients on protocols that are known to produce a > 20% risk of febrile neutropenia. Team discussion helped the Oncology Service understand practice objectively in this area and lead to a change in practice with greater awareness of the role that white blood cell growth factors play in the patient's

care. The impact has been less need for dose delay and hospitalization for those patients on protocols that produce a > 20% risk of febrile neutropenia. Avoidance of dose delay, especially in the adjuvant setting, is critical to ensure the best possible treatment outcome for the patient. (Cancer Care and Oncology Services)

Infection Prevention and Control MRSA Outpatient Clinic

The IPC MRSA Outpatient Clinic has allowed for improved education of MRSA positive individuals and families living in the community. This has served to overcome confusion, fears, and the stigma that MRSA positive individuals often experience following determination of their MRSA positive status. In certain settings, such as recurrent MRSA infections, attempted decolonization may be warranted and this may be coordinated through the clinic. Individuals may be decolonized medically, or spontaneously decolonization may occur. Through the Outpatient Clinic, the MRSA status may be tracked and updated in order to allow for more efficient utilization of inpatient resources should the individual require admission to hospital at a later date. The clinic has also been instrumental in recruiting for and coordinating a randomized-controlled trial studying the impact of topical and systemic decolonization protocols. The clinic is dynamic and accommodating to other departments, for example, high-risk MRSA-positive surgical candidates may be decolonized in a peri-operative fashion to decrease the likelihood of peri-operative MRSA-associated complications. The clinic has improved education among other professional groups in the community, such as physicians, nurse practitioners, Extra Mural,nursing, and the nursing home sector. We have seen an increase in community acquired MRSA and in this regard, the clinic is able to track, screen, educate, decolonize and monitor these patients and families. Analysis of the findings is done and strategies for the sharing of this information with appropriate stakeholders (such as Public Health) is being developed. (Infection Prevention and Control)

Horizon Health Network Research Ethics Board

Horizon Health Network is the only health authority in Canada to successfully implement a centralized research ethics review process replacing the four separate and differently-operating systems that existed prior to amalgamation. The Horizon Health Network REB (Horizon REB) became operational in October 2009 following an extensive prospective analysis of the needs of the newly formed regional health authority and serves one of the largest catchments in Canada and covers the largest geographic area.

The Horizon REB is one of the most efficient, requiring on average only 40 days for a full Board review and 10 days for expedited reviews from submission to decision. The REB meetings are scheduled every 3 weeks though the frequency is regularly evaluated and adjusted based on the number of submissions received with the goal of minimizing turnaround times.

To ensure the high quality, consistency and communication of ethical reviews, Horizon is the only institution in Canada to employ a full-time REB Chair. The membership composition exceeds the minimum requirements and reflects the diversity required to conduct rigorous research ethics reviews.

The REB ensures all research conducted throughout the Region or by researchers affiliated in any way with Horizon Health Network conform with the highest scientific and ethical standards prior to the initiation of the research. It also ensures that safeguards are in place to provide the greatest protection to patients and members of the community who serve as research participants. It currently oversees over 300 active research projects involving over 1700 participants.

The efficiency and effectiveness of the Horizon REB is regularly evaluated through monitoring of annual reports from principal investigators, serious adverse events and Board turnaround times. (Effective Organization)

Medication Care Plan Manager (MCPM) Providing Medication Reconciliation at Discharge

Less time is spent generating the reports to patients, physicians, etc and the flexibility of the program allows for more detailed information to be included in the reports. It is a more user-friendly program compared to the old software, allowing more people to be trained to use it. Most importantly it has the technical support of our in-house IS department, which allows for regular maintenance, and the ability for further improvements as our pharmacy practice evolves. (Medicine Services)

Overview by Quality Dimension

The following table provides an overview of the organization's results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	145	9	3	157
Accessibility (Providing timely and equitable services)	177	9	2	188
Safety (Keeping people safe)	672	54	45	771
Worklife (Supporting wellness in the work environment)	227	8	1	236
Client-centred Services (Putting clients and families first)	311	9	9	329
Continuity of Services (Experiencing coordinated and seamless services)	107	1	0	108
Effectiveness (Doing the right thing to achieve the best possible results)	1060	81	38	1179
Efficiency (Making the best use of resources)	105	8	1	114
Total	**2804**	**179**	**99**	**3082**

Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	87	4	0	91
Effective Organization	105	0	0	105
Infection Prevention and Control	92	8	3	103
Mental Health Populations	63	6	0	69
Public Health Services	111	3	1	115
Ambulatory Care Services	112	4	4	120
Biomedical Laboratory Services	41	11	0	52
Blood Bank and Transfusion Services	99	0	65	164
Cancer Care and Oncology Services	102	7	1	110
Case Management Services	100	0	3	103
Community Health Services	49	19	0	68
Critical Care	103	4	3	110
Developmental Disabilities Services	90	1	0	91
Diagnostic Imaging Services	101	2	1	104
Emergency Department	102	5	0	107
Home Care Services	90	2	3	95
Hospice, Palliative, and End-of-Life Services	131	2	1	134
Laboratory and Blood Services	160	16	0	176
Long Term Care Services	109	5	7	121
Managing Medications	108	27	0	135
Medicine Services	93	11	0	104
Mental Health Services	102	8	1	111
Obstetrics/Perinatal Care Services	112	5	2	119
Operating Rooms	99	3	0	102
Rehabilitation Services	95	8	0	103

Reprocessing and Sterilization of Reusable Medical Devices	86	10	3	99
Substance Abuse and Problem Gambling Services	101	1	1	103
Surgical Care Services	94	7	0	101
Telehealth Services	67	0	0	67
Total	**2804**	**179**	**99**	**3082**

Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

Criteria	Required Organizational Practices
Infection Prevention and Control 1.2	The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends, and shares this information throughout the organization.
Cancer Care and Oncology Services 15.5	The team implements verification processes and other checking systems for high-risk activities.
Critical Care 12.5	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Emergency Department 10.4	The team uses at least two client identifiers before providing any services or procedures.
Long Term Care Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.
Long Term Care Services 12.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Long Term Care Services 16.4	The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.
Managing Medications 3.4	The organization standardizes and limits the number of medication concentrations available.
Managing Medications 3.6	The organization evaluates and limits the availability of narcotic (opioid) products and removes high-dose, high-potency formats from patient care areas.
Managing Medications 10.2	The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.
Managing Medications 18.3	The team uses at least two client identifiers before administering medications.
Medicine Services 4.4	Staff and service providers receive ongoing, effective training on infusion pumps.
Medicine Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Medicine Services 15.2	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Mental Health Services 7.6	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.

Criteria	Required Organizational Practices
Mental Health Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Mental Health Services 15.3	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Obstetrics/Perinatal Care Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Rehabilitation Services 7.4	The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.
Rehabilitation Services 11.3	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Rehabilitation Services 15.2	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Rehabilitation Services 15.4	The team informs and educates its clients and families in writing and verbally about the client's and family's role in promoting safety.
Surgical Care Services 11.4	The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Planning and Service Design

Developing and implementing the infrastructure, programs and service to meet the needs of the community and populations served.

Surveyor Comments

The organization engaged in a comprehensive strategic planning process to develop its mission,vision ,values and strategic plan.There were numerous inputs into the process by multiple internal and external stakeholders.

The Board received its first annual report this June with respect to achievements of strategic goals and objectives.

Board members report that they receive sufficient information to inform them about all issues where a decision is reqired.They also report that they receive this information well in advance of having to make the decision.

The organization has yet to complete a comprehensive needs assessment; however, there are communities within zones where a needs assessment has been completed and a comprehensive environmental scan was completed as part of the strategic planning exercise.

There are multiple community partners at all levels of the organization. Community partners speak positively about these partnerships in terms of mutual respect among the partners,equitable division of work and good communication.

The transformation in Horizon Health Network is supported and or lead by an innovative mechanism called the Health Services Transformation Team. This team is committed to the modernization and transformation of Horizon's programs and services.

Operational plans are aligned to the strategic plan and reports go from the program or service to the relevant vice-president to the Board. Dashboards are used for reporting.

The organization uses multiple processes to manage change. Examples include formal education on change management to select managers who will champion the change as well as many activities initiated by the Health Services Transformation Team.

Tools are utilized to monitor the implementation of plans; however, many of these are manual. It is strongly suggested that these should be automated.

Public Health gathers information about the population on a regular basis primarily from secondary sources. A formal needs assessment has not been conducted.

Evaluation is built into all new program development in Public Health.

Horizon has a coordinated response to the pandemic with an overall community immunization rate in excess of 70%.

Overall leadership for Public Health is primarily at the provincial level .

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Public Health Services		
The organization carries out a complete community health assessment every three years.	1.1	
The organization reviews the community health assessment every year and updates it as necessary	1.2	

Resource Management

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

Surveyor Comments

Resource decisions are made using a value lens tool.

Financial results are monitored monthly be the Finance Committee of the Board. There is good Board discussion regarding financial issues.

There is evidence that the organization has advocated to Government for increased resources when there has been a demonstrated need.

There is good co-operation and a good relationship between the Regional Health Authority and Government with respect to fiscal resources.

Financial policies and procedures are zone specific. Work is underway to integrate these policy sets.

Global budgeting is in place and the organization leaders have the capacity to move resources within the organization.

There are some issues with the allocation of resources related to provincial Public Health provincial and Public Health within Horizon.

Comprehensive budget planning processes are in place through an annual business planning cycle. There is evidence of involvement of stakeholders at all levels of the organization as the Horizon budget is built from the ground up.

The main priority over the past couple of years has been to sustain the funding that has been allocated. This year the emphasis is to understand fixed costs or costs over which the organization has little control, such as increases in volume.

The Board has identified that one of its main challenges is to provide quality services within available resources.

There is sound fiscal leadership in the organization.

No Unmet Criteria for this Priority Process.

Human Capital

Developing the human resource capacity to deliver safe and high quality services to clients.

Surveyor Comments

1. The relationship between the Board and the chief executive Officer (CEO) is excellent as is the Board's relationship with and trust of the members of the Executive Management team.

2. Human Resources is developing an organization wide competency-based position/performance management framework. It is being applied to every position in the organization (600+ positions). The Health Human Resources Strategic Plan provides the framework to enable the right manpower to provide health care that is safe, effective and efficient. It also contains key performance indicators to measure and monitor progress.

The span of control for nurse managers is too broad and needs to be reviewed.

The development of a human resource information system is critical. The current systems from the four previous regions are difficult if not impossible to manage.

The Board Chair acknowledged that no action has been taken to develop a Board evaluation process because of other competing priorities. The Board Governance and Nominating Committee has agreed to work on the development of an evaluation process.

Volunteers are an important part of the organization. Currently more than 3500 individuals across Horizon Health Network volunteer their time and talents visiting patients, running errands, escorting patients to a variety of clinics and acting as mock patients at the new Dalhousie Medical School New Brunswick Program. Additionally, 20 Foundations and many auxiliaries raise millions of dollars annually for Horizon Health Network's facilities and program needs.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Sustainable Governance		
The governing body has a process to elect or appoint its chair.	6.2	
The governing body has a process to regularly evaluate its performance.	7.1	↑
The evaluation includes an assessment of the governing body's own structure, including size and committee structure.	7.2	↑
The governing body reviews the contribution of and provides feedback to individual members.	7.3	

Integrated Quality Management

Continuous, proactive and systematic process to understand, manage and communicate quality from a system-wide perspective to achieve goals and objectives.

Surveyor Comments

The structure and framework for Integrated Quality Management is in place.

Dashboard reporting to the Board is being done through the appropriate committees.

Awareness of patient safety is very evident across the Network based on past zone and present initiatives.

Regular reporting in the "Network" format should replace reporting in the zone format.

As part of the Board Finance Committee dashboard, the performance dimensions of Achieving a better balance, Enhancing Access, Improving efficiency, Making quality count and Population health are regularly reported to the Board. Performance indicators are developed using information readily available in many parts of the organization.

Horizon Health Network has developed a Quality Management framework within the organization's Health Services Planning,Quality and Research portfolio. Sample reports were provided as was a reporting schedule. The reports will be provided to the Board Health Planning and Delivery Committee by the Vice-President of the Portfolio for Quality Improvement and Safety

A Patient Safety Plan has also been developed and is in use as is a Risk Management Plan. The Patient Safety Culture Survey was completed by a large number of staff and a plan is in place to address all high priority flagged items. It will take some time to address all of the items.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

Horizon Health Services has combined the four former Regional Ethics Boards into a single Regional Ethics Board accountable directly to the Board of the Horizon Health Network.

Regional Ethics Services provided 47 educational opportunities for staff, physicians and the public since November 2009.

Regional Ethics Services has completed 53 consultations since January 2009.

Regional Ethics Services includes ethics education, consultation services and the Regional Ethics Board. The service also host Bioethics Grand Rounds on a monthly basis. All policies must be reviewed by Regional Ethics Services before they are approved.

No Unmet Criteria for this Priority Process.

Communication

Communication among various layers of the organization, and with external stakeholders.

Surveyor Comments

A stakeholder consultation process was used in the development of the Horizon Health Network's initial Strategic Plan.

Branding and identity becoming well known internally and externally.

Media relations are rated as very good by organization staff.

Evidence and best practice information is used extensively across the organization.

IM/IT needs to continue working with partners and stakeholders to ensure the organization's needs are being met in a timely basis in both clinical and support areas.

No Unmet Criteria for this Priority Process.

Physical Environment

Providing appropriate and safe structures and facilities to successfully carry out the mission, vision, and goals.

Surveyor Comments

During this survey seven facilities were visited to review the physical environments. These facilities included:

Dr Everett Chalmers Hospital	Fredericton
The Moncton Hospital	Moncton
Sussex Health Centre	Sussex
Saint John Regional Hospital	Saint John

St .Joseph's Hospital	Saint John
Charlotte County Hospital	St. Stephen
Upper River Valley Hospital	Waterville

These facilities were all built at different times and serve a variety of communities but are well maintained and continue to provide a safe environment for patients, visitors and staff. The physical space is generally adequate.

No concerns were expressed about client or staff health and safety at sites where construction projects or renovations are underway.

Utility backup systems vary by community. All have emergency generators regularly tested. All have access to community resource people in the event of a disruption.Security services at all sites are excellent.

Maintenance services meet or exceed requirements at all sites.

Backup utilities are available in most facilities including power, water and natural gas /heating oil.

Staff identification tags should be consistent across all sites within the Network.

Environmental impacts of hospital operations could be enhanced in some communities, such as recycling programs.

No Unmet Criteria for this Priority Process.

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

A comprehensive Health Emergency Management Plan is in place and is being updated to reflect the new organizational structure. Development of the plan includes local, regional and provincial partners.

Implementation of standardized emergency codes across Horizon Health Network's sites is in progress. There are over 100 sites that are part of Horizon Health Network.

Emergency communications is being augmented with the use of volunteer hand radio operators.

Fire safety plans are being revised to ensure applicable fire and safety codes are included.

Information management systems require upgrading including a Network wide intranet site for emergency management.

The HUGS infant abduction prevention system should be installed in those facilities where obstetrical services are provided. It is an excellent way to manage risk.

No Unmet Criteria for this Priority Process.

Patient Flow

Smooth and timely movement of clients and their families through appropriate service and care settings.

Surveyor Comments

Staff in the organization directs considerable effort to supporting patient flow throughout. There is evidence of initiatives at the department, team, facility, community and network level to enhance flow, such as bed board meetings, monitoring wait lists, linkages with community facilities, discharge planning, med continuum, fast tracking, extended hours, and improved physician consultation processes.

The Emergency Department (ED) in Moncton has established an internal patient flow committee to address increasing wait times and works with other EDs and services in the Network to support patient flow across the system. They are commended for their deliberate and frank approach to addressing increasing wait times and declining community satisfaction.

MRI hours have been increased. Radiology has a new speech dictation system that expedites reporting. Surgical patients are registered and prioritized in the provincial surgical registry. Overall, the staff is creative and collaborative across the Network in refining systems and processes to enhance flow. Patient flow activities would be enabled by additional technology.

The key issue identified in patient flow is the lack of extended care facilities for patients identified as alternate level of care (ALC). The recent opening of 35 beds alleviated the problem for several weeks, but the beds were quickly filled and the capacity issues returned. This can be compounded by the occasional closure of the Extra Mural Program because of overcapacity. There is apparently a government initiative underway to further increase the number of long term care (LTC) beds. Both Sackville and Sussex inpatient units experience overflow, primarily due to lack of ALC beds.

Surgical waits are low with the exception of orthopaedic surgery. There are lengthy waits for hip and knee surgery, more than six months, that are being addressed as much as possible through OR scheduling. It is unclear what the impact of patient's choice of physician is having on these wait times. To optimize available resources, orthopaedic cases may be moved from one referral centre to another Smaller centres are very cooperative at repatriating patients to their home communities post referral centre admission.

