ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Horizon Health Network/Réseau de santé Horizon

Fredericton, NB

On-site survey dates: September 16, 2018 - September 21, 2018

Report issued: February 8, 2019

About the Accreditation Report

Horizon Health Network/Réseau de santé Horizon (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2018. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

Horizon Health Network/Réseau de santé Horizon's accreditation decision is:

Accredited

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

About the On-site Survey

- **On-site survey dates: September 16, 2018 to September 21, 2018**

- **Locations**

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

1. Boiestown Health Centre
2. Centracare
3. Central Miramichi Community Health Centre
4. Charlotte County Hospital
5. Dr. Everett Chalmers Regional Hospital
6. Fredericton Addiction and Mental Health Services
7. Fredericton Downtown Community Health Centre
8. Harvey Health Centre
9. Hemodialysis Unit Fredericton
10. Hotel-Dieu of St. Joseph
11. Médisanté Saint-Jean
12. Miramichi Addiction and Mental Health Services
13. Miramichi Regional Hospital
14. Moncton Addiction and Mental Health Services
15. Noreen-Richard Health Centre
16. Oromocto Public Hospital
17. Port Elgin and Region Health Centre
18. Public Health Fredericton
19. Public Health Miramichi-Chatham
20. Public Health Neguac
21. Public Health Oromocto
22. Public Health Perth-Andover
23. Public Health Saint John
24. Queens North Community Health Centre

25. Ridgewood Addiction Services
26. Ridgewood Veteran's Health Wing
27. Sackville Memorial Hospital
28. Saint John Community Mental Health Services
29. Saint John Regional Hospital
30. St. Joseph's Hospital
31. Stan Cassidy Centre for Rehabilitation
32. Sussex Addiction & Mental Health Services
33. Sussex Health Centre
34. The Moncton Hospital
35. Tobique Valley Community Health Centre
36. Veterans Health Unit Fredericton
37. Woodbridge Centre
38. Woodstock Addiction and Mental Health Services

- **Standards**

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

System-Wide Standards

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

Population-specific Standards

5. Population Health and Wellness

Service Excellence Standards

6. Ambulatory Care Services - Service Excellence Standards
7. Biomedical Laboratory Services - Service Excellence Standards
8. Cancer Care - Service Excellence Standards
9. Community Health Services - Service Excellence Standards
10. Community-Based Mental Health Services and Supports - Service Excellence Standards
11. Critical Care Services - Service Excellence Standards
12. Diagnostic Imaging Services - Service Excellence Standards

13. Emergency Department - Service Excellence Standards
14. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
15. Inpatient Services - Service Excellence Standards
16. Long-Term Care Services - Service Excellence Standards
17. Mental Health Services - Service Excellence Standards
18. Obstetrics Services - Service Excellence Standards
19. Perioperative Services and Invasive Procedures - Service Excellence Standards
20. Point-of-Care Testing - Service Excellence Standards
21. Public Health Services - Service Excellence Standards
22. Rehabilitation Services - Service Excellence Standards
23. Reprocessing of Reusable Medical Devices - Service Excellence Standards
24. Substance Abuse and Problem Gambling - Service Excellence Standards
25. Telehealth - Service Excellence Standards
26. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	116	2	2	120
 Accessibility (Give me timely and equitable services)	150	6	6	162
 Safety (Keep me safe)	748	27	103	878
 Worklife (Take care of those who take care of me)	201	3	1	205
 Client-centred Services (Partner with me and my family in our care)	651	9	12	672
 Continuity (Coordinate my care across the continuum)	130	2	4	136
 Appropriateness (Do the right thing to achieve the best results)	1186	41	221	1448
 Efficiency (Make the best use of resources)	73	4	5	82
Total	**3255**	**94**	**354**	**3703**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	49 (100.0%)	0 (0.0%)	1	36 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	1
Leadership	48 (96.0%)	2 (4.0%)	0	91 (94.8%)	5 (5.2%)	0	139 (95.2%)	7 (4.8%)	0
Infection Prevention and Control Standards	39 (97.5%)	1 (2.5%)	0	31 (100.0%)	0 (0.0%)	0	70 (98.6%)	1 (1.4%)	0
Medication Management Standards	71 (91.0%)	7 (9.0%)	0	61 (95.3%)	3 (4.7%)	0	132 (93.0%)	10 (7.0%)	0
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	44 (100.0%)	0 (0.0%)	2	75 (97.4%)	2 (2.6%)	1	119 (98.3%)	2 (1.7%)	3
Biomedical Laboratory Services	11 (100.0%)	0 (0.0%)	60	13 (100.0%)	0 (0.0%)	92	24 (100.0%)	0 (0.0%)	152
Cancer Care	97 (96.0%)	4 (4.0%)	0	122 (95.3%)	6 (4.7%)	0	219 (95.6%)	10 (4.4%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Community Health Services	41 (95.3%)	2 (4.7%)	0	78 (97.5%)	2 (2.5%)	0	119 (96.7%)	4 (3.3%)	0
Community-Based Mental Health Services and Supports	44 (100.0%)	0 (0.0%)	0	92 (97.9%)	2 (2.1%)	0	136 (98.6%)	2 (1.4%)	0
Critical Care Services	58 (96.7%)	2 (3.3%)	0	100 (95.2%)	5 (4.8%)	0	158 (95.8%)	7 (4.2%)	0
Diagnostic Imaging Services	66 (98.5%)	1 (1.5%)	0	67 (98.5%)	1 (1.5%)	1	133 (98.5%)	2 (1.5%)	1
Emergency Department	66 (93.0%)	5 (7.0%)	0	105 (98.1%)	2 (1.9%)	0	171 (96.1%)	7 (3.9%)	0
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	108 (100.0%)	0 (0.0%)	0	153 (100.0%)	0 (0.0%)	0
Inpatient Services	58 (96.7%)	2 (3.3%)	0	81 (95.3%)	4 (4.7%)	0	139 (95.9%)	6 (4.1%)	0
Long-Term Care Services	54 (98.2%)	1 (1.8%)	0	97 (99.0%)	1 (1.0%)	1	151 (98.7%)	2 (1.3%)	1
Mental Health Services	49 (98.0%)	1 (2.0%)	0	92 (100.0%)	0 (0.0%)	0	141 (99.3%)	1 (0.7%)	0
Obstetrics Services	69 (97.2%)	2 (2.8%)	2	88 (100.0%)	0 (0.0%)	0	157 (98.7%)	2 (1.3%)	2
Perioperative Services and Invasive Procedures	112 (97.4%)	3 (2.6%)	0	105 (96.3%)	4 (3.7%)	0	217 (96.9%)	7 (3.1%)	0
Point-of-Care Testing	11 (100.0%)	0 (0.0%)	27	18 (100.0%)	0 (0.0%)	30	29 (100.0%)	0 (0.0%)	57
Public Health Services	42 (89.4%)	5 (10.6%)	0	65 (94.2%)	4 (5.8%)	0	107 (92.2%)	9 (7.8%)	0
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	80 (100.0%)	0 (0.0%)	0	125 (100.0%)	0 (0.0%)	0
Reprocessing of Reusable Medical Devices	80 (93.0%)	6 (7.0%)	2	38 (95.0%)	2 (5.0%)	0	118 (93.7%)	8 (6.3%)	2

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Substance Abuse and Problem Gambling	44 (97.8%)	1 (2.2%)	0	82 (100.0%)	0 (0.0%)	0	126 (99.2%)	1 (0.8%)	0
Telehealth	47 (100.0%)	0 (0.0%)	5	81 (100.0%)	0 (0.0%)	8	128 (100.0%)	0 (0.0%)	13
Transfusion Services	12 (100.0%)	0 (0.0%)	63	12 (100.0%)	0 (0.0%)	57	24 (100.0%)	0 (0.0%)	120
Total	**1306 (96.7%)**	45 (3.3%)	162	1853 (97.7%)	43 (2.3%)	190	3159 (97.3%)	88 (2.7%)	352

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Unmet	5 of 6	0 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Unmet	0 of 1	0 of 0
Client Identification (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Unmet	0 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Unmet	1 of 4	0 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	12 of 12	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Unmet	2 of 4	1 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Unmet	5 of 7	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Critical Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Inpatient Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Suicide Prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Inpatient Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

The organization, Horizon Health Network is to be commended for participating in the Qmentum program. Participation in this program is but one example of the organization's commitment to quality.

Horizon is one of two Regional Health Authorities across New Brunswick and consists of 12 hospitals, 100+ medical facilities, clinics, and offices, and provides services ranging from acute care to community-based health services. There are 12,600 employees, 1,100 physicians, 4,500 volunteers, auxiliary and alumnae members as well as a 15-member Board of Directors. The organization provides health services to a diverse population across a vast geographic area. The organization has several First Nations groups and while there is a francophone health region, New Brunswick is a bilingual province and provides services to both English and French-speaking patients.

The goals and objectives of the Horizon for this survey are four-fold:
1. assess the organization's overall compliance with Accreditation Canada standards and practices within a context of continuous quality;
2. assess engagement of Horizon' staff, physicians and governance to building a culture of patient safety and continuous quality improvement;
3. assess Horizon's effectiveness in building a culture of patient and family centred care within the organization;
4. provide an impression of Horizon's effectiveness with the integration of quality and patient safety initiatives within an integrated "One Horizon" culture.

Horizon has a strong Board of Directors. The board is a skills-based board and works closely with the Executive Leadership Team of the organization. Governance is evidence-based and at a strategic level.

A strength of this board is the patient-centred lens applied to the governance work they do. To keep them centred, the board begins each meeting with a patient story and these stories sometimes provide opportunities to make improvements and/or change.

Quality and safety are important to the board. The Quality and Safety Committee meets regularly and reports to the board at each meeting.

A risk to the current board is succession planning. As the bylaws are currently written, all 15 members could technically be done at the same time, losing all the corporate memory. This is a risk the board is aware of and is working on with government.

Horizon has many partners and works hard to maintain positive and healthy relationships with these diverse groups. The organization has conducted Community Needs Assessments across the network and this has been

a real strength of the organization. Community partners, including municipalities, feel there is two-way communication. A positive impact for the organization is that the outreach through the Community Needs Assessments has raised the credibility of the organization. Horizon is also committed to acting to improve population health and address inequities.