The ultrasound wait times are exceptionally high in Moncton (over 50 weeks). This problem was magnified by a lack of qualified staff. Recent hiring is beginning to have an impact on reducing the wait list, but there is a long way to go.

Intensive care overcapacity occurs routinely in Moncton and it is felt that it would be alleviated by an intermediate care unit, as the acuity of patients is such that they are too sick to go to the general units, but not so acute that they require ICU. A proposal has been submitted to government for an intermediate care unit in Moncton. Overcapacity also occurs in Fredericton and the ICUs work together to move patients to available ICU beds in referral centres.

Mental health care is supported by the availability of mental health nurses in the ED and mental health professionals in the community. The psychiatrist coverage is time of day dependent, and is limited in Moncton especially after 2200 hours daily.

The new Irving Ambulatory Care Centre clinics have facilitated the move of some procedures out of the OR, freeing up OR time particularly for orthopaedics that has a lengthy knee and hip surgery waiting list. There are 200 patients on each list with an approximate wait of six months). The clinics also facilitate early discharge for a variety of patients requiring follow up, including wound care, IV care and diabetes care. The eye clinic has improved the wait time for cataract surgery and has enhanced the efficiency and patient flow for eye procedures. The increase in the number of procedures through the ORs and clinics has substantially increased the workload of the diagnostic and laboratory services, significantly stretching their available resources. The increase in interventional radiology is having an impact on the Emergency Department in Moncton as their staff provides care during the procedures.

Admissions, surgical pre-admission and health records make a substantial contribution to supporting patient flow in Moncton. Health Records provide access to patient records through a well-established process and responds to over 2000 requests per year for patient records.

In Saint John, there is a significant wait time for lab procurement that is resulting in patients leaving Saint John to get timely blood work. Blood work is scheduled; there is no evidence of a walk-in process and some patients are going to Sussex to have blood work completed.

No Unmet Criteria for this Priority Process.

Medical Devices and Equipment

Machinery and technologies designed to aid in the diagnosis and treatment of healthcare problems.

Surveyor Comments

There is a complete and comprehensive Biomedical Program which spans multiple sites. Preventative Maintenance programs including records for specialized equipment that is not managed by Biomedical Engineering, such as sterilizers and equipment in Diagnostic Imaging, are excellent.

Biomedical Engineering staff and others as applicable are for the most part involved in the selection of new medical devices and equipment.

A great deal of work has been done to improve all reprocessing procedures to meet evolving standards despite challenges with space issues. Staff are well trained, have access to education programs and know their roles in patient safety. The use of flash sterilization has been limited and is being monitored.

Reprocessing activities in areas other than in SPD/ Endoscopy should be reviewed and monitored for proper use of gluteraldehyde including required documentation.

The decontamination area at St. Joseph's Hospital is very crowded with carts waiting for the cart washer. There are plans to expand the area which should be given consideration.

Hand Washing sinks in SPD at the Saint John Regional site are all hand operated and do not meet standards. In Oromocto SPD there is a lack of hand washing facilities in critical places such as decontamination.

While items for sterilization are sent across sites within the Horizon health Network, some sites provide sterilization services for others in the community such as clinics and physicians' offices. A risk assessment of this practice is recommended in sites where this occurs in as this makes the organization a 'manufacturer'.

While there are various training methods for staff involved in reprocessing and sterilization activities, a more formalized, coordinated education program across the region and certification process, such as CSA certification is recommended. This includes not only staff in SPD /CSR but in any area where high risk reprocessing is occurring such as OR/endoscopy suites.

Reprocessing and sterilization polices and procedures follow CSA standards although there are various formats at each site. This is an area of opportunity to consolidate the reference materials, policies and procedures, and forms across the Network, with modifications to account for various equipment differences, as there are excellent pockets of documents across the sites.

At Dr. Everett Chalmers Regional Hospital, the sterilization area is open almost in the direct path of a high traffic area. Separation should be considered. There is also no provision of space to allow for the quarantine of sterilized items post sterilization. Freshly sterilized items should be quarantined before they are distributed to allow for the biological indicator testing to be completed. This situation is the same at Oromocto Public Hospital.

Use of sharp towel clips at Oromocto should be discouraged. These are known to result in multiple small holes in linen which can compromise the integrity of sterile packs.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Reprocessing and Sterilization of Reusable Medical Devices		
The organization conducts baseline and annual competency evaluations of staff members involved in reprocessing and sterilization.	2.5	
The medical device reprocessing department is designed to prevent cross-contamination of sterilized and contaminated devices or equipment, isolate incompatible activities, and clearly separate different work areas.	3.3	↑
The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	5.1	
The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	5.2	↑

Staff members have access to the supplies needed to support proper hand hygiene, including properly supplied and functioning soap and towel dispensers or waterless, alcohol-based hand rubs in the working environment.	5.4	
Staff members apply proper hand hygiene technique before beginning and after completing work activities, as well as at other key points to prevent infection.	5.5	↑
The team follows a detailed dress code while in the clean reprocessing area that addresses clothing, hair, jewelry, artificial fingernails of any form, and covered footwear.	5.7	↑
The team wears the appropriate and properly maintained personal protective equipment (PPE) in the decontamination area.	5.8	↑
The record allows team members to track individual items or devices associated with a sterilizer or sterilization cycle.	6.3	↑
The team verifies and documents the quality of reprocessing services provided in other areas, or by contracted services or subsidiaries.	12.6	

Horizontal Integration of Care

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Chronic Disease Management

Integration of services to meet the needs of populations across the continuum of care.

Surveyor Comments

The new Vice-President (VP) of Mental Health and Addictions signals the organizational commitment to this area of service.

There is a good array of services in the areas visited in Saint John and Fredericton.

All programs have goals and objectives and monitor indicators using a scorecard approach.

In Saint John there is a community advisory committee.

The two four bed treatment residences for youth in Saint John are an example of working in partnership to create supportive environments.

There is a good example in community mental health in Fredericton of psychiatrists coordinating care with primary care physicians.

At Centracare the team will send out members to communities to consult with providers who are struggling with the care of adults with complex needs.

Satisfaction surveys are carried out in the community mental health program in Saint John.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Mental Health Populations		
The organization bases incentives and benefits for staff and service providers on the quality of services provided for mental health populations.	1.3	
The information system is linked to evidence-based guidelines and provides reminders that identify clients in need of services or follow-up.	13.1	
During client appointments, the information system provides service providers with information about adherence to applicable evidence-based guidelines and care pathways.	13.2	
Staff and service providers use the information system to schedule appointments.	13.3	
The organization works with primary care providers, partners, and other organizations to integrate information systems.	13.4	
The organization uses the information system to generate regular reports about performance and adherence to guidelines, and to improve services and processes.	13.5	

Population Health and Wellness

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

Surveyor Comments

Horizon Health is in a challenging position in this province due to the employment challenges created with programs in Public Health having two separate employers. This provincial direction means Public Health (PH) Services were transferred to the regional structure to provide PH to the

population within the defined region while the Health Protection Branch with the inspection and legislative function and the Medical Office of Health position and authority is under the Ministry. Despite this division created by separate reporting and employers this PH service has worked collaboratively together to provide coordinated care.

These branches are co-located which lends itself to collaboration. As well they have worked hard to establish and maintain a working relationship that focuses on planning and service delivery for the population. Unfortunately this co-location within the PH regional office with two separate programs, has also highlighted the differences between the programs in terms of budget and support,which at times leads to frustration and sets up the environment for deteriorating relationships. Population needs and programming should be priority zed and resourced based on needs and not restricted to employment and labour relations issues.

There are some very visible inefficiencies created and unnecessary costs associated when each program has a separate clerical and reception staff sitting side by side working independently. This type of arrangement leads to frustrations among staff, is not cost effective and ultimately is confusing to the public. This issue needs to be addressed with population priorities and client needs as the focus.

Despite the formal lines of reporting there are several regional committees that have cross membership such as the Regional Communicable Disease Program and the Infection Control Program.The MHO and the Directors of PH for the region work closely together to plan and provide services.

In addition to this cross program linkage there is dialogue and regular meeting and planning between the directors in the previous 4 areas and the other health region that spans the province. Standard operating procedures have been developed across the 4 previous zones that now make up Horizon Health Network. While other areas in Horizon are structured differently, there should be a concerted effort to ensure planning and regular communication and collaboration across the PH programs and offices. This ensures some consistency in practice and sharing of expertise. PH provides a wealth of educational materials, groups for specific conditions and programs. There is a willingness to link to other similar disciplines in other programs to ensure patients receive consistent information and there is no duplication.

There are several intersectoral linkages evident as well, with partnerships and planning with school superintendents, District Advisory Councils and Social Development programs. PH also has representation on a District Emergency Action committee and works closely with municipal leaders and many other partner agencies including First Nations representatives. This group was responsible for development of the provincial EMO plan and worked closely together during H1N1.

Communicable Disease Management (CD) is done effectively within this partnership with the Ministry Protection branch.The CD nurses work closely with the MHO and family physician to follow and provides clients and contacts with appropriate supports and education. CD management is done in a confidential manner and well managed with 24 hour on call access as needed.
There is a defined process for incident reporting, tracking and trending and follow up by appropriate managers. Review and further staff education of what constitutes an incident would be helpful to ensure all are recognized,,documented and addressed. Currently a client fainting during immunization is documented on their chart but is not viewed as an incident. Once reported this would provide an opportunity to explore and share solutions for improved patient care.

Vaccine storage is well managed and cold chain is ensured. Most facilities have auxiliary back up and sophisticated alarm systems to ensure vaccines are safe. Vaccine practices that occur in small health centres need the same level of attention to this issue to ensure the cold chain is maintained.

The electronic file system allows appropriate provider access and is updated regularly.

The Protection side of PH is hired by and accountable to the MInistry but provides the protection components of PH. There is a formal process for inspections including a system to define risk in specific establishments. This risk assessment is utilized to schedule inspections to ensure compliance with standards and appropriate legislation. Regular reporting of inspections is done through the Ministry to ensure compliance. As well the public can access results form restaurants and public establishments through a public web site. This ensures good public awareness to issues of concern. The Protection division monitors and communicates with facilities providing a coloured level of risk with specific requirements needed to meet standards.There is authority to enforce compliance and can result in withdrawal of facility licensing until standards have been met.The public can easily rise concerns and complaints are followed up with in a timely way. There is follow up communication to the complainant when the process is complete.
Water sampling and shipping processes are managed appropriately. There are no internal lab supports as this is provided through Department of Environment.

There is a wealth of public information materials and several courses are offered including Safe Food Handling courses for restaurants and facilities handling food and preparation.

The MHO participates on provincial committees to develop policies as well as health legislation and ordinances.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Public Health Services		
The organization regularly assesses the impacts of its health promotion activities on the intended outcomes.	11.8	

Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Ambulatory Care Services

Clinical Leadership

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

Surveyor Comments

The Irving Clinic in Moncton was planned over many years with interdisciplinary involvement, including that of IPC. Staff are pleased with the input they had into the design and development of the Clinic. The design is spacious and organized such that care is progressive as you move in the clinics. Patients progress into the clinic space in keeping with the extent of the care. Patients having lab work only go in a few spaces; those having a procedure go into the clinic several spaces. Ambulatory care in Saint John is busy and space is tight. Ambulatory care in Fredericton is busy and crowded and provided in three separate areas.

The clinics have considerable breadth of service including medicine, surgery, ENT, ophthalmology, haematology, wound care, orthopaedics, urology, and plastics. Scheduling is primarily done from the physicians' offices. In Fredericton, the plastics clinic has unpredictable volumes due to unannounced non-urgent visits from other communities. This results in variable and often lengthy waits for some patients.

There are plans established for the delivery of services. An impact analysis must be done for physicians to acquire clinic time in Saint John. There are plans to move additional procedures from the OR at Moncton to the Ambulatory Care clinic. The team is encouraged to consider the impact on diagnostic and laboratory services of any changes or increase in clinic volume and procedures. A previous transfer of procedures to the clinic resulted in more OR time for orthopaedics and required additional diagnostic services time. Also, increases in interventional radiology had an impact on the nursing staff in the Moncton ED.

The teams fully understand who they serve and there is evidence of continuous improvement in meeting the needs of the patient populations in all clinics including diabetes education outreach, care of patients with inherited bleeding disorders and coordination of procedures with dentists and others. The teams are well connected to the community, including physicians' offices, Extra Mural program, Social Development, YMCA, and long term care. Patient safety is considered as a matter of course. This is evident in unit design, patient registration and use of two identifiers, patient flow, documentation, check and double check of blood products, and patient teaching.

There are spaces available at the Irving Clinic for patients requiring isolation such as for MRSA. In other centres, these patients are appropriately diverted.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Care in the ambulatory care centres is provided by an excellent and comprehensive interdisciplinary team, including physicians, RNs, LPNs, pharmacists, clerks,ortho techs, laboratory and diagnostic imaging staff, students and some volunteers.

Staff receive a thorough orientation to the unit and to new products, equipment and procedures and have the skills and experience for the clinical focus, such as clinical diabetes educators, minor surgery, opthalmology. Staff receive performance appraisals and are recognized in a variety of ways for their contribution, including service awards, thank yous, acknowledgement of education achievements, and unit events.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.5	

Episode of Care

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

Surveyor Comments

Medication reconciliation is in place and/or in progress in ambulatory clinics and aligns with the process in Emergency Departments and inpatient units. Pharmacists have been involved in the medication reconciliation planning process.

The team has processes in place to assist patients to find a physician, particularly in cases where the patient has diabetes. Wait lists are short for ambulatory care and are monitored. Physicians' offices do the bookings and early cancellations are most often filled from the physicians in office wait list.

The units appropriately stocked with supplies and equipment is maintained. Central SPD provides the sterile supplies and there are preventative maintenance procedures, including documentation in place for equipment. There are well understood procedures in place for the procurement of equipment and they are well-equipped and have received some new acquisitions such as a mini C-arm in Saint John Clinic.

Patients and families are well prepared and supported through the entire episode of care from admission through discharge and follow-up. Discharge teaching is completed and patients are provided written instructions. There is evidence of staff providing individualized care and patients are well-pleased.

The clinics have the needed equipment and equipment requests are planned and submitted for consideration. A mini C-arm was recently acquired for the Saint John dermatology clinic. Local Foundations are instrumental in providing funds for a lot of patient care equipment.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team follows the organization's established policies on storing and disposing of medications safely and securely.	11.6	↑
The team records, stores, handles, and disposes of medication samples and experimental medications in the same manner as any other medications.	11.7	↑

Decision Support

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

Surveyor Comments

Documentation is thorough and records are appropriately secured. The team would benefit from additional information technology for the development of schedules and point of care documentation.

The team is continually improving the quality of ambulatory care guidelines to ensure that they are evidence-based and reflect best practice, such as in wound care,diabetes care, endoscopy, post procedure care, and care of bleeding disorders. It is a challenge to harmonize the guidelines across Horizon Health. However, they are working together across the Network.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies its needs for new technology and information systems.	15.1	

Impact on Outcomes

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.

Surveyor Comments

There are linkages in the broader Network, particularly at the management level.

Indicators of risk to both patients and staff are monitored and actions are taken. Staff do not have safety-engineered needles.There is evidence that the team looks both internally and externally at opportunities for improvement and reviews and refines performance in the interest of individuals and groups of patients through literature reviews, collaboration across the network, and with external organizations such as IWK and QEII.

There are falls prevention strategies in place. The ophthalmology area was designed to meet the needs of the visually impaired with handrails and distinct flooring.

No Unmet Criteria for this Priority Process.

Biomedical Laboratory Services

Diagnostic Services - Laboratory

Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

Documents are present and used by the staff.

The Share Point software is a very good tool to disseminate and standardize information.

Standardization of the laboratory request forms is required.

The relationships with all the laboratory users via a more formalized structure is needed.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The laboratory has a standardized request form to collect all of the necessary information about the client, the sample(s), and the requested analyses. CSA Reference: Z15189-03, 5.4.1	1.3	
The request form complies with national, regional, or local requirements. CSA Reference: Z15189-03, 5.4.1	1.4	
If tests are performed outside the laboratory, the appropriate individual applies the same processes and procedures as used in the laboratory.	4.7	↑
The authorized laboratory staff member verifies the appropriateness of the laboratory's analyses. CSA Reference: Z15189-03, 5.6.1	4.8	
The organization has defined those situations in which testing and analysis may occur outside the laboratory.	6.1	↑
When monitoring point-of-care testing, the laboratory performs quality control checks on each analysis.	6.3	↑

The laboratory follows its reporting processes for both interim and final reports, as well as for results from referral laboratories. CSA Reference: Z15189-03, 5.8.9	7.7	
The laboratory provides reports to the appropriate individuals within the agreed upon turnaround time. CSA Reference: Z15189-03, 5.8.2, 5.8.11	7.12	
The laboratory informs individual requesters of analyses of their utilization patterns.	8.2	
The laboratory monitors results and analyzes trends.	8.3	
The laboratory uses this information as part of its quality management system to make improvements to future services.	8.4	

Blood Bank and Transfusion Services

Blood Services

Safe processes to handle blood and blood components, from donor selection and blood collection through to providing transfusions.

Surveyor Comments

There are excellent blood distribution services at all sites.

No Unmet Criteria for this Priority Process.

Cancer Care and Oncology Services

Clinical Leadership

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

Surveyor Comments

The Oncology networking group has been meeting to look at policies and procedures, standards of practice and models of care, utilization management, financial monitoring,best practices, resource management, physician practice, education, liaison with academic settings, and risk management. For some of the topic areas, they have just been recognized and minimal discussions have occurred.

The networking group has identified seven policies and procedures that they are working on to standardize. The networking group is encouraged to continue its work; however, It will be important that the networking group is multidisciplinary and includes physicians and other clinicians such as nurses, pharmacists and social workers in its activities. Consideration should also be given to including clients in activities to help ensure their perspective is reflected.

New Brunswick Cancer Care has prepared a report on the incidence of cancer in New Brunswick. The report provides important information on the types of cancer occurring in New Brunswick and can be used to help identify opportunities for cancer prevention and requirements for the treatment of cancer. New Brunswick Cancer Care also monitors and reports on wait times for radiation therapy (within 4 weeks of being ready to treat) and cancer surgery wait times (median and 90th percentile). This information is provided on their website.

The Moncton Hospital has data on services provided through its tertiary program. The program provides services to a large number of patients from outside of Region 1. The data show an increase in the number of outpatients while the number of inpatients has declined. This is consistent with the increased levels of activity that are being seen in the outpatient oncology clinic and the strains that are being placed on the clinic areas.

Horizon is encouraged to work with New Brunswick Cancer Care, Vitalité and the Canadian Cancer Society in the development of a strategic plan for cancer services in New Brunswick. The strategic plan should encompass cancer prevention as well as cancer diagnosis and treatment services.

In view of the establishment of two health regions for the province, it would be timely to review the recommendations in the New Brunswick Cancer Network (NBCN)report, A Cancer Control Accountability Framework, to assess whether the recommendations in the report are still relevant. Cancer screening activities should be strengthened and the variability in participation rates in cancer screening activities such as mammography should be addressed.

There is a need to move from an individual hospital and zone level planning to a province wide/system level planning for services. For example, in the Moncton area consideration should be given to whether there are sufficient numbers of cases for a breast health program at both The Moncton Hospital and Vitalité and whether, for improved quality of care, the program should be focused at one site.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team's goals and objectives for its cancer care and oncology services are clearly written, measurable, and directly linked to the organization's strategic direction.	2.2	

Competency

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

Surveyor Comments

Volunteers are actively engaged in supporting the program.The strategic plan for cancer prevention and care services should include the requirements for staffing, space and equipment.

The current area used for mixing chemotherapy agents needs to be reviewed to ensure that it meets requirements for an aseptic area and provides the required protection for staff that are working in the area. A risk assessment needs to be done whether it is acceptable to continue with the mixed/dual use of the space and whether the measures currently used by staff to establish an aseptic area are sufficient in the interim.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.6	
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.8	

Episode of Care

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

Surveyor Comments

There is a strong multi disciplinary team that has good working relations with other specialists at The Moncton Hospital to respond to their clients' needs. There are established referral mechanisms for referring clients to Halifax and other centres.

A primary care nurse works with oncologists and provides an important link for clients in their care. LPNs are used to their full scope of practice while pharmacists and pharmacy technicians play important roles as well in supporting clients.

Intellidose is used by the pharmacists in calculation of dosages for chemotherapy. Horizon is encouraged to look at the availability of Intellidose or equivalent across all zones.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team meets legal requirements and standards of practice when administering medications and other therapeutic technologies, including radiation therapy.	10.7	

Decision Support

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

protocols have increased costs associated with them such as requiring increased travel by a client, funding support is available to the client to offset the increased costs. The availability of the funding is not mentioned until the client has decided to participate in the study. This is done to avoid any potential influence from the offer to reimburse for costs. One client indicated that they decided not to participate in a trial that they were informed of because of the impact of the increased travel costs given their limited budget. As they had decided not to participate in the research trial, they were not made aware of the available funding. The team is encouraged to look at this issue of how to present information to clients about the travel support so that it is neither a barrier nor an incentive to participate in research trials.

Horizon Health has recently increased the support it provides for research and clinical trials.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

There is wide variation in the outcomes that are achieved across the various zones in Horizon. For example, the participation rate for breast cancer screening rates from 45% to 72% across the zones. There is a variation in the resources provided for cancer prevention and services.

There is a need for the development of province wide standards. Horizon is encouraged to work with New Brunswick Canadian Care and Vitalité.

Horizon is encouraged to report the data on wait lists for cancer services in manner that is consistent with the approach used by New Brunswick Cancer Care.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team implements verification processes and other checking systems for high-risk activities.	15.5	↑
The team evaluates the verification processes and uses information to make improvements.	15.5.3	
The team compares its results with other similar interventions, programs, or organizations.	16.3	↑
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.	16.4	↑

Case Management Services

Clinical Leadership

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

Surveyor Comments

Three sites were visited for case management - Saint John, Oromocto and Moncton. They are all part of the Extra Mural program developed by the province. Program guidelines outline the clients who are eligible for the service. Sites also track the type of clients that are referred to their program.They also utilize CHI data to plan for and evaluate the communities in which they provide service.

Service planning is done with partners such as schools, hospitals, physicians and others. Referrals may be received prior to surgery so that planning for acute discharge and follow up can be initiated timely and effectively. Team is very key to the success of this organization. That is what they are most proud of. There is a team coordinator. The planning and delivery is centred around the client, and anyone who is needed to ensure that success is achieved is part of the planning and service delivery. Care plans are developed with the client and goals are agreed upon. The goal is to return to self management.|Outcomes are monitored with the client. The team supports one another. The offices are set up to enhance collaboration among the teams. Hospital liaison nurses are key to promotion of the organization and the services it can provide. If they do not provide a service, clients are referred to other services for assistance. Best practice is the standard expected and continual upgrading is encouraged. Incident reporting is in place and lessons learned are shared with all staff.

Although staff receive safety training in orientation and annually, and are well aware of how to assess risk and what to do in situations and experienced staff mentor new staff, it would be beneficial to have a policy and procedure developed which clearly outlines the processes to identify risk, establish the plan and a formal check in mechanism to ensure safety when staff are working. They have started working on the home risk assessment tool.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Job descriptions are clear regarding roles and responsibilities. Scope of practice is developed. Practice leads are in place and links with professional associations are developed. Practice councils are utilized as part of current and future practice development. The interdisciplinary team is encouraged. It is evident that it is the way they practise. Everything is for the well being of the client's needs.

They are open and receptive to new ideas. Best practice is the norm and the expectation. Education needs assessments are being utilized to make decisions. The preferred delivery method based on adult education principles is included.

A very thorough orientation is provided. Staff feel very comfortable in requesting assistance at any time. Mentorship is provided. The buddy system is also utilized for staff development. Training and guidelines exist for all equipment including training on Infusion pumps training and expectations for documentation. It is a learning environment. Performance appraisals are completed for all staff .This is an ongoing process not just an annual expectation.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Clients are aware of the organization and are provided with the information as to how to contact the organization as well as how to access emergency services when needed. Client referrals are screened and prioritized based on risk and need. Work assignments are shared based on client changes. Literacy education and language options are available based on client needs. Although the referral may specify only one service if the primary care lead identifies other needs, they feel free to seek out other services such as in the school program and in the community programs.

Service is available 24/7. An answering service is in place. Care planning is done with the client and caregiver and agreed upon goals are established. An effective system for transfer of information exists between providers. A best possible medication history is taken and verified with pharmacy, the physician or referring site. A new pilot with pharmacists in the community has been piloted and the organization hopes to implement it in the future to enhance medication reconciliation across all the extra Mural Programs.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

Records are managed according to policy. Confidentiality is met. IT training is provided. As needed support is also provided on request. Research is encouraged and undertaken. University of New Brunswick (UNB) Practice Councils exist to share practice, look at improvement and plan for new initiatives. One example of this is Optimizing Diabetic Wound Management.

Consolidation of separate IT systems is in the planning phase. It is difficult to produce indicator data and a dashboard with separate systems. At this point with manual systems, the collection of indicator data varies from zone to zone.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

Within the constraints of a manual system, population service delivery plans are developed, service is provided, and best practices are implemented. Where possible, outcome measures are developed and collected, audits are completed, and client satisfaction surveys are completed.

Incident reporting is done and outcomes are reviewed with staff. There is a process to prioritize clients waiting for service. Events are tracked including near misses. Feedback is shared at meetings, as announcements. Satisfaction surveys are under development

Across Horizon Health, because of the varied IT systems it is not possible to have a coordinated dashboard whereby indicators can be collected and compared. This hampers the ability of the programs for amalgamation and comparison. Everything is currently manual.

No Unmet Criteria for this Priority Process.

Community Health Services

Clinical Leadership

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

Surveyor Comments

There was a formal community needs assessment done for the health region. While this is useful at a high planning level, there needs to be some development done to ensure all communities have a more localized and community specific assessment done. This will assist with appropriate planning. and service development. There are some independent community needs assessments conducted informally. These need to be better coordinated to ensure consistency of approach and next steps in the process.

Community linkages are good and extend to schools, Public Health (PH) and other internal programs. Many community health centres have c community development staff who assist with programs such as support groups and various peer lead groups. These community developers meet regularly to ensure they "have their finger on the pulse of the community".

There are excellent student placements in a variety of programs and various health professionals and others quickly become part of the team.

Increased management support and guidance in the smaller more rural health centres would assist and guide the on site managers. This will ensure critical safety issues are recognized and addressed immediately. While practices such as a laxity of keys for drug cupboards has occurred for so long it seems commonplace, these issues need immediate resolution. In Petitcodiac, all staff in the facility including clerical staff had keys to the drug cupboards. While two narcotics were in a separate cupboard the staff had ready access to the balance of the drugs in the facility,including a large and open room of samples. This is a potential liability for the organization and needs leadership intervention and direction to ensure safe management. Staff and physician education sessions need to be done immediately on the safety issue and this issue needs to be addressed by management.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team’s goals and objectives for community health services are measurable and specific.	2.2	

The organization provides support to the team to deliver quality community health services.	2.5

Competency

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

Surveyor Comments

Each community centre varies in terms of interdisciplinary team makeup and is more tailored to their communities needs. There is good sharing and collaboration amongst team members. While some staff areas are a bit congested, efforts are made to ensure there is adequate shared space where needed and communication between the providers happens both formally and informally. Some of the health centres have electronic medical records such as Purkinje. This allows for shared charting and progress reporting and the sharing of assessments and planning for each patient.

Some smaller health centres such as Petitcodiac have minimal electronic charting and rely on the paper chart primarily. As there are two spots where information can be stored this has the potential to cause confusion. There is a risk of missing key documentation. A thoughtful plan and process needs to be developed to ensure staff utilize a consistent process for inserting patient information and test results.

While there is some effort to evaluate the team improvements this needs to be done more formally and specific and measurable outcomes need to be identified and monitored to understand areas for improvement. There needs to be mandatory safety and medication management training at orientation and on a regular basis to all staff in facilities where this is not occurring.
St Joseph's Community Health Centre has a comprehensive orientation program to ensure all staff are familiar with processes in the organization. Smaller health centres have a less formal and structured orientation. Efforts be made to ensure health region wide information is shared consistently across the organization.This is critical in IPC and patient safety policies and protocols.
Staff enjoy several development opportunities and can participate through several mediums.

While in the larger health centres such as St Joseph's there is a formalized plan and process to identify time lines and completion for completing regular performance reviews. This process needs to be formalized within the smaller facilities.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	

Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.7

Episode of Care

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

Surveyor Comments

Community clients felt that while in smaller communities they were aware of the services but there was not good formal communication from the organization to the public. New community members indicated they were not aware of where to get information and had seen none with the exception of in the facility itself. Encouragement is given to utilize a broad communication approach when informing the public about health services and programs offered.

Services are often provided in conjunction with community groups and at alternate locations within the community to encourage access and participation. In several of the health centres space was provided to partnering organization that would offer support to clients. Food security programs GED education, methadone programs and others were available within facilities by partnering programs and agencies.

There does not appear to be a formal complaints process. Clients were not aware of any process but most felt they would either talk to the person in charge or forget about it. None were aware of any concerns that had been brought forward and if or how they might have been addressed.

There appear to be reasonable records and monitoring of program participation and attendances in the various programs across the region. However the individual client records of those receiving services is not consistent. St Joseph's and Riverside Albert have well documented, current patient charts and records of activities. Test results, referrals, discharge summaries as well as medication lists were all current in these organizations.

The smaller facility of Petitcodiac has some significant issues with chart maintenance. There appears to be inconsistent placement of lab results, referrals and patient information due to some information being housed electronically and other information copied and put into the paper chart. A process needs to be developed to ensure there is a clear and standardized process used for management of patient records. Staff and physician education is needed in this process. Medication sheets in this facility were very outdated and while there often was a copy of the prescription on file the medication list on the front of the chart had not been updated for many years.

The facilities visited had secure client records with the exception of Petitcodiac Health Centre. Client records and information were in an area where client also received periodic injections. More of concern was the lack of security for the entire records area. This area is beside the waiting room and while behind the reception counter, it has no door . During the evening there is a dentist using the waiting room for his clients but no one manning the front desk. This leaves the patient records readily accessible for whoever is sitting in the public waiting room. This needs to be addressed and charts immediately secured.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team develops standardized processes and procedures to improve teamwork and minimize duplication.	3.4	
The team gives members of the community, service providers, and referring organizations information about the organization and its services.	6.2	
The team has a process to handle complaints that is open, transparent, and easy for the community to raise issues or concerns.	7.7	
The team responds to the community's complaints in a fair and timely manner.	7.8	
The team maintains accurate and up-to-date records for each community-based program.	8.1	
The team maintains an accurate and up-to-date record for each community member receiving community-based services.	8.2	
The team keeps records confidential and secure.	8.5	

Decision Support

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

Surveyor Comments

There are unmet technology needs within the more rural sites regarding patient records and documentation. Additional technology such as charts on wheels (COWs)) and laptops would assist providers to ensure information is entered in a timely way and is available to providers.

There needs to be more education for staff and physicians and efforts on reviewing best practice guidelines and sharing of resources to establish guidelines. Where present, guidelines are discussed with staff and input sought for their delivery.

There is some availability of up to date and current information and resources that would assist staff in planning services. Assurance that more rural sites have access to the information will ensure practices across the region are consistent as knowledge is gained.
There are also opportunities for staff to attend conferences to keep abreast of new initiatives.

Although minimal research occurs within community services, where done, staff understand the ethics protocols and have access to ethicist experts as needed.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization has a process to select evidence-based guidelines for populations in the community.	10.1	
The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	10.2	
Staff and service providers communicate the evidence-based guidelines, research, and best practice information to the community.	10.7	

Impact on Outcomes

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.

Surveyor Comments

The community services reviews its existing programs and makes adjustments or additions as new needs are identified. Resources are identified.

Closer communication and linkages with like services across the region would allow resources and expertise to be shared. Where best practice has been identified, the community partners are aware.

There needs to be a broad communication plan developed to ensure communities are aware of the services and supports offered. Clients seemed unaware of many services unless they happened to be in the facility. All felt public notification of programs was lacking.

Increased training and staff education needs to be done to ensure all facilities have regular safety training and to be able to recognize and reduce risk areas to improve safety of both staff and patients.

All community health centres appeared to have incident reporting occurring. This reporting has improved over the past year in the smaller facilities and staff are encouraged to continue with this practice. There is reporting of these incidents to management and a tracking of this is reported to the senior leadership. Staff can complete the incident reports on line in some facilities and if paper is used the forms are standardized.

There is a disclosure policy and staff are aware of and have utilized it as needed. Continued support and education is required to ensure this is used consistently.

While there is some utilization data gathered the organization is encouraged to formalize the evaluation process and develop measurable outcomes so that improvements can be monitored and tracked.