Foundations and Auxiliaries are reporting increased engagement with Horizon, this allows them to improve fundraising and the support they provide. First Nations partner reported that engagement with First Nations has been improving and this is welcome. The partners note that the outreach by the Chief Executive Officer (CEO) has been the catalyst to increase the engagement.

The executive leadership team is an established and cohesive group, with only one vacancy currently for the vice president corporate. The Strategic plan (2015-2020) was developed a few years ago, and the Horizon has adapted to the changing provincial landscape by developing an addendum to update the plan. The organization is facing capacity challenges, in part due to be the oldest population in Canada of ages 65+, with the population requiring more, and higher, levels of care. The new corporate risk register (adopted by the board in early 2018) identifies the aging infrastructure as the highest risk, with a significant challenge in providing care in facilities that have been in existence since 1954. In the absence of a comprehensive provincial document of building state/depreciation, most renovations or building changes take place when conditions are urgent, such as concrete crumbling or leaks, which may impact patient care.

A comprehensive operational plan has been established, with vice president's (VPs) reporting on the initiatives. Each clinical network prepares their own quality and safety plan, along with goals and objectives related to the operational plan and priorities. An information technology strategic plan is in development and will help move the organization forward with clinical information systems.

The organization is facing challenges for recruitment currently in some clinical roles, particularly nursing. In response, new models of care are being considered to ensure all staff is working to their full scope. Despite staff working under difficult physical constraints on some sites, with over-capacity scenarios, clutter, and challenging workloads, patients report excellent and compassionate care. The BRAVO awards have been successful to provide online employee peer to peer recognition, based on the four organizational values. This has reinforced positive behaviors, with over 20,000 BRAVOs issued to date. Staff engagement scores have improved by over 10 percent. Years of service and retirement celebrations have been revamped and are now very well attended and enjoyed by staff and invited guests. Staff proudly wears the large pendant with the number of years of service attached to staff IDs. The organization is looking at incorporating physician engagement in a similar way.

Delivery of care is becoming increasingly complex, with up to 33 percent of patients classified as Alternate Level of Care (ALC). Access has been a key area of focus for Horizon. Leadership is aware of the challenges and has established processes to reduce wait times in priority areas. There are significant overcapacity challenges at some sites. System-wide initiatives, technological improvements and remote patient monitoring may help to improve flow of patients through the system. It will be important to continue to roll out an electronic health records solution in all sectors across the province.

Horizon has embraced the philosophy of patient and family centred care. Patient Experience Advisors (PEA's) have been recruited successfully. Patient experience survey results have led to strategies such as hourly rounding and family presence, and an improved staff ID card that patients provided input into. In addition to measuring patient experience every 3 years with the New Brunswick Health Council, annual patient experience measurement is conducted to act on results, in collaboration with the quality teams. Some large projects have had some patient and family input at the schematic design level, and Patient Experience Advisors are engaged in the information technology prioritization process. Patients are represented on the local Medical Advisory Committee (MAC) and regional MAC and patient safety and clinical review committee. The CEO's interview two years ago also included patient representation. Horizon is interested in continuing to do better engaging and co-designing with patients going forward.

The Horizon Health Network is commended for its participation in the accreditation process, which demonstrates the desire to mitigate risk and improve care and organizational performance. Accreditation is a tangible way for Horizon to demonstrate its commitment to accountability, quality improvement, and safety. The organization is to be commended for continuing in their accreditation and "horizonize-ing" journey!

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Safety Culture	
Patient safety incident management A patient safety incident management system that supports reporting and learning is implemented.	· Leadership 15.4
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Emergency Department 12.16
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Inpatient Services 10.2 · Cancer Care 17.1
Patient Safety Goal Area: Medication Use	
Infusion Pumps Training A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.	· Emergency Department 4.9
Patient Safety Goal Area: Worklife/Workforce	
Client Flow Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	· Leadership 13.4

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

Horizon Health Network has a strong Board of Directors (board). The board is a skills-based board who strive hard to utilize all the skills of its 15 directors. The board identifies skills using a Skills Matrix Tool and the current board has a diverse, highly skilled board with both legal and financial skills present as well.

The board consists of 15 directors, eight of whom are elected with elections on a four (4) year cycle. The other seven (7) are appointed by the Minister of Health (MoH) and there are three non-voting members including the CEO of Horizon Health Network. The board works closely with the Executive Leadership Team of the organization and there is great synergy present.

The board operates under bylaws (2013) that have been recently updated/changed and are in the approval process that includes the MoH. There is a good orientation to new members and ongoing education, particularly at the annual board retreat. The board conducts yearly self-assessments as well as evaluation of their chair and CEO.

A strength of this board is the patient-centred lens that is applied to the work they do. To keep them centred, the board begins each meeting with a patient story - sometimes these patients and/or family members have a story about a good experience they have had with the organization and sometimes the story reflects a negative experience. The board is interested to hear all of them, using the negative experiences as opportunities to make improvements and change. Decision-making is by consensus, with a patient-centred lens.

The board works hard to ensure their work is evidence-based and there is constant scanning of the environment in New Brunswick and elsewhere across the country and world. The board provides strong fiscal accountability and approves the capital and operating budgets.

The organization has conducted Community Needs Assessments across the network and this has been a real strength of the organization. Community partners, including municipalities, are feeling there is

two-way communication, and this has raised the credibility of the organization. The board is seen as consultative and encouraging feedback and this is valued by both partners and patients/families.

The main risk to the current board is the succession planning (or lack of). As the bylaws are currently written, all 15 members could technically be done at the same time, losing all the corporate memory. This is a risk the board is aware of and is working on with government. The CEO "serves at the pleasure of the Minister" but reports to the board. The board makes this work by meeting with the CEO and MoH regularly and frequently.

Quality and safety are paramount to the board. While not a mandated committee in the bylaws, the quality and safety committee meets regularly and reports to the board at each meeting.

Priority Process: Planning and Service Design

Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
4.12 Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	

Surveyor comments on the priority process(es)

The organization has developed a Strategic Plan (2015-2020) with a mission of Helping People Be Healthy. The vision of Horizon Health Network is "Exceptional Care. Every Person. Every Day". The organization, their partners and stakeholders (patients, families, staff, and physicians) debated the use of the word "every" and after much discussion decided to leave the word "every" in as they want to strive for this each time, knowing that they may not deliver on it "every" time. Two years into the strategic plan it became evident that government was no longer able to support the strategic priorities as written and so the organization made an addendum to the plan and expanded on their values. The values were previously words and were expanded to become action statements. Example: the value of excellence became "we strive for excellence". The four priorities were reworked to reflect the new direction from government as well as re-focus on quality and safe care.

The organization has put a tremendous amount of work into learning about their communities and their population. The top three health issues are mental health issues (particularly in the youth), chronic disease (COPD and Diabetes) and services to seniors and older adults. Community Needs Assessments have been completed across the organization and these assessments have informed the work of the Horizon Health Network. The processes themselves have added a great deal of credibility to the organization. Services are designed to meet the specific needs of communities, including looking at the assets that are present already and expanding/building on those. The main assets include the ISD Program, Community Health Centres and Collaborative Care for Seniors Health.

The organization has reached out to many partners and have made special efforts to engage their indigenous partners. There are both Francophone and Indigenous Liaison Committees that are helping to engage these partners in meaningful ways.

The organization has begun developing operational plans and over the last year developed their priorities - a challenge for the organization is to avoid having so many priorities that they cannot "move the needle" enough to see progress.

The IT Department, Laundry Department, Materials Management and Clinical Engineering Department have been moved to Service New Brunswick (SNB). SNB has become a major partner with Horizon Health Network which has had unintended consequences. Horizon is a 24/7 operation and having an IT system fail at any time is challenging. The organizations are working to ensure a responsive partner, but there have been challenges. In addition, the planning of IT systems has remained with the organization. The organization has reallocated from within to bring in a Chief Information Officer position. The other unintended consequence of moving these services out of the organization is that now leadership needs to engage with additional partners and this becomes a workload issue that the organization needs to manage.

Another significant challenge for the organization is physician engagement. There is a sense that the physician group, overall, sees themselves as an entity outside of Horizon Health Network. The organization has identified this and has begun a grassroots campaign to engage physicians with some success. The organization is encouraged to formally develop a change management strategy to really improve physician engagement.

The organization has been working on combining their policies from four separate policies into one where appropriate. This takes time and resources, but a consequence is that some policies are quite old. An additional potential concern expressed in some areas was that it was felt that the time for policy approval was excessive. The organization may wish to audit the policy approval process to identify potential barriers to the approval process.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Since the last survey, the finance department has integrated four legacy budget systems into one enterprise-wide system. They now have a full cycle completed. The staff is being grouped into centres of excellence. Fiscal analysts are providing “at the elbow” support to managers/directors. With their strong team, the finance department has moved to electronic pay stubs and T4s as well as electronically entering travel forms. This allows payment on a more reliable timeframe. The organization is challenged by global budget restraints, increasing requests/expectations for services and requests for equipment. While there are some written policies/procedures to guide finance staff, the existing policies/procedures are outdated and need to be updated. Some processes need to be written and shared with staff.

All the IT resources and funding have been moved to Service NB. This has been somewhat challenging as the strategic planning for IT remains with Horizon but without the funding and resources. The organization has reallocated from within to create a team, led by a CIO. They are currently working on the IT Strategy and hope to roll this out in the fall.

Facilities and equipment are aging – this is a major challenge for the organization. Some of the structures pre-date HIV, MRSA, VRE, and SARS leaving it challenging for staff to maintain today’s standards in yesterday's facilities. The facilities/maintenance departments work tirelessly to keep the sites in good working order, despite many challenges.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Human Resources (HR) Portfolio consists of: Engagement Programs, HR Operations, HR Analytics and Optimization, Recruitment and Workforce Planning, Workforce Development and Workforce Relations. This dedicated team works hard to live and instill the values with the staff and physicians of Horizon Health Network. Volunteers are a vital and cherished group within Horizon Health, and their work and kindness were visible and appreciated throughout the accreditation survey.

Examples of leadership's commitment to quality of worklife initiatives include the establishment of Team Values Commitment Charters and the BRAVO awards. The BRAVO program allows employees to be recognized for living Horizon's values in a peer-to-peer approach. Nominations are readily available on-line and using small wall-mounted kiosk/devices by the cafeteria to make acknowledgement and recognition easier. In addition to individual awards, there are now quarterly Bravo Awards for those who best demonstrate excellence in living Horizon's values. There are 200 employees recognized quarterly as semi-finalists and 20 employees are recognized as award recipients.

Horizon is also very proud of their commitment to recognizing and celebrating employees achieving long years of service and those retiring. Examples were shared of the memorable experiences, which included lunches with printed programs and individualized service recognition gifts for employees, in the presence of their managers, and guests of Horizon retirees. Pins attached to staff ID tags are proudly worn by employees, recognizing their service in 5-year increments.

The "HR House" contains 3 strategic pillars of capability and capacity building, positive employee experience, and safe respectful workplace. Horizon health has worked hard in running the "Marathon of Excellence" and "5K" programs to ensure staff are up to date with key education requirements.

Workplace experience presents positive scores that are up by 10.6% among staff and workplace violence is being managed with prevention (applying the patient/client behaviour escalation model) and supports. The health and wellness team meet twice per month, and in addition to webinars on mental health, fitness, healthy eating, there are bike to work challenges and winter activity challenges to help staff manage their health. Professional development is supported, with examples including French language training and LEADS in a Caring Environment (Lead Self, Engage Others, Achieve Results, Develop Coalitions, Systems Transformation) in a Caring Environment training.

The CaRES (Caring, Respect, Excellence, Service) process welcomes new employees and volunteers to Horizon. Mandatory education, orientation and integration within the profession/group department buddies and manager check-ins are part of the process. Living the values and values sustainability is

managed through ongoing infographics and values videos are currently in development. The staff scheduling optimization project may help to optimize staffing and relief pools, particularly in specific areas. HR staff report having a good working relationship with their 3 unions, including 5 agreements. Position profiles have been reviewed for consistency, which has seen a decrease from 800 to 500 position profiles updated in the dictionary. Some span of control for managers are extremely large, making performance evaluation and support challenging. The organization is aware and is trying to implement changes. One example is the ONTRACC Program (Organizing Nursing Team Accountability Resources, Collaboration & Communication).

The organization is commended on implementing both the worklife pulse and physician worklife pulse tools. It will be important to review and update bylaws to ensure alignment with changes in the Health Quality and Patient Safety Act. The organization is encouraged to continue to actively engage with physicians in the network through the strengthening of the credentialing and re-appointment process. Horizon's managing leadership development approach is an example of building maturity and competency, and the mentorship model may prove fruitful in supporting newer/novice leaders going forward.

Priority Process: Integrated Quality Management

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
15.4	A patient safety incident management system that supports reporting and learning is implemented.		ROP
	15.4.1	A patient safety incident management system is developed, reviewed, and updated with input from clients, families, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.	**MAJOR**
	15.4.7	The effectiveness of the patient safety incident management system is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Gathering feedback from clients, families, and team members about the system • Monitoring patient safety incident reports by type and severity • Examining whether improvements are implemented and sustained • Determining whether team members feel comfortable reporting patient safety incidents (e.g., based on results from the Canadian Patient Safety Culture Survey Tool).	**MINOR**

Surveyor comments on the priority process(es)

Horizon Health Network has a strong Quality Management Framework, with a structure that provides for reporting from key committees such as Medication Reconciliation, Network Quality and Safety to executive levels regionally to Board Patient Safety and Quality Improvement Committee and full Board. Although there is no one document called Quality Plan for the organization, the Network/Department/Service each determine their quality and safety priorities, coupled with expectations set from leadership to align with system level expectations, such as partnering with patients through Patient Experience Advisors (PEAs) and implementing system wide improvements, such as an incident reporting system. Horizon's Performance Excellence Process uses best practice methodologies including a strategy map, balanced scorecard, and Lean Six Sigma process improvement. A project management office, and quality improvement staff are in place to support this work. To build capacity, white belt front line projects such as waste walks are conducted. As well, Patient Safety Walkabouts, and the Horizon Quality Quest Awards, and Patient Safety Hero Awards help to foster the awareness and

importance of patient safety and quality.

The Quality and Safety reports have evolved to include a section regarding progress made since the last report on the progress of recommendations. The organization uses a dashboard and key performance indicators to drive improvements, and shares data publicly on their website.

An Integrated Risk Management (IRM) Framework has recently been approved by the Board. Key risks are identified in the context of strategic directions and grounded in the Vision of “Exceptional care. Every person. Every day.” The organization sees the greatest risk currently as the aging infrastructure, which creates challenges in maintaining ongoing operations in service/care delivery.

The new Health Quality and Safety Act for New Brunswick proclaimed in July 2018, provides clear direction on the expectations of quality reviews of patient safety incidents, the need for disclosure, reporting to the board and including patients in receiving the recommendations to improve quality and safety within specific timeframes. The organization is to be commended on seeking external reviews, such as ISMP (Institute for Safe Medication Practices) Canada to provide feedback and recommendations on adverse event/incident management. Although Horizon has 4 different incident management processes currently, there are plans underway to have one incident reporting mechanism across the province, with a standardized taxonomy and a tentative go live date of March 31, 2019. Part of that process will involve the input of patients and families. The organization is also encouraged to engage physicians in a more robust way to continue to enhance the patient safety culture across Horizon. The suggestion of a toolkit for disclosure will help the organization formalize the process and ensure supports are in place for patients and staff alike. The new integration of risk management and quality improvement within the Quality and Patient Centred Care portfolio is a positive step in supporting thorough quality reviews and improvements.

In addition to the Pan-Canadians Hospital experiences survey that the New Brunswick Health Council conducts every three years, Horizon conducts an annual key area 12 question survey. Horizon-wide, facility and unit level results are shared to ensure both accountability at the senior level and quality improvement actions at the local level. The organization is encouraged to continue to actively and authentically engage patients and families in making improvements to the health system.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The ethics department at Horizon Health Network has four main functions: provision of ethics consultations, provision of ethics education, policy review and Research Ethics Board (REB). In terms of consults, the department averages 100+ consults per year. These consults are in real time and are clinical in nature. The top three ethical issues for the organization are substitute decision-making, research advice/review, and refusals/difficult patients. A monthly report is provided to the CEO and the CEO in turn reports to the board on the activities of the ethics department.

The REB is a 17-member skill-based board with methodological, legal, scientific, non-scientific and community members as examples. In 2017, 1,836 documents were processed; there were 35 new studies reviewed. There is an annual peer review process and the REB is committed to reviewing all submissions for the month at each meeting to avoid having a backlog. The organization has reciprocity agreements with several universities.

Every policy for the organization receives a review from the ethics department and this represents approximately 70-80 per year. There are monthly ethics grand rounds and the first ten minutes of each of the grand rounds is devoted to educating attendees as to why we need ethics, educating regarding the framework and how to use it. Executive Leadership Team members and others organizational leaders deliver the grand rounds. This has increased interest and attendance. In the last month, there were approximately 90 attendees.

The ethics team is regional: they operate as one Horizon team with multiple sites. This is appreciated by the different sites. Education on ethics and the framework is provided at orientation and then regularly.

The team is committed, keep excellent statistics and is continually promoting their services. The team needs to keep up the momentum and continue to ensure staff apply an ethical lens to their practices.

Priority Process: Communication

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

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

Surveyor comments on the priority process(es)

Communications is a passionate and exciting part of Horizon. There are several new positions, such as the Chief Information Officer (CIO), and new or enhanced strategies such as magazines like “In Your Community” and “Horizon Star & Star Extra”, community news channels, and increased use of social media.

There is strong collaboration with external stakeholders. Community Engagement through Virtual Town Halls has augmented communication more broadly than traditional town hall meetings, which typically had poor attendance. There are 4 Local Community Engagement Committees (LCEC) established in Moncton, Fredericton, Miramichi and Saint John areas, which help to relay information about what is happening at Horizon to community members and to hear directly from community members. Membership varies by local committee, with representation from foundations, not-for-profits, school districts, first nations, police force, YMCA, business groups, etc.

The Chief Executive Officer (CEO) is to be commended for being visible through several forums, such as: facility visits and tours, video updates and for creating the President@horizonnb.ca email to encourage questions and concerns directly. In addition to meeting with thousands of staff and physicians and hundreds of community leaders, she has been building relationships throughout the province. The community partners report excitement in seeing the CEO, which many have not experienced before. They are even more impressed when the CEO returns for a second visit. Strategies such as Pandemic Planning with First Nations partners and Emergency Preparedness planning are strengths with community partners. Outreach and communicating services such as transportation could be improved, however community partners appreciate that staff may be stretched too thin. The new Community Health Recognition Awards have been well received and have served to increase the profile of Horizon in the community.

Internal communications has focused on ensuring staff are communicated with first internally for news releases, which has increased awareness and trust. Various strategies are used to communicate with staff and the organization. The Communications Resource Centre (CRC) serves as a one stop shop for everything communications related at Horizon. Some “old school” tactics are re-surging, such as the use of bulletin boards and hard copy information. One-page key message documents are also created to

respond to the request of “tell me what I need to know.” The communications team realizes that e-mails may not always be seen and read. They are working to break down barriers and are proactively getting messages out, particularly on social media – where the uptake has surpassed all estimates and target goals. The Horizon stories (articles and videos), social media platforms, patient representatives, public awareness campaigns and website all contribute to connecting with the various audiences Horizon Health Network reaches.

Clinical information systems are complex with several historic legacy information systems that do not align. There are paper-based clinical records as well as electronic records. Service New Brunswick has made this a priority, and a thorough review and gap analysis has been completed, and a strategy is expected soon. A digital security strategy is in the draft stage, and the organization is encouraged to complete this for digital resilience. The efforts of e-health New Brunswick are to provide access to diagnostic testing and laboratory results. Another area that requires some attention is ensuring the policy system and flow meets the needs of the users. There is an automated work flow, however there is some variation across Horizon Health Network in ensuring timely review and updates.