There have been some client satisfaction surveys completed from various community programs and a suggestion box was in place in St .Joseph's. A standardized satisfaction survey needs to be used across the region and results compiled and utilized for future service planning. Evaluation and satisfaction surveys need to be shared with staff and clients. The organization is encouraged to seek out opportunities to share some of their good work .

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team makes the community aware of its services.	6.1	
The team is trained to identify, reduce, and manage risk.	11.1	↑
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.	11.2	↑
The team identifies and monitors process and outcome measures for its community health services.	11.5	↑
The team shares evaluation results with staff and the community.	11.10	

Critical Care

Clinical Leadership

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

Surveyor Comments

Critical Care services were visited in Moncton, Fredericton and Saint John.

A regional team came together to review the roadmaps following the self assessment for accreditation, to compare practice and to share best practices. The plan is that this group will continue to meet with an action plan to develop standardized practice across Horizon Health Network.

The strategic directions of the organization are known and referenced.

There is a strong interdisciplinary approach to care within the critical care areas.

There is good coordination between units on the same site in Fredericton and in Moncton and between sites for referrals. Patients are transferred between units within a site and between sites as required when one area is beyond capacity.

Goals and objectives are identified but these tend to be structured as action plans and not as formally written goals and objectives. The team is encouraged to continue the regional work initiated in the review of the accreditation roadmaps for planning and monitoring of services and activities within the critical care program.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team's goals and objectives for its critical care services are measurable and specific.	2.2	

Competency

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

Surveyor Comments

There is a strong focus on recruitment with initiatives such as providing preceptors for critical care program learners, hiring students and promoting the critical care units to staff who may be interested in transferring. Recruitment initiatives have been successful.

There is a strong interdisciplinary approach to care.

Staff report feeling supported and having many opportunities for learning and professional development. Newly hired staff are provided with a structured orientation which they described as meeting their needs. Many staff have been supported to attend the provincial critical care nursing program and learners within the program spend time in the critical care units for clinical experience.

Staff and managers report having regular performance reviews.

The team is encouraged to develop a process to regularly review how they work together as a team, to celebrate their successes and identify areas where there is opportunity for improvement.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.10	

Episode of Care

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

Surveyor Comments

Comprehensive assessments are consistently completed for all patients in critical care units across the program.

Critical care staff provide leadership for the rapid response teams. Feedback from staff on the inpatient units is that the rapid response team is a valued support to them in emergency situations.

Patients and family members interviewed consistently report feeling included and well informed by the team members.

End of life care needs are identified and addressed in a compassionate and caring manner.

Dedicated clinical pharmacy is available in several program areas to support medication delivery processes which is identified as a significant support for quality of care and patient safety.

Team members utilize tools and a variety of methods to transfer information at handoffs such as transfers to another unit/facility.

The team is encouraged to develop a formal process of following up with those who receive patients from them in transfer for the purposes of identifying areas for improvement.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	12.5	↑
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	12.5.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	12.5.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	12.5.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	12.5.5	

The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	12.5.6	
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.	12.7	

Decision Support

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

Surveyor Comments

All critical care units visited are closed units provides consistency through a small number of dedicated physicians.

Documentation of care is comprehensive and accessible to team members.

A regional critical care group is working together using their accreditation roadmaps identify best practices within their program areas. The goal is to develop action plans to standardize practices across the region.

The open design of some units, with curtains separating cubicles, creates challenges in maintaining privacy and confidentiality for patients. Staff make concerted efforts to minimize the impact of this in providing care.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

The team participates in Safer Healthcare Now! initiatives which provides an opportunity for benchmarking with other organizations.

There is a consistent and strong focus on safety for patients and staff.

Evidence was provided of appropriate use of the disclosure process and use of appropriate supports for staff and family members following a sentinel event.

The team is encouraged to further develop the use of indicators to include analysis of trends and reporting/monitoring of action taken/results achieved.

The team is monitoring indicators on a regular basis. However these are not brought together in a comprehensive report with trending and analysis. Incidents are reported and action taken to address issues that arise. Examples were provided of change in practice as a result of near misses.

No Unmet Criteria for this Priority Process.

Developmental Disabilities Services

Clinical Leadership

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

Surveyor Comments

The team provides exceptional educational outreach services to parents and teaching assistants of their clients to ensure heightened discharge planning success. One example is the two-day course on Coaching Caregivers.

The team feels that successful discharge planning is often hindered by a lack of community resources and qualified therapists to meet the ongoing needs of their clients upon discharge.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team's goals and objectives for its developmental disabilities services are measurable and specific.	2.2	

Competency

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

Surveyor Comments

The team describes a wide variety of internal and external educational opportunities being offered/ supported by the organization which they describe as having a direct impact on their ability to provide specialized services on a provincial basis.

The team enjoys the innovative building design and space of the four year old facility they feel privileged to work in. They appreciate the building design efforts that were made to ensure staff offices were located on the perimeters of the facility to incorporate offices with windows. They are also particularly proud of the recently completed outdoor assessment area that will further enhance rehabilitative assessment in a variety of outdoor settings.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Services were reviewed at the Stan Cassidy Centre for Rehabilitation. The two main streams of service delivery are for children diagnosed with neurological impairments and those diagnosed with complex autism disorders. These are both offered on an outpatient basis. There is a multidisciplinary approach to service delivery, through a comprehensive and committed team of professionals who give particular praise to the physician who leads the team. The team reports significant challenges in their ability to meet the needs of children who are wait listed for as long as three years for admission to the autism program.

Team members describe their pride belonging to a dedicated, professional, supportive and truly multidisciplinary team. They give particular recognition to the inclusive and participative involvement of physicians on the team.

The innovative physical design of the facility includes transitional living suites that have all of the necessary resources for children and their families to learn, re-learn and practice necessary daily living skills to facilitate success in living as independently as possible. There are also a wide variety of assistive technology services provided to ensure individualized tailoring of adaptive and mobility devices.

The team identifies insufficient space and staffing resources to meet the current and future needs of the Children's Autism Program.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

All standards have been met.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

The new and innovative physical design of the building has included a number of features to improve team exposure to risks associated with managing aggressive / hard to manage clients such as video cameras, two way windows, emergency call systems, and ceiling lifts. The team has also implemented a related training intervention - non violent crisis intervention for autism clients.

No Unmet Criteria for this Priority Process.

Diagnostic Imaging Services

Impact on Outcomes

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.

Surveyor Comments

Strengths
There are multiple points of checking identity with the DI departments before any procedures is performed on a patient .

Radiologists do review some requests for procedures and may suggest or modify an order offering a safer or more practical alternative procedure.
Checklists are completed before high risk procedures.

Staff identify any risk factors before any procedure on a patient (pregnancy status, implants, risk to fall etc.).

No Unmet Criteria for this Priority Process.

Diagnostic Services - Diagnostic Imaging

Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

Overall, all Diagnostic Imaging (DI) departments are well managed and patient satisfaction is good. Staff and radiologists are well trained, knowledgeable and patient centred. Equipment is in good condition and up to date.

Wait times for some modalities at some sites, such as ultrasound at 50 weeks in Miramichi and Moncton, needs to be addressed. Although radiologists triage cases, they do so based on the clinical information provided which may not always be complete.

A province wide effort should be made to introduce ultrasound, MRI and other specialty courses into the education system to address staffing shortages which account for some of the wait time issues. Recruitment efforts out of province, Canada wide, could be considered for a short term solution as well as increasing hours of operation where possible.

Electronic verification systems are available at all sites and should be utilized to reduce turn around time at sites where the manual process still exists, such as in Saint John.

There is no record of the ER physician interpretation for X-rays available for radiologists for comparison or to ensure proper patient follow up. Electronic systems are available through PACS to record ER physician findings. It is recommended that the systems available be fully utilized.

Recent changes in Standards of Practice for Nurse Practitioners with regards to the ordering of diagnostic tests requires clarification. The new 'list' is very vague. There needs to be a more specific list as there was previously. If they are now allowed to order any X-ray or ultrasound this needs to be clarified. There is also confusion as to the requirement for physician consultation .

Most sites have portable ultrasound units in the ER and or other areas. There is no involvement with DI as to selection, quality control or maintenance of such equipment. Nor are there any requirements for training or policies on who can use the equipment. There are also no permanent copies of the images by which a diagnosis may be made. This practice needs to be reviewed by the organization for evidence of risk.

In smaller sites with no porters, there may be situations where patient transport to and from ER or nursing units is an issue. This may result in delays or back-ups in DI compromising patient flow. Managers are encouraged to work together for a solution.

Improved communication of new procedures, changes in procedures or alternate procedures to referring physicians is suggested to keep them informed.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies, and removes where possible, physical and systemic barriers that prevent clients or referring medical professionals from accessing diagnostic imaging services.	2.2	
Before storage, a qualified staff member rinses each DI device or piece of equipment using sterile water or water filtered using a submicron filter.	7.12	↑

Emergency Department

Clinical Leadership

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

Surveyor Comments

A review of the clinical leadership standards in the Emergency Department demonstrates the following.
The teams fully understand the community and referral population served and have designed services to meet the population needs. This is evidenced in the overall provision of care and noted specifically in the delivery of cardiac, trauma, mental health and sexual assault care.

The Emergency Department (ED) teams routinely collaborate with internal and external partners to deliver service in the Horizon Health Network, including the Extra Mural Program, corrections, mental health community, long term care facilities, and EMS.

The team in Moncton has adequate workspace in an aesthetically pleasing, recently built department that is designed to support the delivery of care and patient and staff safety. This includes space to isolate patients with known or suspected infections. At Dr. Everett Chalmers Regional Hospital (DECH), there is limited adequate space for patient isolation. Space in Sackville is tight in some areas, but well organized and utilized. Space in the Sussex ED is adequate; however, the triage and area is awkward. The waiting room is not visible by nursing staff or registration staff and is often busy. This is a safety concern, especially when the department is busy and waits are extended. There is no camera surveillance of the area.

There is adequate and well-maintained equipment in the department and the staff and physicians have had the opportunity to participate in identifying equipment needs and feel that their needs are heard.

Individual departments are beginning to work together as a broader Horizon Emergency Department Network to develop goals and objectives and align policies and protocols.

In Moncton, the department has established a patient flow team to address the increasing wait times and declining community satisfaction.The team is commended for their introspection and commitment to meeting the needs and expectations of the community. The size of the space of the new department and the division into acute, non-acute and trauma areas is responsible to some extent for an unintended consequence of longer wait times. Physician workload is also considered to be a contributor. The current physician coverage is resulting in periods of long patient waits and, while physicians are confident in the triage process, they are concerned about their capacity to get to the patients expeditiously.

Volunteers in the Moncton department are making a valuable contribution supporting the triage and registration process and the patients in the waiting room. They are well-prepared for their role and appreciated by staff.

The EDs welcome medical, nursing, and paramedicine students and residents and actively promote the career opportunity and rewards of the ED. Students and new staff are well supported in orientation, by the educator, clinical resource nurse and department staff.

The team supports the community in providing emergency nursing care at large scale events such as concerts in Moncton.

The team conducts fan-out exercises and table top exercises. (e.g.airport large scale event). The team has not participated in a full scale emergency/disaster exercise for several years and is encouraged to host or participate in an exercise locally or as part of the broader Network. Sussex did participate in a scenario last year with the inpatient unit.

There is one nurse practitioner working in the department in Moncton and another one will arrive shortly. This is a new initiative and the roles are being reviewed and defined as the position develops.

Staff sharing and coverage plans have been made in small departments, particularly for the night shift. (Charlotte County Hospital, Sackville, Sussex) Small town EDs are commended for educating all RNs in ACLS. The small centres are well connected to their referral centres and are well prepared to stabilize seriously ill or injured patients for transport. They are impacted by the changes in EMS that have occurred over the past couple of years; they are required to send nurses more often on transports and EMS carries out less complex interventions. This is most noted in Sussex where EMS providers assisted in the ED prior to the transition.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team has the workspace needed to deliver effective services in the Emergency Department.	2.8	

Competency

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

Surveyor Comments

The EDs take full advantage of the interdisciplinary team in the interest of the patient and staff in each work very well together. The team includes pharmacists, pharmacy techs, physicians, RNs, LPNs, social workers, consultants, volunteers, discharge planning, educators, a patient safety nurse, unit and communication clerks,social workers, and more. Each fully understands and appreciates the contribution of the other and works together as a matter of routine. Small centres are well connected to referral centres.

Recruitment is challenging, especially in small centres. EDs are creative in recruiting students, returnees to the Maritimes, and friends of friends. The average age of nursing staff in ED is over 50 years and the ED has had difficulty recruiting. Physician recruitment can also be challenging. Sackville has family doctors who work the department and take call overnight. Sussex has 24 hour staffing. There are fill-in casual physicians in all locations. Sussex was forced to close one night in the past year. The public was notified through radio and posted signs to go to Saint John.

New staff receives a comprehensive classroom orientation to the department and equipment and works in a buddy system for several weeks. There is considerable ongoing training and staff are recognized in a number of ways for their efforts. They are required to be ACLS certified. Many staff in EDs have the TNCC certification.

Triage nurses have a minimum of two years of prior experience in the department and while there has been some shortage and turnover of staff, the department has been able to maintain this level of experience at triage.

Staff have their credentials checked annually. They have access to e-learning and to educators.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

EDs have recently started notifying patients of the expected length of wait in ED and have prepared a triage information pamphlet for patients and families. New signs are also being created for the waiting area. The waiting room is constantly monitored by a security guard and additionally by an LPN in the evenings and often a volunteer at Moncton. The waiting area is visible from triage and registration in Moncton. Patients are routinely re-assessed and the CTAS scores are documented. The waiting area in Sackville is somewhat visible and in Sussex, it is not visible to nurses or registration staff. The signage is poor in Sussex and makes way finding difficult and confusing for patients.

Patient assessment is thorough and documented and there is an excellent process for medication reconciliation that is completed by the pharmacist or pharmacy tech and supported after hours by nursing staff and in some locations, LPNs. Families are encouraged to participate in care and patients and families are educated as a matter of course. Patients are thoroughly prepared for

admission, transfer and discharge with the appropriate transfer of patient information. There is an established process for contacting consultants and a timely response. Coverage by psychiatry is limited after 2200 hours in Moncton. Mental health non-physician professional support is available 24 hours in Sussex from the local community program.

There are mental health nurses in the department that provide care and assessment and liaison with community mental health programs. In addition, there is a comprehensive Sexual Assault Nurse Examiner Program (SANE) that provides on call resources 24 hours per day. The small centres refer/transport cases to their assigned SANE referral centres.

St Joseph's Urgent Care Centre has a strong team of staff who clearly understand the community they serve. The Centre serves primarily CTAS 4&5's although CTAS 3's do arrive at the Centre. All CTAS 2's are appropriately transported by EMS to the ED. Nurse practitioners work in the department providing care to patients classified as CTAS 4 or 5. They are supported by a physician.

EMS offload times are acceptable and the team attempts and for the most part achieves an excellent offload time of 20 minutes. The team works cooperatively with EMS and dispatch and informs dispatch if offload times are likely to be extended so that EMS can adjust accordingly. EMS monitors offload times.

Length of stay in ED is not consistently monitored across the system, especially in small centres where it has less impact on overall ED and hospital operations.

There is no consistent stroke protocol or stroke care checklist and there is evidence that there may be delays in care.

Staff are working to continually improve door to needle time in the administration of thrombolytics to MI patients and in Moncton have completed an analysis of possible causes of delay. The team is encouraged to share the information across the network.

Clients and families are highly satisfied with the care provided in the ED. Occasional concern was expressed by patients about wait times, often on behalf of a friend or family member, i.e., " I didn't have to wait, but my neighbour did". Patients did have an understanding of the triage system and said that it was explained to them.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

Many patient care and administrative processes are manual and would be enabled by additional information technology such as an Emergency Department information system, electronic patient record, and electronic order entry. This would reduce re-work, transcription errors,and facilitate department-wide patient flow strategies and monitoring of key indicators. There is an EDIS at Everett Chalmers but it is not fully integrated with pharmacy and monitors. There is no electronic charting.

The team has active and supportive physician and administrative leadership that facilitate and sponsor the review and development of guidelines. The guidelines reflect the latest evidence. The team is encouraged in its work with the broader ED network to refine and standardize guidelines and policies and measures. The team is supported by an ethicist and a risk manager in decision making and policy development.

Meaningful research, such as a retrospective review, is being conducted in the larger centres.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team has timely access to information technology that impacts client care.	13.1	
Staff and service providers use information technology to share information with the interdisciplinary team.	13.2	

Impact on Outcomes

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.

Surveyor Comments

The commitment to continuous quality improvement is evident throughout the EDs. The participation in improving care is encouraged and evident from all disciplines.