The 360 – Effective and Integrated Communications Strategy is helpful in aligning with the strategic plan and vision, providing brand recognition and trust through measurement and metrics. There is palpable excitement amongst the communications team for the successes achieved to date and for new opportunities such as news-style journalism – the Horizon Community News channel launches soon, and documentaries.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Horizon Health Network's leaders are challenged with maintaining an aging infrastructure and they are doing what they can to mediate this situation. Both local and regional management are challenged by a lack of funding that would allow all the improvements that they feel are required to be made. Staff at each site are aware of management's efforts and they are doing their best to cope with the situation.

Initiatives to maintain and/or improve the physical environment include systematic "environmental walk-throughs" to ensure that plumbing, carpentry, electrical systems, flooring, paint, etc. are being maintained on a room-by-room basis.

The aging emergency electrical generators at Saint John Regional Hospital are tested weekly under load. They are being replaced by newer models that will provide the facility with increased output.

A shortage of storage space was noted at some sites and as a result, clutter was seen in many areas. However, no unsafe conditions were found.

The housekeeping staff are to be commended for the overall cleanliness of their facilities.

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
14.5	The organization's all-hazard disaster and emergency response plans are regularly tested with drills and exercises to evaluate the state of response preparedness.	!
14.9	A business continuity plan is developed and implemented in order to continue critical operations during and following a disaster or emergency.	
14.10	The business continuity plan addresses back-up systems for essential utilities and systems during and following emergency situations.	!

Surveyor comments on the priority process(es)

The Emergency Preparedness processes are overall well organized. They have a very strong and lean group.

There is excellent partnerships with community such as the Department of Health, New Brunswick Emergency Management Officer, RCMP and Fire, etc.

They won two awards since the last survey: Technology & Innovation Award (2014), Award for Excellence in Service Delivery, Radiological, Nuclear Medicine, Emergency Preparedness & Response (June 2017) as well as being recognized by the Health Sector for "strong planning and exercise performance".

The team participated in HEPA (Healthcare Emergency Preparedness Alliance) and work hard to ensure best practice.

Since the last survey, they have standardized emergency responses in over 100 sites.

Recently the team was involved in assisting with a community emergency, deploying many staff from various sites to help. This is reported to have been executed quite well.

Any plans they have for the hospitals are connected to the systems and processes are in place for city and province.

The team is also planning to create a statistical tool that will allow them to track events under each colour code. Right now, they do not have drills in a consistent way with all codes in all sites - although many are done - as they cannot track when actual events have occurred and areas where no drill or event has

occurred. It is suggested that these could happen on a small scale by unit and code over a long period of time.

A suggestion for code blue might be: instead of residents doing code blue mock codes in the lecture theatre, have them do them on the wards in an empty bed so nursing staff can participate and it is done in the real world of space limitation, other patients, etc.

The team keeps track of some of the events in which the hospital is directly involved and note the review after the action occurred. They call this debriefing - after action review.

There was a mock disaster experience in August on two escaping clients - one with a medical emergency. This occurred on a weekend. It was well attended and much was felt to have been learned by many staff. This was an excellent idea that also informed the Emergency Preparedness group of things that could be better around reporting and informing.

It was also noted that a lack of funding prevents the managers from hiring additional staff that would lighten their workload enough, so they could focus more on developing strategic initiatives. They are able to keep up with their current initiatives, but it is difficult to find time to develop and implement new ones.

The department also reviewed all its colour codes and standardized them. More than 90 percent of staff also completed emergency preparedness training.

The team has a great plan for space usage in Moncton that might benefit from a colour coded floor plan for casualties/media/families, etc., to better direct people to where they need to go.

Emergency preparedness relates to infection prevention and control, and example is with the pandemic planning.

The organization is encouraged to have a business continuity plan for the backup systems.

Fire drills occur once per month in all hospitals and one per year in community clinics/locations.

Regarding communication, the team could review best methods/preferred methods of contact for staff and physicians, consider going to group text rather than fan out list. Test the text group. Review the method and provide follow up for quality improvement.

Priority Process: People-Centred Care

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

Unmet Criteria	High Priority Criteria
Standards Set: Obstetrics Services	
8.1 Each client's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family.	!

Surveyor comments on the priority process(es)

The organization is to be commended for their progress towards people-centred care since the last survey. The organization has made this a priority, from the board level to the front-line services. In 2014, the organization formed a Patient Advisory Council (PAC). Since then, the organization has recruited 76 Patient Experience Advisors (PEA's) who have participated in 98 projects, committees, and focus groups. In speaking with a group of these PEAs, it is "more than token-ism". PEA's believe they are part of the team, their input is appreciated, and they have made a difference. More and more of the staff are seeing value in having the voice of the customer on the team.

Horizon has made a strong effort to incorporate and embed the PEA's into the culture of the organization, including at the Medical Advisory Committee (MAC) level. Initially, the MAC may have struggled about the appropriateness, one of the PEAs reports the same practitioner who may have struggled the most has now explained they see the value-add and appreciate the PEA being present.

The organization has dedicated resources to work with the Patient Advisory Council and PEAs. The department is shown on the organizational chart and has developed a robust intake process as well as the orientation process. There are a patient advocate and patient representative available to clients and families across the organization. A patient/family who spoke of this were quite appreciative of the resources they were able to access in a rural community.

The organization has made many efforts enterprise-wide to be more people-centred, including having staff simply say Hello-Bonjour to indicate they would service clients in their language of choice (English/French). Name tags are worn by most staff and the letters/name are a larger font. This is appreciated by patients/residents. The organization has pockets where there may be some work to do; however, overall there is evidence of people-centred care.

The organization has begun to develop metrics to gauge their people-centredness. There are 30 committees that are mandated to have PEAs. On the most recent quarterly report, the organization is at 86.7 percent and are trending to reach 100 percent by next quarter.

When asked to use one word to describe Horizon Health Network, the patients/families in the focus group used the following words: caring, dynamic, empathy (nurses), non-trump, professional, improving and "work in motion".

Priority Process: Patient Flow

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

Unmet Criteria			High Priority Criteria
Standards Set: Emergency Department			
3.1	Client flow throughout the organization is addressed and managed in collaboration with organizational leaders, and with input from clients and families.		!
Standards Set: Leadership			
13.1	Client flow information is collected and analyzed in order to identify barriers to optimal client flow, their causes, and the impact on client experience and safety.		
13.2	Information about barriers to client flow is used to develop a strategy to build the organization's capacity to meet the demand for service and improve client flow throughout the organization.		
13.4	Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors. NOTE: This ROP only applies to organizations with an emergency department that can admit clients.		ROP
	13.4.1	The organization's leaders, including physicians, are held accountable for working proactively to improve client flow and mitigate emergency department overcrowding.	**MAJOR**
	13.4.6	Interventions to improve client flow that address identified barriers and variations in demand are implemented.	**MAJOR**
Standards Set: Perioperative Services and Invasive Procedures			
9.6	There is a standardized, proactive process to prioritize and schedule elective procedures.		

Surveyor comments on the priority process(es)

Patient flow is a priority for Horizon Health Network and there is ongoing effort to identify and mitigate bottlenecks to improve patient access and care. Many factors are outside of the organization's control and they are working with partners to address these external factors – in particular, the "Why Wait" Program to divert patients from the emergency, identifying trends in high-frequency emergency users, working with Ambulance NB to implement a transfer service, and collaborating with long-term care services to

prioritize admitted patients for placement.

Ensuring the right person is in the right bed at the right time is paramount for patient flow and safety. Many projects have been initiated to manage the complex patient flow issues acknowledged throughout their organization. These are ongoing as the organization analyzes and assesses bottlenecks and acts to mitigate identified areas.

Expanding medical directive usage may be a consideration, particularly in the emergency departments. Providing the education and directives for nursing staff to initiate investigations and treatments in line with evidence-based criteria (e.g. Ottawa ankle rules) will decrease the time the patient in is the emergency department and streamline flow through this department. Implementing an Estimated Discharge Date (EDD) on admission to establish goals and assist in identifying barriers to meeting EDD may also be beneficial. Setting this goal may assist clinicians in discharging (especially when cross covering) and provide data for auditing services.

Best practice guidelines have been established for many services and the organization is encouraged to audit compliance across all sites. Providing support and authority to the professional practice leads would support the organization in educating healthcare providers on best practice on the front line. A practical example is in diagnostic imaging where establishing criteria for imaging may result in flagging inappropriate requisitions and decrease the pressure on high demand services.

The perioperative teams have done some excellent work in standardizing equipment and wait-list criteria. Continuing these efforts across the organization and with all specialties to standardize care, surgical trays and prioritize wait-lists may help to improve efficiencies. The organization provides resources for a significant number of non-medically required procedures. Horizon Health Network may wish to review their processes to balance non-medically required resource allocation with the wait lists for medically required procedures.

When services are added to Horizon Health Network, the organization will need to assess the impacts across the entire breadth of the organization. For example, additional operating room time does not just impact the perioperative team. Inpatient beds, diagnostic imaging, laboratory services and other auxiliary health professionals are also impacted and need to be considered.

Regionally, the client flow team may help identify opportunities to improve flow across the Network. An example of regional opportunity might be to utilize low volume sites proactively to relieve surge pressures from overcapacity sites.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Perioperative Services and Invasive Procedures		
4.13	Clean and sterile surgical equipment, medical devices, and supplies are stored separately from soiled equipment and waste, and according to manufacturers' instructions.	!
Standards Set: Reprocessing of Reusable Medical Devices		
3.5	Appropriate environmental conditions are maintained within the MDR department and storage areas.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
3.7	The MDR department is clean and well-maintained.	!
7.1	Clear and concise policies are developed and maintained for reprocessing services.	!
7.5	Clear and concise Standard Operating Procedures (SOPs) are developed and maintained for reprocessing services.	
7.9	Policies and SOPs are regularly updated, and signed off according to organizational requirements, as appropriate.	!
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	
12.1	The MDR department has an appropriate storage area for sterilized medical devices and equipment.	!

Surveyor comments on the priority process(es)

During the review of the Medical Devices and Equipment standards, all team members were energetically engaged in the accreditation process, clearly committed to continuous quality improvement, and very proud of their programs and services.

The organization has a good process to address on demand maintenance requests as they are identified, and the team responds in a timely fashion to any issues identified. In partnership with the Clinical Engineers through Service New Brunswick, Horizon has access to a very robust Resource Management System clearly outlining service contracts, preventative maintenance, work orders, and equipment lifecycle. This system was recognized internationally "for demonstrating a commitment to the highest standards of safety, quality, and cost-effectiveness in healthcare."

Throughout Horizon, the Medical Devices and Reprocessing Department (MDRD) staff were found to be extremely dedicated and committed to performing high-quality work. The MDRD is organized in a network model across all the sites with regional program leadership. While not all sites at this time are completely integrated in their standards and policies there is purposeful intent to achieve this and evident in their goals and objectives. There is no reprocessing of single-use devices.

Sites reported that flash sterilization is only being utilized in emergency situations and was documented as part of the key performance indicators. The accountability for reprocessing of medical devices in certain areas outside of MDRD rests with the department performing the reprocessing and Horizon is encouraged to continue moving forward with their plan to ensure alignment across all reprocessing areas.

The physical environment of the medical device reprocessing departments/areas varies by site. Some sites have opportunities for improvement that could enhance the quality of the service. Some of these opportunities will require capital investment while others may simply require adjustments to workflow. It was observed that there is a lack of physical separation between the clean and dirty areas. Some sites require minor modifications to ensure that cross-contamination from outside areas does not occur. Others appear to require more substantive renovations. The organization is encouraged to address the physical infrastructure challenges to ensure a physical separation and consistency in one-way flow in addition to adequate storage in the MDRD.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

Standards Set: Population Health and Wellness - Horizontal Integration of Care

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness

Population Health and Wellness, highlighted Youth Mental Health and Integrated Service Delivery (ISD). This is an excellent example of what is possible with integration and leveraging of available resources (internally and externally) in new ways. The current work, was preceded by testing and a staged roll out. It is now across the Horizon Health Network. The organization and partners which include Education, Justice, and Social Development are to be commended for their openness to working in new ways in pursuit of a goal. This makes it easier to pull in additional stakeholders such as community and leaders to maximize success and service while encouraging community ownership.

The broad representation during the Population Health and Wellness Accreditation survey visit demonstrated the depth of interest and commitment to this work.

The Child and Youth ISD model provides a significant opportunity of learning for this and other programs. The team and organization may want to consider reaching out and pursuing involvement as a partner in 'Action Research' with the university(s) to both strengthen and add to learning, and outcomes.

The current substantial effort, partnerships, data collection and early outcomes at all levels, are very promising for population health and wellness. Well done!

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Public Health

- Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.5	Resources and infrastructure needed to clean and reprocess reusable devices are accessible in the service area, as required.	
2.7	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		
The network has strong processes in place for strategic and operation planning and quality improvement. The network regularly reviews the top 3 incidents and the patient survey results as well as the audit results for medication reconciliation, hand hygiene and falls risk assessment. Clinics select 10 charts for audits ranging from monthly to quarterly.		

Patients and families are involved in the strategic and operational planning.

There is a strong commitment to quality at the leadership, site and individual team. There is good collaboration across the different services provided in ambulatory care as well as with other service areas.

The New Brunswick Health Council does not do surveys of ambulatory patients. Horizon is encouraged to explore with the New Brunswick Health Council the feasibility of expanding their surveys to include ambulatory care.

Priority Process: Competency

A collaborative team-based approach is used. Staff are focused on the needs of the clients and delivering safe care. Clients spoke highly of the healthcare workers and physicians who provided their care. Staff indicated that they either had regular performance appraisals or performance conversations. There was support for continuing professional development within budget constraints. Education was provided when new equipment was introduced.

Priority Process: Episode of Care

The focus is on the needs of the patient and family and responding to the issues identified in the patient satisfaction survey and the risk issues identified by incident reporting. The example was given of how ambulatory care with the support of quality improvement staff (black belt experts) worked on improving patient scheduling at one site and then spreading the improvements to other sites. Patients spoke highly of being offered options for appointments that fit their needs. The referral process has been changed to benefit the patient (time of choice and clinic) rather than the provider. The result has been fewer missed appointments and optimum use of resources and reducing the number of forms that physicians must complete.

Priority Process: Decision Support

Ambulatory Care uses a paper-based record system except at one site where the facility has an electronic health record. Client confidentiality is protected. The use of a paper-based system creates several challenges. There is extensive use of copiers and faxes to facilitate the flow of information to other services and to physicians who are referring or caring for patients.

There is a need for an electronic health record to help support functioning of ambulatory care.

For chart audits, it means that staff must be dedicated to review the paper records and collect the required information for reporting on key performance indicators or to collect the necessary information for quality improvement initiatives. Until an electronic health record solution is in place, the team is encouraged to explore whether it is possible to use coders to collect the information as occurs in acute care rather than having to assign clinical staff.

Priority Process: Impact on Outcomes

The team's commitment to improving patient safety is illustrated by the quality improvement initiative identified from incident reports. Specimen labeling was identified as a patient safety issue through critical incident reporting.

The team involves New Brunswick Health Council in the selection of clinical practice guidelines. The team uses current national guidelines such as the Canadian Endoscopy Guidelines. They carry out a formal gap analysis when a standard is developed and then monitor through regular reporting that the gaps are addressed, and the service is aligned with the guidelines.

There is also a formal feedback loop to staff to keep them informed of the results of quality improvement initiatives.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

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

The organization has met all criteria for this priority process.

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

Horizon Health Network Laboratory Services are accredited by the Institute for Quality Management in Health Care (IQMH). Accreditation Canada recognizes the results of the IQMH assessment. The laboratory service provides a quality laboratory service that works as a network of laboratories. The laboratories also work closely with Vitalité.

Health Network to provide services across the province of New Brunswick. Quality indicators are measured, and the information gathered is used to make improvements to the laboratory service.

The laboratory continues to identify opportunities for improvement that will enhance the laboratory service and maintain fiscal responsibility. The laboratory identifies improvements and consults with patients and families when making improvements.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.7	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
17.12	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
14.10	The client's informed consent is obtained and documented before providing services.	!
14.12	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	
17.1	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
17.1.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
18.5	Environmental distractions are minimized for team members who are performing critical tasks requiring concentration.	
22.5	Survivorship planning is incorporated into the transition plans in partnership with clients and families.	
24.4	Technologies, systems, and software are interoperable.	
Priority Process: Decision Support		
23.1	An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.	!
23.3	Policies and procedures to securely collect, document, access, and use client information are followed.	!
Priority Process: Impact on Outcomes		

The organization has met all criteria for this priority process.

Priority Process: Medication Management

6.2	Systemic therapy only: Computerized physician order entry (CPOE) or Pre-Printed Orders (PPO) are used when ordering systemic cancer therapy medications.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Cancer care across Horizon Health Network is overseen by the Oncology Network. The network includes all relevant stakeholders, including a patient experience advisor. The team is very active, and its work has improved standardization of practices across the region, from the larger centres to the small satellite sites. The network has also improved communication among the different health care providers. Initiatives undertaken at the network level benefit all patients and ensures safer care.

A strategic planning day in May 2018 has resulted in many potential actions and there is an exercise underway to prioritize actions and provide timelines for completion. Three major themes were selected by the group and actions will be aligned to the themes.

A communication letter is also produced by the network to help disseminate information related to cancer care.

There is a strong partnership with the Dr. Georges-L.-Dumont University Hospital Centre and Vitalité Network in the areas of research and patient care. Radiation therapy is only provided at the George Dumont hospital for Moncton cancer patients; the collaboration works well between the two groups.

Priority Process: Competency

Horizon Health Network has created an Oncology Nursing Systemic Cancer Therapy Certification Program that was last reviewed in 2014. There is also an Oncology Services Standards document that has helped standardize practice. There is a plan to review and update these standards. Employees also have access to education, either through the eLearning system or by attending internal or external presentations and conferences.

Employees have a regular evaluation of their performance and they were satisfied with the process in place. Initial education and regular recertification for the infusion pumps are well done and the activities are monitored for compliance. The use of the pump library has been identified as a challenge and audits demonstrate that the library is not used for all infusions.

The radiation therapy group is also active, providing education and ensuring staff involved with radiation are trained and qualified to perform the work. There is a designated program lead and a radiation safety officer in place. The radiation team is commended for the work done to ensure all standards were reviewed and met.

Priority Process: Episode of Care

The number of patients seen, and treatments administered is increasing steadily which creates workload issues with staff and space challenges where there is no room for expansion. The outpatient area at the Saint John Regional Hospital is to be expanded soon, which will provide a better patient experience and a safer environment for both staff and patients.

There is evidence of good interdisciplinary work and the roles are well established and understood. The emergence of more oral therapy options for the treatment of cancer has created new challenges and new expectations for the pharmacy and nursing teams but the work done by these teams is excellent. Patients are also provided education before systemic treatments and a safety checklist is used to reduce the risk of errors.

Medication reconciliation is well done both in the inpatient and outpatient settings. Venous thromboembolism (VTE) prophylaxis need is assessed for all at-risk patients.

Priority Process: Decision Support

The use of different systems to document patient information and to prescribe treatments continues to be a challenge for this program. Some centres receive treatment prescriptions from different systems and in different languages for the same protocol. Systems do not interface with each other, so parts of the patient record can be found in three different areas in some of the outpatient treatment centres.

The health care providers take great care in selecting, verifying and administering chemotherapy treatments to ensure patient safety. All medication orders are double- and triple-checked to ensure accuracy. However, treatment protocols are not standardized across sites, which increases the risk of errors and misinterpretation. The organization is encouraged to work with stakeholders to develop standard treatment protocols for the more common oncologic conditions.

Priority Process: Impact on Outcomes

The Oncology Network leverages evidence-informed guidelines from other Canadian cancer organizations such as the BC Cancer Agency (BCCA) and Cancer Care Ontario (CCO).

The Oncology Network has a robust dashboard and keeps track of several key performance indicators such as the number of telehealth visits, and number of curative radiation plans reviewed by an independent physician, among others. Patient and staff incidents are documented, tracked, and analyzed for trends. Corrective measures are put in place as needed. The data is compiled and reviewed locally but also reviewed at the network level.

Quality improvement initiatives are initiated at the network level and implemented at all relevant sites.