The team has historically established and monitored a number of indicators in the department and has recently been working with the broader Horizon ED network to identify and monitor common measures. The team is encouraged to develop and monitor additional outcomes measures, including those linked to specific etiologies, such as stroke care, cardiac care, and orthopaedics.

The team monitors client complaints and has established strategies to respond to increasing complaints about ED wait times, especially in Moncton and Saint John. These include posting signs, reporting waiting times, making the waiting experience more pleasant, and adding LPN staff at the triage and waiting area to greet, monitor and support patients and families.

There is a department wide commitment and understanding of the fundamentals of patient safety with emphasis on medication administration and infection control.

Staff safety is also a priority and the referral departments have 24 hour security staff and processes in place for ensuring staff safety, access to police, and response to Code White. Sackville has 24 hour hospital wide security and Sussex has evening and night security.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team uses at least two client identifiers before providing any services or procedures.	10.4	↑
The team uses at least two client identifiers before providing any service or procedure.	10.4.1	
The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.	15.4	↑

Home Care Services

Clinical Leadership

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

Surveyor Comments

The Extra Mural program is set by the province. It includes preschool, school, and adult programs through a team of professionals Four locations were visited: Saint John, Moncton, Fredericton and Oromocto. The sites themselves review local data and CIHI information to plan for the population that they serve.

Goals and actions have been developed that align with the overall strategic plan for the organization. The overall goal is to meet the client's goal of returning to be independent. Teamwork is supported. Staff resources are appropriately allocated. Staff help each other, prioritize their clients, and ensure that transfer of information occurs so that continuity of care is maintained. In some sites, a charge has been put in place to organize the team and assist with planning.

Clients receive information regarding the service and know how to call for help or where to go in an emergency as this service is not an emergency service. Literacy and cultures are respected. Safety risks are assessed in the home and planning done around the risks. They have started the planning for the home risk assessment tool. Rounds are held to consult with the team as a whole, share information and collaborate as professionals.

Although staff are aware of looking at risks for safety in the homes, and sharing that information with other staff members, a formal process to document risks and transfer that information among staff needs to be formalized. Horizon Health needs to set up a formal mechanism to ensure staff report when their shift starts and when it ends so they know they are safe. Another mechanism is needed for staff who are called out at night.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization has a procedure for reporting safety risks which arise in the client's home.	8.4	↑

Competency

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

Surveyor Comments

Job descriptions are in place for all professionals. Staff seek and are encouraged to attend education, and seek new practice. Staff believe and use evidence based best practice.Orientation is provided and staff feel comfortable to ask for help at any time.

A process exists for equipment, tagging of unsafe equipment. Pump training is provided. Performance reviews are completed, but not consistently. Staff feel that education is provided whether it is part of a new skill or a refresher for an intervention they have not done for a long time, hence not feeling competent to do until refreshed. Mentorship is also provided to assist staff.

Ensure performance appraisals are done consistently.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization regularly evaluates and documents each staff member's performance in an objective, interactive, and positive way.	4.10	

Episode of Care

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

Surveyor Comments

The staff work in teams. What is key is the fact that based on the assessment by any staff member, other members of the team are consulted. The person is looked at as a whole. There is very comprehensive assessment and planning taking place. Referrals can be sent to any member of the team that the primary care provider feels is needed for that client. Special mechanisms are in place to transfer and confirm information related to clients' service so continuity is assured.

A primary care lead is designated for all clients. It can be any professional. A pain assessment is used on all clients. Informed consent is completed. The ethical framework is in place. Sites are currently utilizing the services of an ethicist and other supports. Members of the team include nurses, PT ,OT, RT Speeach/Language ,social worker,dietician, LPN and office staff.The staff situated in acute care are also part of the team. What is unique is that clients may be seen prior to surgery and then after as well.

Ambulatory clinics exist at some sites for clients who are mobile thus avoiding a home visit. Quick response programs are being piloted and have been very effective in diverting client's from emergency. A standard pain assessment is in place. A best possible medication history is taken and verified with the pharmacist, physician or referring care giver and the client. A pilot project utilizing pharmacists in the Extra Mural Program has just been completed. If adopted it would be an enhancement to the current medication reconciliation activities and well received.The palliative program is of note because of the broadness of service and 24 hour delivery

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

Confidentiality is adhered to. An ethics framework is in place. Field staff are aware of how to identify an ethical issue and how to seek assistance when needed. This is provided as ongoing education. Specialists exist within the organization. IT system needs are being identified for the new organization.

Best practice guidelines utilized include Braden Scale, falls assessment on admission, pain assessment, palliative care symptom assessment, DNR and ARO screening on admission, IV pump training, and wound protocol. This is coordinated through the clinical specialist. The teams also identify learning needs through surveys or at team meetings and plan specific site needs. Research is encouraged and undertaken. One example is Optimizing Diabetic Wound Management with UNB.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

Informal evaluation takes place. The team is looking forward to having one data system so they can evaluate the overall program and arrange planning with other organizations. Incident reporting is completed. The learnings are shared with the staff. Transfer of client information at transfer of service is very good. A check exists to ensure other members of the care team have in fact received and read the information. Leading practice is now being shared among the organization as a whole. There is expertise all over and once pooled will provide a valuable database. There is a willingness to take the best and confirm it as the best practice.

Although the organization does collect some indicators and in fact share and utilize what they have to plan, the implementation of one system would enhance the capability of the organization to develop a robust enhanced quality network.

No Unmet Criteria for this Priority Process.

Hospice, Palliative, and End-of-Life Services

Clinical Leadership

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

Surveyor Comments

The Saint John Regional Hospital has an eight bed inpatient unit. The palliative care team is a strong team and to be commended for the service that they provide. Patients report that they were pleased with the care that they received, they were kept well informed about their condition, were advised about safety issues, including hand washing, and identification. The environment is clean and tidy. The unit runs at 100% occupancy.

The family medicine and palliative care program takes a lead in providing strategic direction for the program. Palliative care provides monthly reports, budget variance reports and quality indicators. They try to “live the goal”

There is a good relationship with both internal and external partners

The caring compassionate staff on this unit make is a special and respected place to be.

There is dedicated physician support for the program.

Consultative and pain management services to the rest of the hospital for palliative patients.

There is palliative outreach services to the community.

There is strong support for education and clinical certification.

Although, privately owned the opening if Hope Hospice, a 10 bed residential unit and the first of its kind in Atlantic Canada, will help to the need for longer term palliative care patients.

The organization has a good relationship and works well with community based groups such as Hospice and Extra Mural.

The team is strong and includes the ExtraMural liaison nurse, pharmacist, pastoral care, pharmacy and physician support. There is a strong volunteer base that supports the program. There are committed volunteers. For example, there is a volunteer who comes every Monday and bakes for the patients.

The organization is encouraged to continue to grow the regional palliative care network with common care standards.

Bed availability is sometimes a challenge. The organization is encouraged to monitor demand so as to appropriately respond to the need for palliative care services.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

Staff are caring, compassionate, competent and dedicated to excellence in patient care. There is good collaboration among team members. Staff members reported feeling good about the work that they do and know that they are making a difference for the patients on the unit. They are astute and make people feel comfortable.There is a team approach and a lot of one on one teaching and communication.

There is also evidence of an interdisciplinary team functioning well together. There is a very cooperative relationship with the extra mural program and internal departments. There is a triage committee with established admission criteria.

The team regularly reviews the role and functioning and identifies additional resources as required. There appears to be good support for each other and several people acknowledged the role of humour as a support mechanism.

There are a weekly team rounds and a complete review of new patients.

Staff is supported form an education perspective including the international conference in palliative care. Eight nurses are certified in palliative care.

The organization is encouraged to continue to find ways to recognize staff for their contribution on a unit level.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	

Episode of Care

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

Surveyor Comments

The palliative care team offers a consultation service to people who are palliative throughout the hospital. For example there were 39 consults for pain and symptom management this month and about 50 consultation visits. This gives people an opportunity to be exposed to the unit and start to develop a relationship with staff on the unit.

An episode of care was traced on one of the patients and included the admission process and care received on the unit. Both the patient and one of his family members reported a very positive experience on the unit. The chart was complete and included electronic and paper components. There were good processes in place for medication and pain management. The

patient and his family were kept informed and information was provided as needed. The team maintains a respectful and peaceful environment for its clients. This quiet respectful atmosphere on the unit and the caring and compassionate staff were very much appreciated.

There is an interruption in palliative care services provided on the unit resulting from participation in the overcapacity protocol. There is a room designated for family who wish to stay overnight when their loved one is in the dying process. During times of overcapacity this room is taken for an additional patient space. Although there is an effort to match appropriate patients to the unit it is not always possible. This sometimes results in an inappropriate placement of a non palliative patient on the unit and lack of space for family. The organization is encouraged to re-evaluate the use of the palliative care space as part of the overcapacity protocol.

There is access to a patient advocate, if required.

There is ongoing support for family members and an access to a grief recovery program. There is also an annual memorial services which is attended by about 200 people.

The team is encouraged to evaluate the location of the phone that is made available for families. It is located just off the main corridor and there is no privacy for personal calls.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Current and potential clients and their families can access palliative care expertise or essential services 24-hours a day, seven days a week.	6.2	

Decision Support

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

Surveyor Comments

Staff are encouraged to attend conferences and to keep up to date on best practices.

At times when there is a lack of available beds the physican will make a decision on the most appropiate use of the bed.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

The team works together to ensure that the end of life transition is the best possible for the patient.

There is a regular environmental audit and safety inspection on the unit. There is also a patient audit tool. The FAMCARE is mailed out to substitute decision makers after three months have passed.

Patient satisfaction is monitored regularly. If a complaint is received, it is addressed as soon as possible.

There are palliative care protocols in place as well as a best practice guideline on falls prevention. There is a focus on falls prevention when appropriate.

There is a medication reconciliation audit done three times per month.

Clinical documentation audits are monthly.

No Unmet Criteria for this Priority Process.

Infection Prevention and Control

Infection Prevention and Control

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents.

Surveyor Comments

There are sufficient resources to support the needs of the Infection Control program demonstrating the organization understands that important role. Practitioners are a knowledgeable and well organized team. Infection rates are low and outbreaks that do occur from time to time are well managed, indicative of a good program.

There are strong linkages with infection control practitioners across sites, and with Public Health through a Regional Infection Control Committee.

Infection Control provides education and information for some area college programs and other organizations in Saint John.

The MRSA clinic in Saint John area is unique and commendable and consideration should be given to expand to other sites.

The organization is very clean and well maintained. This applies to all sites.

Environmental Services, SPD and Endoscopy staff are efficient, knowledgeable and understand their important roles in infection control.

Nursing staff are well informed on processes for dealing with notifications of a positive culture or lab report and for handling isolation patients.

The hand washing campaign in Moncton is highly successful utilizing innovation approaches well accepted by staff.

Hand washing stations in public and staff entrances at a few sites are not always visible. Of all the visitors observed coming through the doors at several sites, no one used the gel. Improved awareness campaigns of hand washing for the public/visitors is encouraged.

Space in the endoscopy cleaning area at the Saint John Regional Hospital is very limited and maintaining separation of the clean and dirty area is difficult especially with the volumes of scopes going through the rooms daily.

Space in endoscopy cleaning area at St. Joseph's is also crowded but they are somewhat able to separate clean and dirty areas.

Infection rates are reported to managers but the information is not always disseminated to staff.

While there are information pamphlets available, there is no documentation in patient charts at most sites that infection control information was provided to clients and families.

While the organization itself does not send out items for sterilization to an outside provider, it does provide sterilization services for others in the community such as clinics and physician offices. A risk assessment of this practice is recommended.

At Saint John Regional Hospital, monitoring of client care and other high risk areas for proper housekeeping procedures areas should be undertaken such as audits, and daily checklists. The education program for environmental staff on cleaning techniques could be improved to ensure that all staff receive consistent and appropriate training, and that training records are maintained.

Safety engineered devices for sharps and other high risk items should be implemented.

Improved documentation in the endoscopy suite at the Saint John site is recommended to meet the standards.

Use of Cidex was thought to be restricted to certain areas but there are still many areas using the product. This needs to be reviewed to ensure all safety precautions and processing procedures are followed. None of the sites were aware that a sterile water rinse is required according to standards, which is over and above manufactures directions.

Explore opportunities to liaison with other service providers such as Emergency Medical Services (EMS) and nursing homes to coordinate and standardize where possible infection control practices across the continuum of care..

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends, and shares this information throughout the organization.	1.2	
Staff and service providers know the infection rates and recommendations from outbreak reviews.	1.2.3	

The organization reviews and updates its policies and procedures at least every three years, and as new information becomes available.	4.7	
The organization offers IPAC education and training to partners, other organizations, and the community.	5.5	
Information provided to clients and families is documented in the client record.	7.3	
The organization regularly monitors the quality of its cleaning and disinfection of the physical environment, and uses the information to make changes to policies and procedures.	10.6	
Staff members wear appropriate personal protective equipment (PPE) when handling contaminated materials and equipment.	11.3	↑
The organization uses safety engineered devices for sharps and other high-risk materials.	11.6	↑
The record of endoscopy device reprocessing includes the identification number and type of endoscope, the identification of the automated endoscope reprocessor (AED) if applicable, date and time of the clinical procedure, the name or unique identifier of the client, results of the individual inspection and leak test, and the name of the person reprocessing the endoscope.	13.13	

Laboratory and Blood Services

Diagnostic Services - Laboratory

Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

Surveyor Comments

The personnel are competent, professional, dedicated and well trained.

The continuing education program is outstanding for safety and quality management.

The physical environment is clean, spacious and well design for the activities.

Formalize contracts with referral laboratories.

Some phlebotomy centres are inadequate for the population they serve.

Laboratories should be represented and participate on the hospital multidisciplinary committee.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The laboratory collects and reviews information at least annually about service volumes, client perspectives on services, and patterns of requests from service providers and other organizations. CSA Reference: Z15189-03, 4.1.2	1.1	
The laboratory establishes a contract with each service provider that clearly outlines the laboratory's requirements. CSA Reference: Z15189-03, 4.4.1	2.1	
The laboratory verifies that the service provider can meet the contract requirements. CSA Reference: Z15189-03, 4.4.1	2.2	
The laboratory annually reviews its contracts with service providers to confirm requirements are being met. CSA Reference: Z15189-03, 4.4.1, 4.4.5	2.3	↑
The laboratory maintains records of all contracts with service providers, including any relevant changes. CSA Reference: Z15189-03, 4.4.2	2.4	
The laboratory informs its clients in a timely manner of changes to or significant deviations from the contract. CSA Reference: Z15189-03, 4.4.4	2.5	↑
The laboratory has a policy and procedure manual for the LIS and its applications that is available to staff at all times, and that is regularly updated to make sure it is complete and accurate. CSA Reference: Z15189-03, Annex B.3, B.3.3; Z902-04, 20.2.1	12.2	
The laboratory assesses the competency of all LIS users, and provides additional training as needed. CSA Reference: Z902-04, 20.5	12.3	
The laboratory develops controls to safeguard the LIS against loss, destruction, tampering, and unauthorized access. CSA Reference: Z15189-03, Annex B.4, B.5.8; B.6.4, B.6.5, 6.6, 7.2-7.3; Z902-04, 20.6.2, 20.6.3	12.8	↑

The laboratory's collection areas ensure client comfort and privacy, and accommodate disabilities. CSA Reference: Z15189-03, 5.2.3; Z902-04, 21.4.2	13.3	↑
The laboratory carries out and records regular checks of temperature, humidity levels, and any other critical factors. CSA Reference: Z902-04, 9.4.6, 9.4.7	17.2	
The laboratory uses a standardized and consistent format to label supplies, reagents, and media.	18.4	
The laboratory prevents the use of inappropriate, expired, deteriorated, and substandard supplies, reagents, and media.	18.5	
Laboratory managers have access to complete and up-to-date records of supplies, reagents, and media. CSA Reference: Z15189-03, 4.6.3, 4.15.2m	18.7	
The laboratory annually reviews its risk-reduction strategies, incidents which have occurred, and makes changes to its policies or training activities.	22.5	↑
The laboratory identifies potential sources of nonconformities and their root causes, and implements and monitors action plans to prevent nonconformities. CSA Reference: Z15189-03, 4.9, 4.9.1, 4.9.2, 4.10.1, 4.10.2, 4.10.3, 4.11.1, 4.11.2	25.5	↑

Long Term Care Services

Clinical Leadership

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

Surveyor Comments

Two long term care (LTC) homes were included in the survey. Both are managed by Horizon Health Network for Veteran Affairs Canada. The Veterans Health Unit in Fredericton is a 47 bed home that was opened in 2001 and the Ridgewood Veterans Wing in Saint John is a 80 bed home with 52 beds for LTC and a 24 bed protective care unit. The level of acuity varies but roughly one third of the veterans are fairly independent. Ridgewood is an older home but has been well maintained. Services are comprehensive at both sites and are generally readily available. Veterans Affairs funds the operations of the homes and performs an annual inspection of the home. Veterans Affairs determine the staffing mix and levels required and have been fortunate to have a dedicated, caring and enthusiastic staff. Some policies such as the one regarding the smoke room maintained at the Ridgewood home are at the direction of Veteran Affairs. The ratings in this survey apply to both homes unless otherwise indicated.