Priority Process: Medication Management

Medication management is well done, and systemic therapy is prepared and administered in a safe fashion by knowledgeable and dedicated staff. Some of the chemotherapy preparation areas do not meet the new Canadian standards and significant investment will be required to ensure the pharmacy sterile preparation rooms are upgraded accordingly.

Standards Set: Community Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.9	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Community Health Centers within Horizon Health Network have been designed to meet the specific needs of each community from a community needs assessment done in 2012. No clinic is the same and the venues are varied. Programs offered at each center are diversified and innovative. Too numerous to mention but to name a few, Bulk Food Program, seniors exercise and education programs, GED support, winter and summer wellness challenges, and "Roots of Empathy".

The common theme for each of these centers is the networking and integration with their community. Community partners range from church groups, outreach programs, recreation centers, schools, and needle exchange programs to name a few.

Opportunities:

- Review the use of Pushbutton locks on interview rooms potentially placing staff at risk in the

event of a violent client.

- Provision of puncture proof gloves for those preforming laundering services.
- Improve the cooperation for the intake processes between Community Health Centers and Mental Health Community Health Centers (MHCHC).

Priority Process: Competency

Staff competencies are mandated and tracked by management. There are electronic learning packages employees are expected to complete each year or every two years. Staff are recognized by the Horizon Health Network Bravo Awards. For the community health centers, there is a Regional Health Education Forum sponsored by Horizon Health Network every two years. All staff from the community are encouraged to attend and present each "Promising Practice" from their community.

As staff are interested, a specialized community care education is encouraged. Physicians tend to be active in the communities, particularly involved in associated communities such as recreational center improvements, curling club, fundraising, Harvey Helps and multiple other events and programs.

Priority Process: Episode of Care

Community Health Centers within Horizon Health Network have been designed to meet the specific needs of each community by a community needs assessment done in 2012. Some of the clinics continue to strive to reach the mandate, while others are preparing to perform a second one to ensure the community needs are met. No clinic is the same as none of the populations are the same. Some clinics have been launched in unused parts of a school or space in the community where space was available. Two visited much to the outcry of the community have been contained in repurposed community hospitals. Overall the community agrees now the services are much more robust than what the inpatient hospital was able to offer.

Programs offered at each of these clinics are diversified and innovative. There is an education forum held every two years for clinic teams to share pilots from their clinics to present to their peers. Too numerous to mention all the initiatives but to name a few, Bulk Food Program, Seniors Exercise Program, GED support, seniors education for wills, taxes and power of attorneys, winter wellness (purchase of snowshoes for the community with sign out at the local library. Also, summer wellness activity challenges, senior bus tours, slow cooker classes and "Roots of Empathy" are offered in the schools.

What each of these clinics has in common is the networking and integration within their community. The community supports, and programs range from churches, grocery stores, meals on wheels, outreach programs, fairs, fundraisers, the United Way, YMCA, local recreation centers, curling associations, schools, needle exchange programs, Immigration Services, UNB, and Association Regionale de la Communauté Francophone (ARCF) of Saint John to name only a few.

Another common feature is there is the ability to see people who are asking for services on the same day depending upon vulnerability and the matching of the directives for the health clinic. Although,

depending upon the location wait times for appointments can vary at each clinic from no wait to 5 - 6 weeks.

Priority Process: Decision Support

One of the largest challenges facing the Community Health Centers is that of documentation electronically. Currently there are two different electronic medical records and the paper charts. Ideally, all the CHC would use the same software as the family physicians to enable the charts being seen out of the clinics by physicians and by health professionals.

Priority Process: Impact on Outcomes

Capacity to collect indicator data is limited to data that is currently collected in the EMR that decision support can retrieve. There is not the ability for the manager to be able to pull data for program planning and evaluation that the EMR was originally supposed to offer.

Currently there seems to be a lack of organized statistics to compare the effectiveness of the quality initiatives. For example, the phone calls to post-hospital discharge to decrease ER visits and readmits. There are multiple electronic platforms used as well as paper charts.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
7.2	Hours of operation are flexible and address the needs of the clients and families it serves.	
8.11	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Community based mental health services are offered in Fredericton, Miramichi, Saint John and Moncton. Services offered are: FACT; Mobile Crisis; Child and Youth Teams (ISD); Adult Treatment; Early Psychosis; Adult and Youth Inpatient Psychiatry; Detox and Methadone Clinics; Intake; ER Mental Health; OPC Addictions; OSI Clinic (not in all places).

Teams are multidisciplinary. Services can be for adults and/or children/youth.

When visiting the community-based addictions and mental health service, it was evident that client-centered care was happening here.

The psychiatrists lead the way, visiting clients in their homes, taking on youth clients because there was a need, spending extra time with clients, and being a strong resource for staff.

Woodstock and Sussex were also visited. A strong multidisciplinary team was also in evidence.

The program works well with parts of the hospital, psychiatry, and detox. It is very client-focused. It was less clear if there were other non-health related partnerships.

There is a strong multi-disciplinary team of social workers, psychologists (although very hard to find them to hire), nurses and psychiatrists. From stories told, clients find the workers very keen to help them, get them out into the community, and etc., by going with them to events and creating conferences, and special days that work to eradicate stigma (Stomp out Stigma event in Newcastle Park, Link for life at that same event). As well, the program offers workshops to the public and organized an anti-stigma conference a few years ago.

The facility is accessible, there is parking around the office and access for wheelchairs. The clients took on the renovating of the waiting room and made it very cozy with paint, pictures, new chair groupings, and lower lights. This was encouraged by the staff.

The program created a First Nations Project with 3 bands, this planning is ready for a memorandum of Understanding to be signed. This plan would mean addictions services could be offered in the communities, easier access for clients. They also spoke about some Syrian families coming to New Brunswick and providing services even though they did not eventually stay in the province.

It is obvious from the interaction observed with clients and the way in which staff are attentive to staff feedback that they are very people-centered.

Priority Process: Competency

Staff receive and are offered a great deal of training and access to new learning. There is required training (such as ASIST for suicide prevention) and then there is training offered in other parts of NB and the Atlantic provinces by video conferencing. Staff are also encouraged to go to conferences.

In some communities, clinical supervision is being offered to clinicians.

Every staff received "family involvement training". As well, they received training on the recovery model which was very important for their work.

There is a team feeling to this program, one that has shared values about recovery and a focus on client care.

Staff communicate about clients through a very robust client record database that appears very secure and yet open to access by people who need to know about the client. When many services are being offered in many different areas and sometimes clients return or go to the hospital and elsewhere, this record is excellent for people to easily see what is happening holistically with clients. As far as communicating with families of clients is concerned, the team takes direction from the desires of the

client.

There is no spiritual space. However, the waiting room is a very peaceful space and since the program is in a small town, there are places of worship that are easily accessible.

Priority Process: Episode of Care

The office of Addictions and Mental Health Services is in Miramichi, there are only services for adults there. Children's services are now located in school locations.

The office is open only 8:30-4:30 Monday - Friday. The organization may want to consider different hours for client access. There is a 24-hour crisis service that all clients can use called Chimo. A brochure containing information about this is given to all clients.

Rights and responsibilities are clearly noted.

Clients arrive and are greeted by a receptionist. No one is turned away. Walk-ins are given a short assessment of needs interview. It appears that people are seen quickly and with relative ease. The waiting room was full, people were talking with each other, there was an air of comfortability when the surveyor was there.

Clients report being very cared for by the counselors. It is reported that the staff will go out of their way to help the most vulnerable clients and this is noted and appreciated. It was evident that the staff are very client-focused in many ways.

Client files are electronic at this site. There is a hard copy file that houses only collateral information. The e-file is easy to read, access and maneuver through. There is a connection of this file to the hospital units and this is described as a real help for the counselors as their clients may be admitted to hospital and knowing this early is always good.

Ethics and managing dilemmas might need some work for the front-line staff. People are aware of the ethicist and having access as well as knowing there is a framework. The ability to put it all into practice was unclear.

Staff are well trained and sensitive to the effect changes of any kind have on their clients.

Priority Process: Decision Support

Access to files is very collaborative.

It is recommended in Moncton that the organization continue working on integrating health records to decrease duplication and risk of key client information being missed.

There are few problems with client file technology, this is very up to date.

Team members are very conscientious about privacy and the use of any client information by others.

Mental health services at Horizon have embarked on the implementation of the Addictions and Mental Health Information Systems (AMHIS), which is a cost workload and outcome data base. Four modules of e-learning are required to ensure privacy, patient consent and understanding the role of the patient advocate. A pilot test in underway to help reduce the number of no show appointments by the use of text messaging.

Priority Process: Impact on Outcomes

There are a few KPI's and program statistics of note, a guarantee of an appointment within 3 days, clinicians and intake scheduling 4 clients per day and nurses providing injection services are scheduling 6-8 clients per day.

It is suggested that expanding the breadth of "outcomes" be done, perhaps using session rating scales to access immediate client feedback and a distress scale to see if a session was successful from the client's point of view.

The program is very client focused and client’s voices are welcomed. It is unclear how much say clients might have in developing scales and outcome measures, but their feedback would be sought once an instrument is being used.

Incidents that occur are reported in a timely fashion using the network's processes.

The programs across different communities work together. They are excited to begin using a new work load collection tool which will help them track the work they do and the progress for their clients.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	A tailored approach is used to provide critical care to various client populations including neonatal, pediatric, and/or adult clients.	!
1.5	Services are reviewed and monitored for appropriateness, with input from clients and families.	
4.3	The critical care unit model of care is appropriate to the level of care provided.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
6.1	There is a process to screen potential clients against admission criteria for critical care.	
11.5	The transition plan is documented in the client record.	
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Organ and Tissue Donation		
12.12	Data gathered on all ICU deaths is accessible and there is a process for reviewing the data to identify lost opportunities for donation and refer the information appropriately.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Critical care services for neonatal are in three cities: Moncton, Saint John and Fredericton. Adult critical care facilities are more widely spread in different cities: Fredericton, Miramichi, Moncton, Saint John and

the Upper River Valley Hospitals. We did not survey the Upper River Valley Hospital facility. Since the last accreditation visit the leadership has carried out several quality improvement initiatives such as medication reconciliation, thromboprophylaxis and interventions to prevent pressure ulcer development.

The care model design workbook provides valuable information to the individual intensive care/critical care units (ICU/CCU), as well as for the critical care program, with both utilization data and type of clients receiving care. However, some discrepancy and variations between sites was observed. The organization is encouraged to follow this quality improvement indicator since it can have repercussions on the availability of beds for post-surgical situations. We did notice that some cancellations were due to unavailable beds in the intensive care sector. There are also environmental considerations in some locations in terms of space available. For example, no waiting room for patients who want to visit their loved ones at the CCU at the Dr. Everett Chalmers Hospital. There is a new project for Fredericton and leadership is encouraged to have input from patients and families early in the projection phase.

There are adequate numbers of physicians and nurses for providing critical care services. The team is to be commended for its auditing capabilities. Performance indicators are present. The critical care leadership receives and reviews unit specific information regularly.

The organization is encouraged to consider the following quality improvement initiatives: a closed intensive care unit with intensivist managing all patients; establish admission/discharge criteria for all admissions, discharges which are consistent with best practices; continuing audits which verify qualitative issues such as professional notes and care plan for physicians; finally it is imperative to audit acuity of intensive care patients allowing the organization to determine if there should be a modification in allocation of number of beds according to severity.

Priority Process: Competency

There is a well-developed system for the verification of credentials for professionals and doctors. All new staff undergo an orientation process. Performance appraisals are done mostly annually and serve as an opportunity to identify educational needs. There is ongoing professional development that takes place in all locations. There is an interdisciplinary team present that works effectively together. There is research carried out and in such circumstances the Research Ethics Board provides the necessary terms of reference for its application. Patient engagement is present.

The neonatal intensive care team is an interdisciplinary team much involved with families in the planning, patient care and discharge. The families interviewed during the on-site survey spoke extremely high of the team including doctors, nurse, social worker and other staff.

Priority Process: Episode of Care

Horizon Health Network has new Critical Care Standards which were developed and created as a quality improvement initiative. These standards define the basic and essential expectations for the network. Comprehensive assessment is undertaken by the team and appropriate laboratory and diagnostic testing

is carried out. Access to diagnostic and laboratory use is available always.

A treatment plan should be developed in collaboration with patient and family. This was not evidenced in some files reviewed. The organization is encouraged to adopt audit verification on this quality improvement issue. There is the use of checklists that assure that all aspects of the patient's condition are being considered. In addition, checklists are also used to help archives better designate and identify the classification of that case in the data system.

In considering the type of patients in the intensive care unit, be it at the adult or neonatal level, there are indications that there is inappropriate use of the unit. For example, for neonatal sectors the admission statistic with regards to percent of newborns treated in intensive care is higher than the benchmark. Analysis of such an indicator could lead to explanations that justify such scores or they may not. In the adult sector for example, there are unclear indications as to when the intensive care unit patient of level three can be admitted to a step-down unit.

Parents indicate being well supported during their child's admission at the neonatal intensive care units. They describe that upon admission they feel extensive support. In all Intensive Care Units there is ethical and spiritual support readily available. If a transfer is needed information is provided to the patient and family. There is an inter-facility transfer of care report between critical care areas.

Priority Process: Decision Support

In the neonatal intensive care units there is use of updated evidence-based protocols that reflect current research and best practice for providing emergency care. The teams are involved in some research activities which meet research and ethics standards and protocols. Clients and families are provided with information about their rights and responsibilities.

The information for decision making is accessible depending on the location, via electronic or paper method. In our observations confidentiality is always on the forefront. As an example, in neonatal intensive care, where the environment is one of open concept, to assure confidentiality, the parents that remain during the medical rounds wear headphones to respect the privacy of conversation between staff and doctor with the family. Staff educate families on expected course of outcome.

Priority Process: Impact on Outcomes

There is a culture of quality improvement. Indicators are followed, and results are shared with the team. As an example, we saw all across the organization local percentages of hand hygiene compliance. There is also concern for efficiency and cost-effectiveness.

Adverse events are analyzed, and results are used to avoid recurrence or become quality improvement initiatives. Disclosure and support measures to the family are provided.

The organization constantly monitors and applies known safety practices such as: fall prevention, infusion

pump education, pressure ulcer prevention, double identification, deep vein thrombosis prophylaxis (where applicable) and medication reconciliation. The organization is encouraged to work on medication reconciliation at discharge.

Priority Process: Organ and Tissue Donation

There are well established protocols for organ donation. Staff members in the adult intensive care units receive training on the process that must be followed to initiate the process. In the adult units there is an awareness of the program and how to approach potential donors. Missed opportunities are analyzed.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
6.7 The team annually reviews and updates the Policy and Procedure Manual.	
Surveyor comments on the priority process(es)	
Priority Process: Diagnostic Services: Imaging	

Horizon Health Network has a transparent, robust and consistent process for the prioritization, selection, and purchase of diagnostic imaging equipment. The imaging equipment is generally up to date but some of the general x-ray and fluoroscopy machines are aging to the point where they will soon be in need of replacement. Some of the machines are near “end of life” and if they are not replaced will have to be used beyond that point. There is a five-year plan for capital acquisitions but obtaining the funding to replace some of the aging imaging equipment is a challenge.

The imaging machines are serviced primarily by the vendor and undergo regular preventative maintenance inspections. The biomedical team assists with the servicing of these units where appropriate.

Endocavitary ultrasound probes are currently being reprocessed in the ultrasound department but there are plans to have the medical device reprocessing department assume this task.

Four different PACS are used within the region but a complex consolidation plan to replace them with a single PACS is underway. It is thought that this initiative will result in increased efficiencies in moving images between sites and will also aid in the reporting of images via tele-radiology.

Policies, procedures, guidelines, and standard operating procedures are available but are not all up to date.

The sites have a robust radiation safety program which is supported by a strategic focus on all aspects of radiation safety including diagnostic reference levels, equipment management, and repeat reject analysis. Physicists assist with the radiation safety program. Safe patient care and an awareness of occupationally related risks is evident.

Medical imaging staff in the region are well trained, conscientious, and engaged. However, recruitment and retention of technologists in some areas, most notably ultrasound and MRI, presents a challenge to some departments. Staff report that they are pleased with their leadership.

Patient experience advisors are an integral part of the department and frequently attend management meetings where they provide input from a patient perspective.

Patients and referring clinicians are happy with the Diagnostic Imaging service in general and with their access to timely reports. Service is provided in both French and English.

A Lean Six Sigma Program was initiated approximately five years ago. It is ongoing and has been reported to be largely successful.

At one of the sites the Fast Track physician in the emergency room interviews patients behind a curtain next to the medical imaging clerk and conversations are easily heard. It would be beneficial to consider ways to enable those conversations to be made in private.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
4.9	A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.		ROP
	4.9.2	Initial and re-training on the safe use of infusion pumps is provided to team members: • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed When infusion pumps are used very infrequently, just-in-time training is provided.	**MAJOR**
	4.9.4	The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.	**MAJOR**
	4.9.5	The effectiveness of the approach is evaluated. Evaluation mechanisms may include: • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from clients, families, and team members.	**MINOR**
Priority Process: Episode of Care			
7.1	Entrance(s) to the emergency department are clearly marked and accessible.		!
8.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.		

10.14	Priority access to consultation services is available 24 hours a day, 7 days a week.	!
12.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
12.16.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
12.16.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
12.16.3	During care transitions, clients and families are given information that they need to make decisions and support their own care.	**MAJOR**
12.16.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
Priority Process: Decision Support		
14.6	Policies and procedures for securely storing, retaining, and destroying client records are followed.	!
14.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
18.5	Ambulance offload response times are measured and used to set target times for clients brought to the emergency department by EMS.	
Priority Process: Organ and Tissue Donation		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Horizon Health Network collects extensive data on emergency department indicators. This information is used to direct and prioritize initiatives and programs to mitigate identified areas of concern and objectively measure the impact of new programs. Excellent work has been done on including Patient Experience Advisers (PEAs) in a variety of committees relating to the emergency department and services.

High volumes in the emergency department continue to be of significant concern for the organization. The efforts of the team to educate the public on alternatives to accessing medical care, the Why Wait Program, is of note as the organization attempts to decrease public reliance on the emergency department for non-emergent reasons.

Within the organization's emergency response plan, the emergency department has clearly defined roles. The organization has complied with requirements for pandemic and Ebola response.

Priority Process: Competency

The emergency department teams reflect the required skill sets required in the department and new employees are provided with an extensive orientation. Training is provided on an annual basis to staff, with additional training as required for new equipment or protocols. Recording and verification of training are identified as ongoing issues. While individual staff indicate they are up to date on infusion pump training, completion of training is not automatically compiled. The team was unable to verify that infusion pump training was completed for staff and there are no automated means to inform staff of the need for recertification.

Teams in the department seem to work in a collaborative manner and adjust and support each other to respond to the needs of the patients and the department. This flexibility and effort was of note in heavily congested sites where the teams adjusted to manage the requirements of acuity and high patient volume.

Horizon Health Network recently celebrated their 10-year anniversary and they demonstrate an ongoing commitment to educating the staff, physicians, patients and families on their care delivery model and the priorities for the organization.

Priority Process: Episode of Care

Many of the emergency departments throughout Horizon Health Network are high volume. The organization had made significant efforts to educate the public on available alternatives to secure non-emergent care. An ongoing concern is the ability to monitor CTAS 3 patients who wait for extended periods in the emergency room. In recognizing this area of risk, one site has redefined roles so LPN staff rotate through the emergency during high volume periods to assess these higher-risk patients. The effectiveness of this program is being monitored, but initial reports seem positive in mitigating this issue.

Two patient identifiers are consistently followed but continuing education is encouraged as staff,

especially those at smaller sites, may struggle with the importance of checking identifiers when the patients are well known to the unit. Falls assessment is consistently completed in the departments but it is noted that staff do not find the tool consistently useful as it seems to under-identify fall risk in the emergency room setting.

Although most sites across the organization have acceptable signage for the emergency department, the organization is encouraged to do a walk through and potentially utilize the PEA to see where signage could be improved for both internal and external access to this department.