The team is not involved in the assessment and placement process and usually has no contact with the new admission until the veteran arrives at the home.

Strengths include resident-centred care, a caring and dedicated staff, and a commitment to education and clinical competence.

Areas for improvement include medication reconciliation and formalizing processes around resident safety.

There is good collaboration with Horizon Health and long term care partners in the region as needed. There is good use of the interdisciplinary team including nursing, OT, PT, social work, recreation, music therapy and pastoral care.

At the Veterans Unit they use the NEST approach (Needs Environment Stimulation Techniques) approach to dealing with challenging behaviours.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

There is a focus on resident centred care and a good use of team work. There is support for clinical education and a focus on learning.

There is no use of pumps at the Veterans Health Unit. There had been a pump in use at Ridgewood and staff had been trained to use it.

At the Veterans Unit there is an option of peer or manager only review or self and manager review using standard templates.

Recognition includes service awards, nurses week and information unit activities.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The assessment team includes nursing, medicine, social work, physiotherapy, recreation, music therapy and spiritual care, when appropriate.

Advanced care directives are recorded and placed in the chart when they are complete. However, only Veterans Health Unit is having them completed regularly on all residents.

The social worker and pastoral care worker provide support to veterans and their families.

The team reviews progress monthly.

Good wound assessment program in place.

The grounds have been developed to support outdoor activities.

At Ridgewood food services will source food locally, if possible, and it is home cooked on site. At the Veteran Unit there is a combination of hospital prepared food and some baking in the home kitchen.

Information is passed on transfer but should be formalized according to the medication reconciliation guidelines.

There is a definite focus on resident centred care. This would be strengthened by including residents in the planning process whenever possible. The homes are encouraged to review the current committee and team structures with a view to forming a committee that includes the resident and provides direct access and input for the resident into team process.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.	7.4	
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The team generates a Best Possible Medication History (BPMH) for the client upon admission.	7.4.2	
Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	7.4.3	
The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	7.4.4	
The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	7.4.5	
The team regularly discusses the advance directives with the client and family, and documents any changes.	10.7	

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medication to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	12.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	12.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	12.3.2	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	12.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	12.3.4	
The processes makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	12.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	12.3.6	
Following transition, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition planning.	12.8	↑

Decision Support

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

Surveyor Comments

There is good support from a clinical and education perspective.

The organization is encouraged to formalize benchmarking opportunities. A dashboard template is being developed with health and aging network. There is a rollout expected in September.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

There has been a falls prevention strategy in long term care for several years. .

There is a new document entitled "It's your Health" which is only recently available. While most clients/families were aware of safety practices others were not. LTC is encouraged to make the pamphlet with safety information available to all residents/family upon admission.

The homes are encouraged to continue to evaluate the quality of the services they receive through use of survey.

Residents who were interviewed expressed satisfaction with the services provided in their home. They felt that their needs were met and that the care provided them was good. There were activities and religious services for those who were interested. There was good support from the social worker and from pastoral care.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team informs and educates its clients and families in writing and verbally about the client and family's role in promoting safety.	16.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	16.4.1	
Clients consistently indicate that they have received both written and verbal communication about their role in client safety.	16.4.3	

Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

The regional pharmacy team has a solid foundation to build on. Pockets of excellence exist within the organization including pharmacists practising pharmaceutical care on patient care units; the hospital pharmacy residency program; participation in drug research; state of the art unit dose technology; and USP 797 compliant IV admixture rooms. The goal is to spread these programs so they are consistently available to patients at all facilities.

The use of handwritten and multi day MARs has contributed to a number of reported adverse events and presents a major safety risk to the organization.

The workload burden in pharmacy is impacted by servicing existing programs, such as oncology, with unexpected growth and new programs, such as stem cell transplantation, that are launched without adequate resources. Pharmacy does not have adequate clinical pharmacist availability, both in time and expertise, to manage stem cell transplant patients on complex protocols used to treat haematological cancers. This concern has been expressed many times by pharmacy leadership. These may have been contributing factors to a recent, serious error that is currently undergoing a root cause analysis.

A large gap currently exists with the physician impact process. In the past two years 66 new physicians have been recruited to Horizon Health Network without the commensurate increase in allied health resources that are required to support these clinicians. In many areas, resources have been stretched to an unsustainable level.

It is difficult to access client specific medication-related information on transfer from another zone due to lack of an enterprise wide computer program. Also, the same problem is seen for clients admitted to hospital from the community because of the lack of a provincial prescription database.

At The Moncton Hospital, all clinical staff including physicians are oriented by pharmacy before they start working.However this is not consistent at other sites as the Chief of Staff stated that, except for the CPOE component, physicians are not oriented to the medication use process before they are permitted to work independently at Saint John Regional Hospital. Lack of a formal orientation program was also confirmed with the Emergency Department Medical Director.

Though regular pharmacy bulletins and email information are provided to all staff and clinical pharmacists do raise any critical patient safety issues with the teams they support, physicians generally do not participate in education programs for new formulary drugs.

At the Dr. Everett Chalmers Regional Hospital (DECH), evidence of standardized and limited concentrations was not found given the large variety of insulin vials found on patient care units. The Upper River Valley adult SC insulin order sheet lists 14 insulin products that prescribers may select.

High potency hydromorphone 10 mg/mL was found on the orthopaedic ward in The Moncton Hospital, on the CCU step down unit at the Dr. Everett Chalmers Regional Hospital and on a patient care unit in the Oromocto Public Hospital and in Miramichi Regional Hospital.

At Moncton, the pharmacy space is crowded and work processes have to be adjusted to fit within the available space. Of greatest concern is the space in the oncology clinic that is used for mixing chemotherapy. There is a clean anteroom. The area where the flow hood is located is a shared workspace with computers, reference books and medication supplies. At DECH there is no clean anteroom for the oncology clinic. Workspace within pharmacy departments in the Saint John Regional Hospital and DECH is not adequate for the services that are provided.

The pharmacy does not consistently dispense in unit dose packaging at every facility. The packaging of controlled substances in sleeves of 25 doses at Saint John Regional Hospital promotes the pre pouring of doses in the medication room.

At Saint John Regional Hospital, pharmacy staff expressed concerns about the lack of control with delivery of medications by pottering staff.

At Saint John Regional Hospital, DECH, Oromocto and Waterville, it was observed that care staff did not use two client identifiers and do not take the MAR to the bedside during the administration of medications. Members of the medication management committee at DECH stated that learnings from serious events are not often shared and if error reduction strategies are being implemented, staff are not told why the changes are being made.

Though policies exist in each zone, staff at Saint John Regional Hospital and Dr. Everett Chalmers Regional Hospital were not able to outline the process about which committee[s] receive completed reviews and how learnings get disseminated.

Considerable duplication of resources is devoted to the manual medication supply chain seen within each zone.

Part doses of injectable medications are wasted down the sink on many patient care units.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Pharmacists and pharmacy staff are part of the organization's interdisciplinary team.	1.1	
Prescribing medical professionals and other service providers have access to accurate medication-related information specific to their client population/client care area.	1.3	
The organization orients staff and service providers to the medication use process before they are permitted to work independently.	1.9	↑
The organization educates staff and service providers about new medications prior to their use.	2.6	↑
The organization standardizes and limits the number of medication concentrations available.	3.4	↑
Medication concentrations are standardized and limited across the organization.	3.4.1	
The organization evaluates and limits the availability of narcotic (opioid) products and removes high-dose, high-potency formats from patient care areas.	3.6	↑
The organization has removed the following products: hydromorphone ampoules or vials with concentration greater than 2 mg/ml (exceptions include palliative care); and morphine ampoules or vials with concentration greater than 15 mg/ml.	3.6.2	
The organization has a policy and process to manage the availability of sample medications.	3.7	
Medications are stored in secure areas accessible only by authorized staff.	6.3	↑

Medication storage areas meet legislated requirements for controlled substances.	6.6	↑
Medications for client service areas are stocked in ready-to-use formats, where available.	7.3	
Medications for client service areas are stored in labelled, unit dose packaging.	7.4	↑
Unit dose oral medications remain in the manufacturer's or pharmacy's packaging until they are administered.	7.5	↑
The organization securely stores anaesthetic gases in a segregated area with adequate ventilation.	8.4	↑
The organization maintains each client's ongoing medication profile so that it is accessible to staff and other service providers who need it to deliver safe care/service.	9.2	
Prescribing professionals write or electronically enter complete medication orders, reorders, or reassessments upon admission, end of service, or transfer to another level of care.	10.1	↑
The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.	10.2	↑
The organization implements the Do Not Use List and applies this to all medication-related documentation when hand written or entered as free text into a computer.	10.2.2	
The organization's preprinted forms, related to medication-use, do not include any abbreviations, symbols, and dose designations identified on the Do Not Use List.	10.2.3	
The organization audits compliance with the Do Not Use List and implements process changes based on identified issues.	10.2.7	
The pharmacy and other service providers accept verbal orders for medication only in emergencies.	10.9	↑
The pharmacy and other service providers accept telephone orders for medication only in emergencies.	10.10	↑

The organization monitors compliance with its policies and processes for prescribing medications.	10.13	↑
The organization provides workspace to pharmacy staff to support safe and effective preparation of medications.	12.1	
The pharmacy dispenses medications in unit dose packaging.	13.3	↑
The organization delivers medications from the pharmacy to client service areas.	15.1	
The team uses at least two client identifiers before administering medications.	18.3	↑
The team uses at least two client identifiers before administering medications.	18.3.1	
Service providers refer to the client's medication administration record each time medication is administered.	18.4	↑
The organization minimizes the use of multi-dose vials in client care areas.	19.5	↑
The organization uses the findings of adverse drug event investigations to identify and implement improvements.	21.8	↑
The organization provides staff and service providers with regular feedback about adverse drug events, hazardous situations, and risk reduction strategies that are being implemented.	21.9	

Medicine Services

Clinical Leadership

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

Surveyor Comments

The conduct of clinical research activities would be highly desirable but needs the creation of a supportive research infrastructure.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team's goals and objectives for its medicine services are measurable and specific.	2.2	
The organization provides support to the team to deliver quality medicine services.	2.5	

Competency

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

Surveyor Comments

A committed and well motivated group of staff and physicians applies contemporary care.

A library for children, and their care providers explaining in accessible and engaging ways the nature of many of the diseases or disabilities was created and is maintained in Paediatrics. Stories featuring children with conditions such as diabetes leading active lives help acceptance of these conditions. This bibliotherapy is highly commended.

The education of staff is opportunistic depending on external offerings and identified needs. There is not a survey for the evaluation of processes of care as they are done to identify actual learning needs.

Resources are lacking in some areas. In Paediatrics there is a lack of mental health services and of sufficient interventions for attention deficit and behavioural problems

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Staff and service providers receive ongoing, effective training on infusion pumps.	4.4	↑
There is documented evidence of ongoing, effective training on infusion pumps.	4.4.1	
The team monitors and meets each team member's ongoing education, training, and development needs.	4.7	

Episode of Care

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

Surveyor Comments

There is strong nursing leadership and an obviously caring staff. There is discharge planning and, where applicable, and if there was prior planning, a seamless transition to the Extra Mural Program.

The wards are frequently overcapacity with many patients awaiting alternative placements. Care maps are often not used and as a result the day of discharge may not be anticipated.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team has access to the necessary diagnostic services, results, and expert consultation or advice to complete a proper assessment.	7.7	
A qualified team member fills the prescription and dispenses the medication in a timely and accurate way.	10.3	↑
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	11.6	↑

Decision Support

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

Surveyor Comments

The Region Teams in specific areas such as stroke) evaluate evidence and plan for its implementation in care.

There is little research done but the hope that with the establishment of a fully distributed medical school based in Saint John and throughout the province this will be enhanced.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

Although adverse events are recorded and are considered with conclusions drawn and sometimes changes made. However, there is not frequent feedback to those making the initial observations that action has been taken as appropriate. This failure to close the loo" on reports is a disincentive to further reports that could be learning opportunities.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team shares benchmark and best practice information with its partners and other organizations.	14.5	
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.2	↑
The team has implemented a falls prevention strategy.	15.2.1	
The strategy addresses the specific needs of the populations at risk for falls.	15.2.3	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.2.5	
The team monitors clients' perspectives on the quality of its medicine services.	16.2	

Mental Health Services

Clinical Leadership

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

Surveyor Comments

Information about the population it serves is well known and understood by the mental health team.

There are numerous examples of good coordination among service providers such as the Department of Social Development.

The regional management team has made decisions to terminate some services and to transfer resources to their areas of need.

The regional management team meets on a regular basis to coordinate the delivery of mental health services across Horizon.

The program has documented service goals.

In some program areas volunteers are utilized, such as in Centracare/Open Door Club.

There is a new Vice-President of Mental Health and Addictions.

Student physicians were evident in the program.

A comprehensive review of Mental Health has just been carried out by the Centre of Addition and Mental Health (CAMH) and the recommendations are in the process of being implemented.

There is a specific Mental Health Court in Saint John.

In the past year the team in Saint John has worked with the Department of Social Development to open two 4 bed treatment homes for 15-17 year olds with complex needs.

The table below indicates the specific criteria that require attention based on the accreditation review.

Criteria	Location	Priority for
The team has access to the supplies and equipment needed to deliver mental health services.	2.4	

Competency

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

Surveyor Comments

There is a good interdisciplinary team with well defined roles and responsibilities of team members.

The team approach is the method of service delivery.Teams include long term adults, seniors, justice, short term adults, children/adolescents, psychoeducation and community development.

Most of the team members are professionals.

All teams meet on a regular basis to co-ordinate their individual functioning.There are occasions when all the teams are brought together.

The team has multiple processes for identifying and making improvements.Two examples are suicide review and FMEA.

In Moncton there was an observation of a potential safety issue related to entering a secure portion of a unit alone without a personal security device. There was a buzzer on the wall; however if there were difficulties then this may not have been accessible.

In this province ASSIST is mandatory for all mental health staff.

Staff are trained in non-violent crises intervention.

Teams do discuss who is the best person to provide service but also have processes to have another provide service in the place of the best provider. An example of this is the St. Stephen High School Project.

It was reported to staff in Moncton that staff do receive training on the use of infusion pumps.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	3.5	

Episode of Care

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

Surveyor Comments

The following refers to the Saint John Community Mental Health Program.

In some program areas there are multiple client records. Some are electronic and some are paper.

The regional teams gets together on a regular basis to make sure that there is no duplication of service.There are emergency services available 24/7. There is a mobile mental health team.

Some programs have lengthy waitlists.The children/adolescents team is an example of a program where from time to time there have been lengthy wait lists.

There are multiple easy to read pamphlets about the services that the team provides.
Wait lists are monitored and there are mechanisms to fast track services for those who are in need, such as urgent referrals from ER to community programs.

The team works with relevant others to develop and implement transition and end of service plans.

The long term adult program in Saint John has mechanisms to inform referring agencies and professionals the reasons why a referral is inappropriate. The same team does provide consultation services to referring organizations when they are unwilling or unable to accept a client.

Comprehensive goal orientated plans are evident in all services. Clients are involved in the development of these plans when they have the capacity to do so.

Consent processes are in place.

The long term adult program has both consumer and family advisory committees.

The program has a community advisory committee which makes recommendations and suggestions to the regional management team. It also has a strong advocacy role.

There are good examples of work orientation rehabilitation programs, such as Simply Good Catering.

There is good information collected prior to admission in Centracare and in the seniors program.

There is good use of telehealth in service provision in some zones.

The following refers to the Fredericton Community Mental Health Program.

There is a psychiatric nurse on call for ER.

This is a strong community mental health program. Psychiatrists are members of the team.

There is good collaboration among team members.

There is good flow from the ER to the psychiatric unit out to community.

The liaison nurse is the interface from unit to community.

The leadership team is committed to make the changes suggested by CAMH.

There is a comprehensive assessment done on intake.

Telehealth is used for psychiatric consultation ER to ER.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client's medications upon admission to the organization, with the involvement of the client, family or caregiver.	7.6	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.6.1	
The team generates a Best Possible Medication History (BPMH) for the client upon admission.	7.6.2	

Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	7.6.3	
The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	7.6.4	
The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	7.6.5	
Medication Reconciliation at Admission	7.7	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.7.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.7.2	
The team follows the organization's process to identify, address, and record all ethics-related issues.	8.10	↑
The team identifies who is responsible for prescribing, storing, handling, and disposing of medications, as well as who is responsible for recording medication information in the client record.	10.1	↑
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	

The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6

Decision Support

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

Surveyor Comments

Many clients have more than one record. There is a need to develop one electronic health record for each client of Horizon.

Improvements are made based on evidence. There is evidence that comprehensive literature searches have been conducted prior to the development of many improvement initiatives.

There is good use of the accreditation process in the quality framework for this program.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

There is a need for both transitional housing and for affordable housing options for persons with persistent mental illness in the Saint John area.

There are policies in place related to staff safety while they provide service.These include the use of cell phones, buddy systems and communication mechanisms.

A comprehensive falls prevention strategy has not been implemented in this program area; however, work in this area has begun.

There are pamphlets related to patient /client safety which are given to clients.

This program reviews all suicides and uses the finding of these reviews to make improvements.

Client satisfaction is monitored.

In Moncton evidence related to process and outcome measures was not available.

A report card has been developed.

The team needs to consider how it will share the information and recommendations of its review of suicides with family members. It also needs to close the loop regarding the sharing of information with program staff.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.3	↑
The team has implemented a falls prevention strategy.	15.3.1	
The strategy identifies the populations at risk for falls.	15.3.2	
The strategy addresses the specific needs of the populations at risk for falls.	15.3.3	
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.3.4	
The team uses the evaluation information to make improvements to its falls prevention strategy.	15.3.5	

Obstetrics/Perinatal Care Services

Clinical Leadership

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

Surveyor Comments

There is cooperative medical and nursing leadership in individual zones and a staff that is well educated and well intentioned.

The objectives measured such as breast feeding rate and caesarean section rate are important but limited in scope.

Collection of data is variable. Creation of a provincial perinatal data base would provide the opportunity to measure and enhance care and then evaluate intended improvements. If this could be similar to the established Nova Scotia database, comparisons would be facilitated.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team proactively collects information about its clients and the community.	1.1	
The organization provides support to the team to deliver quality obstetrics/perinatal services.	2.5	

Competency

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

Surveyor Comments

There are highly skilled and well motivated staff and physicians in this service.

The family group practice for low risk pregnancy and delivery care in Upper River Valley Hospital is a model of how to organize and provide such care. It should be both an education site and a model that is repeated in similar facilities through out the province and the country.

Although there is good and relevant education it is not based on needs assessments.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team monitors and meets each team member's ongoing education, training, and development needs.	4.9	

Episode of Care

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

Surveyor Comments

Pre Printed orders are often used which enhances consistency of care.

Care maps for complicated cases are not commonly used.

Security of newborn babies is not consistently assured. While some nurseries use technology such as HUGS, this is not done in all nurseries, but should be throughout the Region.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies, and removes where possible, barriers that prevent clients, families, providers, and referring organizations from accessing services.	6.1	

The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a single documented, comprehensive list all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	

Decision Support

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

Surveyor Comments

The Clinical Networks enhance the selection and introduction of evidence based care.

Participation in the MORE OB program would facilitate this.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

Although adverse events are reported, evaluated and may be acted upon, there is not necessarily information provided back about what the effects, if any, have been of making the report.

No Unmet Criteria for this Priority Process.

Rehabilitation Services

Clinical Leadership

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

Surveyor Comments

The rehabilitation sites surveyed were the Stan Cassidy Centre for Rehabilitation and the Rehabilitation Unit at the Saint John Regional Hospital.

Strong interdisciplinary teams are present who demonstrate passion and dedication to providing rehabilitation services.

Program planning is carried out primarily at the program lead level and does not demonstrate evidence that the team has been involved in the process.

The Rehabilitation Program goals and objectives are not demonstrated in specific and measurable terms.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team works together to develop goals and objectives.	2.1	
The team's goals and objectives for rehabilitation services are measurable and specific.	2.2	

Competency

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

Surveyor Comments

Team members report there is strong support from the organization for internal and external educational opportunities. The team also reports there are numerous e-learning opportunities provided on the intranet ,both mandatory and optional.

The workplace environments are well designed, with ample space to support interdisciplinary team functioning and interaction.

It is recognized that the team is working toward establishing a more formalized process to regularly evaluate its functioning so that it is better positioned to identify priorities for action.

Performance evaluations are not completed as per the parameters of the organization's policy.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.8	

Episode of Care

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

Surveyor Comments

Rehabilitation services were reviewed at the Stan Cassidy Centre for Rehabilitation and the Rehabilitation Unit at the Saint John Regional Hospital where inpatient, day patient and specialized clinic services are provided. A variety of specialized and intervention services are offered to clients with complex disabilities from across the province. Support services to therapists providing service in the community are also offered. The rehabilitation team also actively participates in research activities. The team is particularly proud of several innovative physical attributes at the Stan Cassidy Centre for Rehabilitation that include transitional living suites, isolation suites that provide controlled air flow, and a recently opened outdoor assessment park. They attribute the success of these and other unique projects is due to the support and funding they receive from their Foundation.

Patients report that Information packages for inpatient and outpatient rehabilitation services are well laid out and very informative.

There are very specific admission criteria for admission to rehabilitation services which is understood and upheld by the team.

The team reports that they have access to the full range of necessary diagnostic services and expert consultations to allow them to complete full assessments for their patients.

The multidisciplinary team holds weekly, patient centred meetings to review the comprehensive service plan and to revise goals and expected results as necessary.

The teams have developed strong policies and practices in medication self-administration that should be shared in other appropriate areas of service delivery throughout the organization.

The process of medication reconciliation is understood, but the team advises this requirement has not yet been implemented. It is the team's understanding that this process will be rolled out on an organization-wide basis in the near future.

It is suggested that teams review their process for sharing individual patients' daily service/rehabilitation plans on large whiteboards in public areas of the facilities, to ensure these practices fully meet privacy legislation requirements.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team reconciles the client’s medications upon admission to the organization, with the involvement of the client, family or caregiver.	7.4	↑
There is a demonstrated, formal process to reconcile client medications upon admission.	7.4.1	
The team generates a Best Possible Medication History (BPMH) for the client upon admission.	7.4.2	

Depending on the model, the prescriber uses the BPMH to create admission medication orders (proactive), OR, the team makes a timely comparison of the BPMH against the admission medication orders (retroactive).	7.4.3	
The team documents that the BPMH and admission medication orders have been reconciled; and appropriate modifications to medications have been made where necessary.	7.4.4	
The process is a shared responsibility involving the client and one or more health care practitioner(s), such as nursing staff, medical staff, pharmacists, and pharmacy technicians, as appropriate.	7.4.5	
Medication Reconciliation at Admission	7.5	
The team follows Accreditation Canada's protocols and definitions to collect and submit data on medication reconciliation at admission.	7.5.1	
The team does not have any unaddressed priority for action flags based on their medication reconciliation at admission indicator results.	7.5.2	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.3	↑
There is a demonstrated, formal process to reconcile client medications at referral or transfer.	11.3.1	
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.3.2	
The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.3.3	
The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.3.4	
The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.3.5	
The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.3.6	

Decision Support

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

Surveyor Comments

The organization is commended for it's exemplary support for innovative projects such as the transitional care units, the "Telerehabilitation" project which is expected to be piloted within the next several weeks, and the outdoor assessment area opened last week.

The team is commended for it's active participation in clinical research projects and it's commitment to utilizing current research and evidence-based guidelines to implement best practices in rehabilitation services.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

The rehabilitation sites surveyed were the Stan Cassidy Centre for Rehabilitation and the Rehabilitation Unit at the St. John Hospital.

STRENGTHS
The teams collect benchmarked information on a variety of indicators. They also seek patient feedback through client satisfaction surveys in an effort to identify areas they can improve their care and service delivery.

AREAS FOR IMPROVEMENT
There is a newly developed brochure that is well designed to inform and advise patients and families about their role in safety. However it has only just been completed and has not been fully rolled out to all patients and their families. It will be a tremendous tool once this final piece of the project has been completed.
The team advises they have not yet fully implemented a Falls Prevention Strategy / Program, but they understand this is expected to be rolled out across the organization in the fall of 2010.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	15.2	↑
The team has implemented a falls prevention strategy.	15.2.1	
The strategy identifies the populations at risk for falls.	15.2.2	
The strategy addresses the specific needs of the populations at risk for falls.	15.2.3	
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	15.2.4	

The team uses the evaluation information to make improvements to its falls prevention strategy.	15.2.5	
The team informs and educates its clients and families in writing and verbally about the client's and family's role in promoting safety.	15.4	↑
Written and verbal information is provided to clients and families about their role in promoting safety.	15.4.1	
Staff uses written and verbal approaches to inform and educate clients about their role in promoting safety.	15.4.2	
Clients indicate that they have received written and verbal communication about their role in promoting safety.	15.4.3	

Substance Abuse and Problem Gambling Services

Clinical Leadership

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

Surveyor Comments

The needs of this population are well understood by the senior leadership team. Many examples of improvements have been made as a result of this knowledge, such as changes to the methadone clinic, and changes to the program at Lone Water Farm.

There is a client centred campus of care at Ridgewood.

Services are offered to staff.

There is a strong senior leadership committed to continuous quality improvement. There are many examples of program improvements over time.

Continued integration with mental health services is encouraged.

There is a new Vice-President of Mental Health and Addictions.

There are innovations in service delivery include the CAT program in Campobello and the Real Program in detox at Ridgewood.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

There is a self motivated inter disciplinary team present in all programs at the Ridgewood site each with a commitment to continually enhancing their skills. For example, one nurse is being trained in an alternative to twelve step programs.

Regular team meetings in all programs and regular meetings of the entire leadership team to coordinate services between and among services.

In Saint John, team planning is used to educate themselves on service provision to youth as this is a pressing need.

Numerous workplace safety initiatives are in place such as swipe card access to most sites. This was found in Fredericton.

Cross training of all mental health and addictions staff is encouraged.

Staff report that they are given significant freedom to act and to innovate.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Many standardized processes and protocols exist. As this was originally a provincial program many of these are region-wide.

Strong individual programs and a seamless continuum of service are offered at Ridgewood and are in evidence in Fredericton.

There are some problems with wait lists in detox and in rehabilitation.

After-hours services can be accessed through emergency rooms and through mobile crises teams.

There are good partnerships with mental health, Social Development and community groups.

Detox at Ridgewood has a phone follow up at 7 and 30 days.

Clinicians continually review the groups they run in consultation with peers and clients and make changes based on this feedback.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team follows the organization's process to identify, address, and record all ethics-related issues.	8.9	↑

Decision Support

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

Surveyor Comments

As this used to be a provincial program many of the guidlines and processes that are used were provincially determined.

The teams are highly interactiveand regularly make process improvements based on team discussion and input.

There are many manual processes; however no problems with these were identified.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

Addictions 101 is now being offered to community partners and to mental health staff.

This program has well-developed mechanisms to compare outcome data across zones.

No Unmet Criteria for this Priority Process.

Telehealth Services

Clinical Leadership

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

Surveyor Comments

This is an exceptional team of clinical and telehealth experts who are fully dedicated to the goal of integrating telehealth services into every facet of care and service delivery throughout Horizon Health Network.

Professional evidence-based research has been well documented to support each new phase or area of telehealth program development, implementation and evaluation.

The team recognizes there is still work to be done to educate all members of the broader health care team about the benefits of telehealth service delivery and the philosophy that bringing healthcare to the patient versus the patient to healthcare is a viable and even preferred method of health care delivery for many patients.

The team identifies that continued dialogue to engage the medical professionals throughout Horizon Health will be necessary to ensure the continued success and growth of telehealth programs.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

There are clear position descriptions for all positions and the ongoing learning needs of the telehealth team are viewed as a high priority.

The team identified that the accreditation survey helped serve as a catalyst to creating a continued telehealth operations work group.

The team recognizes that challenges exist regarding certification for inter provincial members of the Horizon telehealth team.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

Telehealth services were reviewed at the Dr. Everett Chalmers Regional Hospital with telehealth site team members as well as members from other zones who participated by using the telehealth system. Several clients also shared their personal experiences using the telehealth system and all reported positive experiences.

A dynamic and skilled team of experts have successfully developed and implemented a large variety of telehealth services across the Horizon Health Network over the past several years. Telehealth services are available in 123 locations in health care settings across the region. Telehealth services are use to facilitate administrative meetings; to provide educational instruction to both staff and clients; and most importantly, to facilitate and deliver health services to the clients in Horizon Health.

The telehealth teams are committed to increasing both the clinical and non-clinical utilization of telehealth services across the region and foresee limitless opportunities where these services can be delivered. They are focused on achieving the goal of integrating telehealth as a mainstream method of practice for delivering healthcare services across Horizon Health. All accreditation standards were met.

Telehealth services and programs throughout Horizon Health are clearly an integral and growing component of their health delivery system. There is a visionary group of leaders who are dedicated to the goal of promoting and implementing telehealth services throughout the organization and the province of New Brunswick. Telehealth "Visioning Workshops" have been held to support the clinical transformation and direction of telehealth services throughout Horizon Health.

Horizon Health has demonstrated significant support of telehealth initiatives through the provision of dedicated human, capital and operational resources.

Clear reporting relationships have been well defined for the telehealth team. Policies, procedures, regulatory requirements and operational documentation for telehealth services have been well researched and implemented.

Clients report clear support for telehealth services and programs.

The team sees the need for continued work to fully integrate telehealth services in to every facet of the organization.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

Expert knowledge and application of privacy legislation is demonstrated by the leaders of the telehealth team.

The team is aware that their goals to expand telehealth services to new venues such as the outdoors and public locations will also present new privacy challenges to be addressed.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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.

Surveyor Comments

Well documented telehealth projects and programs identify clear evidence of program success and the positive impacts on patient care and efficiencies that have been and could be achieved in organizational spending in this area.

The continued success and growth of the telehealth program will most certainly identify Horizon Health as a leader in this emerging field of care.

No Unmet Criteria for this Priority Process.

Surgical Procedures

Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Surveyor Comments

There is a strong interdisciplinary approach within the surgical programs across the organization. Team members in all areas visited were enthusiastic and positive in describing their roles and the quality of their workplace. New roles have been introduced to meet identified needs and to support patient safety and access. Processes are in place for coordination of care and smooth flow between perioperative services and other areas.

The surgical care network and site based OR committees provide a structure for planning and monitoring of surgical program activities.

There is attention to maintaining a respectful workplace which is supported by the new code of mutual respect.

There is a comprehensive orientation program and staff report feeling supported until they are ready to practice independently in their new environment.

There is a strong emphasis on continued learning and development. Staff report having regular opportunities to attend external conferences and in-house programs. They share knowledge and information gained through providing presentations for their co-workers.

Staff and managers report that performance appraisals are current and consistently completed.

The surgical checklist has been implemented and compliance is audited and reported on a regular basis.

Adherence to required safety policy and procedures was consistently evident in the operating rooms visited.

A patient safety focus is evident in all areas within the surgical program.

The use of flash sterilization is limited and the practice is closely monitored.

Patients and family members who were interviewed consistently expressed satisfaction with all areas of the surgical program where they had received care.

The team is monitoring indicators on a regular basis; however, these are not brought together in a comprehensive report with trending and analysis.

Incidents are reported and action is taken to address issues that arise. Examples were provided of change in practice as a result of near misses.

Participation in the provincial surgical access registry is providing objective data to support surgical scheduling. Wait times are being monitored and have decreased since implementation. Wait times for orthopaedic hip and knee replacements continue to exceed the targets.

The team is encouraged to continue development of a regional approach to surgical care within Horizon Health Network and to develop standardized processes and protocols to support best practice across the program.

There is limited use of evidence-based care maps or pathways within the surgical program. The regional surgical care team is encouraged to review the tools currently being used in each zone with the objective of standardization where ever appropriate using a best practice approach.

The team is encouraged to develop a process to formally review how they work together as a team and to celebrate their successes and identify opportunities for improvement .

The surgical team is encouraged to identify program and departmental goals and objectives.

The opportunity for increased efficiency in the allocation of operating time on the basis of wait lists should be explored using the data available from the surgical access registry.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Operating Rooms		
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.	1.3	
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	1.8	
The team sets performance goals and objectives and measures their achievement.	14.4	
Surgical Care Services		
The team works together to develop goals and objectives.	2.1	
The team's goals and objectives for its surgical care services are measurable and specific.	2.2	
The team identifies the resources needed to achieve its goals and objectives.	2.3	
The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	3.7	
The team uses a procedure-specific care map to guide the client through preparation for and recovery from the procedure.	7.1	
The team has a process to evaluate client requests to bring in or self-administer their own medication.	10.5	
The team reconciles medications with the client at referral or transfer, and communicates information about the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	11.4	↑
The process includes generating a comprehensive list of all medications the client has been taking prior to referral or transfer.	11.4.2	

	The process includes a timely comparison of the prior-to-referral or prior-to-transfer medication list with the list of new medications ordered at referral or transfer.	11.4.3
	The process requires documentation that the two lists have been compared; differences have been identified, discussed, and resolved; and appropriate modifications to the new medications have been made.	11.4.4
	The process makes it clear that medication reconciliation is a shared responsibility involving the client, nursing staff, medical staff and pharmacists, as appropriate.	11.4.5
	The organization has a documented plan to implement throughout the organization, and before the next accreditation survey, a medication reconciliation process at referral and transfer.	11.4.6

Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.

Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization's services. The following tables summarize the organization's results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.

Governance Functioning Tool

The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

	Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
		Organization	Organization	Organization	
1	We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	86	0	14	
2	We have explicit criteria to recruit and select new members.	60	0	40	⚠
3	Our renewal cycle is appropriately managed to ensure continuity on the governing body.	92	0	8	
4	The composition of our governing body allows us to meet stakeholder and community needs.	83	0	17	
5	Clear written policies define term lengths and limits for individual members, as well as compensation.	100	0	0	
6	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	92	0	8	
7	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	92	0	8	
8	We review our own structure, including size and sub-committee structure.	91	0	9	
9	We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10	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.	100	0	0	
11	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	

12	Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0	
13	Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0	
14	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0	
15	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	92	0	8	
16	Our governance processes make sure that everyone participates in decision-making.	100	0	0	
17	Individual members are actively involved in policy-making and strategic planning.	83	0	17	
18	The composition of our governing body contributes to high governance and leadership performance.	83	0	17	
19	Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0	
20	Our ongoing education and professional development is encouraged.	100	0	0	
21	Working relationships among individual members and committees are positive.	100	0	0	
22	We have a process to set bylaws and corporate policies.	100	0	0	
23	Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0	
24	We formally evaluate our own performance on a regular basis.	22	0	78	
25	We benchmark our performance against other similar organizations and/or national standards.	60	0	40	
26	Contributions of individual members are reviewed regularly.	44	0	56	
27	As a team, we regularly review how we function together and how our governance processes could be improved.	67	0	33	
28	There is a process for improving individual effectiveness when non-performance is an issue.	13	0	88	

29	We regularly identify areas for improvement and engage in our own quality improvement activities.	75	0	25	
30	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.	91	0	9	
31	As individual members, we receive adequate feedback about our contribution to the governing body.	45	0	55	✗
32	We have a process to elect or appoint our chair.	20	0	80	✗
33	Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0	

Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.

Summary of Results

Number of survey respondents = 4548 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	12	20	69	▲
2 Good communication flow exists up the chain of command regarding patient safety issues	17	22	61	▲
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	74	16	9	▲
4 Senior management has a clear picture of the risk associated with patient care	23	25	52	▲
5 My unit takes the time to identify and assess risks to patients	7	14	79	
6 My unit does a good job managing risks to ensure patient safety	7	14	80	
7 Senior management provides a climate that promotes patient safety	13	25	62	▲
8 Asking for help is a sign of incompetence	92	5	3	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	94	3	3	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	18	23	59	▲
11 I am less effective at work when I am fatigued	8	9	83	
12 Senior management considers patient safety when program changes are discussed	10	34	55	▲
13 Personal problems can adversely affect my performance	27	19	54	▲
14 I will suffer negative consequences if I report a patient safety problem	83	12	5	

15	If I report a patient safety incident, I know that management will act on it	13	25	62	⚠
16	I am rewarded for taking quick action to identify a serious mistake	30	41	28	✖
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	40	28	32	✖
18	I have enough time to complete patient care tasks safely	21	21	58	⚠
19	I am not sure about the value of completing incident reports	56	21	23	⚠
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	61	15	23	⚠
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	30	24	46	✖
22	I have made significant errors in my work that I attribute to my own fatigue	84	10	6	
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	12	17	71	⚠
24	I believe health care errors often go unreported	22	27	52	✖
25	My organization effectively balances the need for patient safety and the need for productivity	17	32	51	⚠
26	I work in an environment where patient safety is a high priority	8	15	77	
27	Staff are given feedback about changes put into place based on incident reports	31	29	40	✖
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	27	25	48	✖
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	25	26	49	✖
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	13	23	64	⚠
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	74	17	9	⚠
32	My supervisor/manager overlooks patient safety problems that happen over and over	76	14	10	

33	On this unit, when an incident occurs, we think about it carefully	7	20	72	⚠
34	On this unit, when people make mistakes, they ask others about how they could have prevented it	12	25	63	⚠
35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	7	17	76	
36	On this unit, when an incident occurs, we analyze it thoroughly	14	28	59	⚠
37	On this unit, it is difficult to discuss errors	65	21	14	⚠
38	On this unit, after an incident has occurred, we think long and hard about how to correct it	12	28	60	⚠
	B. These questions are about your perceptions of overall patient safety	**% Good/ Excellent**	**% Acceptable**	**% Poor/ Failing**	**Priority for Action**
		Organization	Organization	Organization	
39	Please give your unit an overall grade on patient safety	65	30	5	⚠
40	Please give the organization an overall grade on patient safety	44	45	12	✖
	C. These questions are about what happens after a Major Event	**% Disagree**	**% Neutral**	**% Agree**	**Priority for Action**
		Organization	Organization	Organization	
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	8	30	62	⚠
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	10	40	50	⚠
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	14	41	45	✖
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	17	48	36	✖

45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	15	25	60	
46	Changes are made to reduce re-occurrence of major events	6	25	69	

Worklife Pulse

The concept of 'quality of worklife' is central to Accreditation Canada's accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the 'pulse' of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, 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.

Summary of Results

Number of survey respondents = 6670 respondents

How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 I am satisfied with communications in this organization.	23	24	53	Δ
2 I am satisfied with communications in my work area.	20	19	61	Δ
3 I am satisfied with my supervisor.	11	18	71	Δ
4 I am satisfied with the amount of control I have over my job activities.	15	17	69	Δ
5 I am clear about what is expected of me to do my job.	6	9	84	
6 I am satisfied with my involvement in decision making processes in this organization.	25	28	47	×
7 I have enough time to do my job adequately.	27	19	54	Δ
8 I feel that I can trust this organization.	19	33	49	×
9 This organization supports my learning and development.	18	22	60	Δ
10 My work environment is safe.	13	17	70	Δ
11 My job allows me to balance my work and family/personal life.	13	18	70	Δ

Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were…	20	49	31	✕
	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is…	55	38	7	△
14 In general, would you say your mental health is…	57	35	8	△
15 In general, would you say your physical health is…	50	40	10	✕
	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	91	8	2	
	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	84	8	8	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	87	8	5	
	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	3	20	77	

	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	14	28	57	⚠
21 Working conditions in my area contribute to patient safety.	11	21	68	⚠

Indicator Results

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
YELLOW	Zone 1 - Sackville Memorial Hospital	Medicine Services (Medicine Services)	01/01/2010 31/03/2010	81
RED	Zone 1 - Sackville Memorial Hospital	Medicine Services (Medicine Services)	01/04/2010 30/06/2010	70
GREEN	Zone 1 - The Moncton Hospital	Emergency Department Services (Emergency Department Services)	01/01/2010 31/03/2010	100
GREEN	Zone 1 - The Moncton Hospital	Emergency Department Services (Emergency Department Services)	01/04/2010 30/06/2010	100
RED	Zone 1 - The Moncton Hospital	Mental Health Services (Mental Health Services)	01/01/2010 31/03/2010	36
RED	Zone 1 - The Moncton Hospital	Mental Health Services (Mental Health Services)	01/04/2010 30/06/2010	63
GREEN	Zone 2 - Centracare - Saint John	Mental Health Services (Mental Health Services)	01/01/2010 31/03/2010	100
GREEN	Zone 2 - Centracare - Saint John	Mental Health Services (Mental Health Services)	01/04/2010 30/06/2010	100
YELLOW	Zone 2 - Charlotte County Hospital	Emergency Department Services (Emergency Department Services)	01/01/2010 31/03/2010	88

Medication Reconciliation at Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
GREEN	Zone 2 - Charlotte County Hospital	Emergency Department Services (Emergency Department Services)	01/04/2010 30/06/2010	99
RED	Zone 2 - Charlotte County Hospital	Medicine Services (Medicine Services)	01/01/2010 31/03/2010	68
YELLOW	Zone 2 - Charlotte County Hospital	Medicine Services (Medicine Services)	01/04/2010 30/06/2010	80
GREEN	Zone 2 - Ridgewood Veteran's Wing - Saint John	Long Term Care Services (Long Term Care Services)	01/01/2010 31/03/2010	100
GREEN	Zone 2 - Ridgewood Veteran's Wing - Saint John	Long Term Care Services (Long Term Care Services)	01/04/2010 30/06/2010	100
GREEN	Zone 2 - Saint John Regional Hospital	Medicine Services (Medicine Services)	01/04/2010 30/06/2010	92
YELLOW	Zone 2 - St. Joseph's Hospital	Long Term Care Services (Long Term Care Services)	01/01/2010 31/03/2010	89
GREEN	Zone 2 - St. Joseph's Hospital	Long Term Care Services (Long Term Care Services)	01/04/2010 30/06/2010	100
GREEN	Zone 2 - St. Joseph's Hospital	Medicine Services (Medicine Services)	01/01/2010 31/03/2010	97
GREEN	Zone 2 - St. Joseph's Hospital	Medicine Services (Medicine Services)	01/04/2010 30/06/2010	100
GREEN	Zone 2 - Sussex Health Centre	Medicine Services (Medicine Services)	01/01/2010 31/03/2010	100
RED	Zone 2 - Sussex Health Centre	Medicine Services (Medicine Services)	01/04/2010 30/06/2010	70
RED	Zone 7 - Miramichi Regional Hospital	Medicine Services (Medicine Services)	01/04/2010 30/06/2010	74
RED	Zone 7 - Miramichi Regional Hospital	Surgical Care Services (Surgical Care Services)	01/04/2010 30/06/2010	55

Threshold for Flags
RED: < 75/100
YELLOW: >= 75/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection

Post-surgical infection rate is a key outcome measure that reflects process interventions.

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Cardiac Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	2
	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	1

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	8.6
	Zone 3 - Hotel-Dieu of St. Joseph	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
	Zone 3 - Upper River Valley Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
	Zone 3 - Upper River Valley Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	20

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	29

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - C-Section				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	3
	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	3.2

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - C-Section

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	7.4
	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
	Zone 3 - Hotel-Dieu of St. Joseph	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
	Zone 3 - Hotel-Dieu of St. Joseph	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
	Zone 3 - Upper River Valley Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	20
	Zone 3 - Upper River Valley Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Total Joint Arthroplasty

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	3
	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0.58

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Total Joint Arthroplasty

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0

The thresholds for this performance indicator are currently in development. Performance ratings will be provided when the thresholds are finalized.

Surgical Site Infection: Post-Surgical Infection - Spinal Surgery

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% post-surgical infections
	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	3.8
	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	1.2
	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	2
	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	6

Surgical Site Infection

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Surgical Site Infection: Prophylactic Antibiotics - Cardiac Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
YELLOW	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	84
GREEN	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	93

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Colorectal Surgery				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
RED	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	62
GREEN	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	100
RED	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	71

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Hysterectomy				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	96
RED	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	76
YELLOW	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	86
GREEN	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	93

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Surgical Site Infection: Prophylactic Antibiotics - Total Joint Arthroplasty				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics
GREEN	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	91
GREEN	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	100
GREEN	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	100
YELLOW	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	88

Threshold for Flags
RED: < 80/100
YELLOW: >= 80/100 AND < 90/100
GREEN: >= 90/100

Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care-Associated MRSA & C. difficile - C. difficile

Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 10,000 patient days
GREEN	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	3.9
GREEN	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	1.2
GREEN	Zone 2 - Charlotte County Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 2 - Charlotte County Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Zone 2 - Grand Manan Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 2 - Grand Manan Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Zone 2 - Ridgewood Veteran's Wing - Saint John	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	1.5
GREEN	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	2.3

Health Care-Associated MRSA & C. difficile - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 10,000 patient days
GREEN	Zone 2 - St. Joseph's Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 2 - Sussex Health Centre	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 2 - Sussex Health Centre	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0.68
GREEN	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	3.4
GREEN	Zone 3 - Hotel-Dieu of St. Joseph	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 3 - Hotel-Dieu of St. Joseph	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Zone 3 - Oromocto Public Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 3 - Upper River Valley Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 3 - Upper River Valley Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	3
GREEN	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	2.9

Health Care-Associated MRSA & C. difficile - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 10,000 patient days
GREEN	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	1.5

Threshold for Flags
RED: > 80/10,000
YELLOW: <= 80/10,000 AND > 60/10,000
GREEN: <= 60/10,000

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 10,000 patient days
GREEN	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0.2
GREEN	Zone 1 - The Moncton Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	2.4
GREEN	Zone 2 - Charlotte County Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	9
GREEN	Zone 2 - Charlotte County Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	20
GREEN	Zone 2 - Grand Manan Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 2 - Grand Manan Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	21
GREEN	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	5.9

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 10,000 patient days
GREEN	Zone 2 - Saint John Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	5.6
GREEN	Zone 2 - Sussex Health Centre	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 2 - Sussex Health Centre	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	3.6
GREEN	Zone 3 - Dr. Everett Chalmers Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	2.2
GREEN	Zone 3 - Hotel-Dieu of St. Joseph	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0
GREEN	Zone 3 - Hotel-Dieu of St. Joseph	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Zone 3 - Oromocto Public Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	5.2
GREEN	Zone 3 - Upper River Valley Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	6.4
GREEN	Zone 3 - Upper River Valley Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	1.5
GREEN	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/01/2010 31/03/2010	0

Health Care-Associated MRSA & C. difficile - MRSA				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 10,000 patient days
GREEN	Zone 7 - Miramichi Regional Hospital	Infection Prevention & Control (Infection Prevention and Control)	01/04/2010 30/06/2010	0.74

Threshold for Flags
RED: > 80/10,000
YELLOW: <= 80/10,000 AND > 60/10,000
GREEN: <= 60/10,000

Next Steps

Congratulations! You have just completed your Qmentum on-site survey visit. Please note the following check list items that you need to attend to in the coming days and months.

- ☐ We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.

- ☐ In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.

- ☐ You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

Appendix A – Accreditation Decision Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. Population focus
2. Accessibility
3. Safety
4. Worklife
5. Client-centred services
6. Continuity of services
7. Effectiveness
8. Efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

Accreditation Canada High Priority Criteria

Accreditation Canada identifies high priority criteria by their alignment with several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for healthcare organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2010 Qmentum surveys are:

Option 1: Accreditation
An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

(a) 90% or more of high priority criteria met per standard section, AND
(b) Compliance with all of the Required Organizational Practices, AND
(c) Compliance with collection of all the performance measures,

If the organization is a CSSS, participating in the Joint Program with Conseil québecois d'agrément (CQA) and Accreditation Canada, the following additional criteria are required, which are specific CQA indicators relating to customer service and worklife:

(d) Compliance with ≥66.6% of Client Satisfaction Indicators AND
(e) Compliance with ≥66.6% of Employees Mobilization Indicators

Option 2: Accreditation with Condition: Report and/or Focused Visit
An organization will receive Accreditation with Condition: Report and/or Focused Visit if any of following criteria is met:

(a) More than 10% and less than 30% of high priority criteria unmet in any standard section,
OR
(b) Non-compliance with any one of the Required Organizational Practices
OR
(c) Non-compliance with the collection of any one of the performance measures

If the organization is a CSSS, participating in the Joint Program with CQA and Accreditation Canada, the following addition criteria apply:

(d) Compliance with less than 66.6% of Client Satisfaction Indicators,
OR
(e) Compliance with less than 66.6% of Employees Mobilization Indicators

The condition, i.e. submission of a report or focused visit; and timeframe, i.e. 6 months or 12 months; is based upon the nature of the recommendations. If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.

Organizations are required to submit follow-up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress, and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

For organizations that fail to complete a satisfactory focused visit within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

Option 3: Non-accreditation
An organization will NOT be accredited if the following conditions exist:

(a) One or more ROPs not in place
AND
(b) 30% or more high priority criteria unmet in one or more standards sections
AND
(c) 20% or more criteria unmet overall for all standards applied to the organization

Should an organization wish to have their non-accreditation status reviewed within 6 months post survey, they are required to complete a focused visit within 5 months. Organizations that fail to complete a satisfactory focused visit within the required timeframe will maintain a non-accreditation status.

If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.