Medication reconciliation has been a significant project for the organization over the last few years and is becoming more ingrained in the culture of the department. Pharmacy technicians have been identified as being particularly valuable in the management of this task. There is a potential medication safety issue in Meditech. Past medication orders carry forward even if only prescribed for a short period and thus appear as a home medication. Meditech is one of the sources used to complete the BPMH and this risk will need to be mitigated at affected sites.

It was noted that consultation services were not consistently accessible across the organization, particularly between midnight and 0800 hours. Monitoring accessibility of consulting physicians may assist in identifying sites and specialties of concern and providing the targeting education.

Transition forms within sites are standardized but not across sites. Standardizing these forms and procedures across the organization and educating all staff on the process is vital to ensuring that critical information is not missed. It was noted that utilization of transition tools was not consistent across the organization.

Priority Process: Decision Support

Standardized forms for admission, transfers and clinical protocols have been developed locally but these have not been standardized across the organization. Continued efforts to standardize forms across Horizon Health Network will help to promote a consistent standard of care and reduce risk of error as patients and providers move between sites within the organization.

Some aspects of the Electronic Medical Record are electronic but the majority of the patient file is still paper based. The organization is encouraged to continue their efforts towards obtaining an integrated electronic health record allows for a single chart and facilitates communication between care providers throughout the organization.

Criteria met but must be noted that there is a potential medication safety issue in Meditech in at least one site. Past medications carry forward (e.g. even if only ordered for five days) so they appear as a home medication. Meditech is one of the sources used to do the BPMH and thus, this is a significant risk.

It was noted in one location that the doors to medical records were not locked and staff routinely utilized medical records as a short cut. This department needs to be secured and access limited.

Priority Process: Impact on Outcomes

The organization has placed considerable focus on measuring emergency room data and recognize the impact of high volumes at many sites. Many initiatives have been put into place to mitigate the pressures placed on this department and Horizon Health Network continues to monitor and manage these risks.

As the organization moves forward, Medical Directives may be considered to enable triage staff to order indicated testing and treatment immediately upon entering the department. This may substantially impact the time to treatment and shorten the patient's time within the emergency department.

There may also be opportunities to standardize and simplify common procedures such as admission orders throughout the organization which may save time for the emergency physician admitting a patient and ensure that standard admission orders are considered. Standardization of all forms across the organization is recommended.

Priority Process: Organ and Tissue Donation

The Horizon Health Network Organ and Tissue Donation program is robust and comprehensive. The organization has the appropriate protocols and procedures in place to facilitate the recognition of potential donors and to facilitate the required investigations.

Dedicated Organ and Tissue donation staff coordinate all aspects of the organ donation process including discussion with family, coordinating medical logistics and liaising with the Legacy of Life (Nova Scotia) and Trillium (Ontario) to ensure that all suitable organs are transported to the appropriate locations and recipients.

Champions of the organ and tissue donation program educate staff and are available for consultation whenever the question of donation arises throughout the organization.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The palliative care network provides a common meeting ground for the evaluation of on-going services in the hospice, palliative care and end of life sector. The liaison for continuity of care after the client has been discharged from the palliative unit is provided by hospice care with the newly created Medavie Program (Extra Mural) or the in-home services which can be long-term, and this is provided by the department of social development. The organization is encouraged to increase awareness of the admission criteria to the palliative unit since misconception is still present among the general public and professionals.

The palliative care standards are formalized through the palliative care network. The weekly team meetings, which are held at the local units of care, allow for specific client goals to be addressed in a holistic manner. A culture of care is present among all team members and the rest of the staff. Volunteers provide an important contribution within this specific setting.

The process of consistency of practice is rendered a challenge by the geographical considerations and the type of unit considered (closed palliative care unit; designated beds; palliative care unit and family practice). With this set up, patient management is a result of the availability of onsite expertise and

resources in a specific location. The palliative care network does provide continuous support to reduce possible inconsistencies.

Priority Process: Competency

There is a collaborative approach in providing high-quality and compassionate care. Strong emphasis is put on education, as an example, we can name the "Learning Essential Approaches to Palliative care" (LEAP) for professionals. This training, however, has encountered geographical challenges since it is not available in all areas. There are also on-line educational resources used by staff and professionals. All training and education initiatives are recorded in the personnel file. Staff value the possibility to pursue additional continuing education opportunities.

Orientation to the unit for new staff members is a priority and is appreciated by the new staff. The interdisciplinary team works together and indicates being well supported by their colleagues and managers. There is also the initiative of "Lunch and Learn" which provides an educational opportunity for all staff and professionals to address specific themes and share experiences.

Priority Process: Episode of Care

The palliative care team is focused on providing client-centered care. Care planning includes family members and the latter report a high level of satisfaction with the services they receive. The families are an integral part of the spectrum of care and much attention is devoted to them. They have almost unlimited access to the patient and are included in conversations between the patient and staff members if the patient wishes.

Closed palliative care units are present in Miramichi and Saint John. However, in all areas, except Saint John, patients remain under the care of the family physician and the degree of ongoing involvement of the palliative physician is based on the complexity of the patient in managing palliative symptoms. The organization is encouraged to increase its efforts in evaluating the appropriate use of palliative care beds so as they remain for that purpose in an environment conducive to such type of care.

The patient's psychological well-being is considered, and pain management is well followed. Efforts are made to provide the seamless continuum of care in the organization of the discharge to the community. The discharge will only take place if patient-safety and well-being are secured; this, for example, may happen in cases with clients with special needs. Detailed summary sheets are forwarded to the professional providing the continuity of care.

The surveyors did notice a variable level of medication reconciliation at different locations. The organization is encouraged to continue its efforts in following this required organizational practice, especially for discharge.

Priority Process: Decision Support

In most locations, there is a hybrid system in place for the maintenance of the health record. The electronic record contains mainly lab information, nursing, and professional notes while the paper-based record has medical notes, preliminary admission sheets, and progress sheets. As a result, the content of the patient file varies from lcoation to location. The organization is encouraged to pursue the endeavour of having a unified compatible system which facilitates access to information for all professionals within the network.

Technology is being integrated in several facets of service delivery. As an example, infusion pumps are operated with a Computerized Ambulatory Drug Delivery (CADD) system for improving patient safety. If research does not occur the patient and families are informed and the proposed research must obtain approval from the Research Ethics Board.

Priority Process: Impact on Outcomes

Evidence-based guidelines are followed. Initial meetings with patient and family allow goals to be identified and there is a discussion on family involvement regarding care. Measures and indicators are tracked and followed up in team meetings.

Patient care and outcomes are the priority of the staff members on the palliative care units. The presence of the team approach has a positive impact on care allowing for a synergy of effort in goal attaining the preset objectives. Incident reporting is carried out and contributes to identifying and putting into place quality improvement initiatives. There is disclosure not only to the "hospital" but to patients and families as well. Incidents are followed up and are treated as learning opportunities.

In the past, a palliative care satisfaction survey (FAM CARE) was provided to families to identify opportunities for service improvement. Due to confidentiality considerations, the policy on consent is under review. The organization is encouraged to finalize such a policy to allow the survey to be reintroduced since it provided useful information on patient and family experience. In addition, it also provided points which could be worked into quality improvement initiatives.

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

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
7.7 Safety engineered devices for sharps are used.	!
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

The regional Infection Prevention and Control (IPAC) team is led by an enthusiastic group of highly engaged and dedicated leaders. The team is organized into different Areas across Horizon and meet on a consistent basis to discuss both local and regional issues. There is a fully integrated regional committee focused on the KPIs and strategic priorities for the region. Roles and responsibilities are well defined and documented in the IPAC program. There is also clear evidence of the IPAC team being involved in the procurement of equipment in partnership with the Medical Device Reprocessing Department (MDRD) and Service New Brunswick (SNB) and of their involvement in facility projects or renovations.

The infection control practitioners work throughout Horizon and have a close partnership with affiliate facilities across the region. The team provides IPAC information for staff, providers and volunteers at initial orientation and ongoing education is provided as required.

Policies and procedures related to IPAC are located on a central database (Skyline) and are updated regularly as required. The use of Skyline by staff to access the policies was evident and helps to support document control and limiting access to outdated materials.

The organization is to be commended on the collection, dissemination, and posting of hand hygiene rates. There was a clear awareness of the importance of hand hygiene and the use of sinks and/or dispensers by staff, physicians, volunteers and by families was evident.

There are good processes for managing outbreaks and attempting to identify the root-cause of the outbreak. IPAC reports infection rates on the dashboard, however, there was no evidence of rates being posted on the units nor were staff aware of their rates; only of patients currently on precautions. It is advisable that the organization publish this information on unit quality improvement boards for broader information and dissemination.

Due to challenges with space, some inpatient units were quite cluttered with equipment and medical devices in the corridors and hallways. The staff could not confirm whether the equipment located in the corridors was clean or dirty. In some sites, equipment was cleaned in the dirty utility room and stored in the same room until it was needed. The organization is encouraged to improve upon the practice of

identification and clear separation of clean and dirty.

In addition, many storage rooms were using external shipping containers and had items on the floor. This practice is not in accordance with the organization's policy and should be followed up on.

The organization has policies, procedures and several posters pertaining to the use of Personal Protective Equipment (PPE) appropriate to the task being performed. However, the use of the PPE during these tasks varied from staff to staff and in some instances was not used at all. In addition, there was inconsistency in the use of safety engineered sharps. It would be advisable for the organization to ensure staff are aware of the risk and reminded of the importance of the use of PPE.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.14	Ongoing professional development, education, and training opportunities are available to each team member.	
Priority Process: Episode of Care		
7.6	Clients and families are provided with information on how to identify when an escalation in care may be needed and how to initiate the process.	
8.8	The client's capacity to provide informed consent is determined.	
8.9	The client's informed consent is obtained and documented before providing services.	!
8.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
10.1	The client's individualized care plan is followed when services are provided.	
10.2	Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
10.2.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a good evidence of a well functioning multidisciplinary team. Nurses, physicians, occupational therapist (OT), physical therapist (PT), respiratory therapist (RT), registered dietician (RD), social worker (SW) and spiritual care providers are present in most teams. The relationships are good and there was evidence of trust and respect within the teams. The spiritual care team offer support to both patients and staff and participate in rounds. Although a small group, they are able to enhance the patient experience while in hospital with visits and connecting with community faith leaders. they involve the ethicist as needed and they have a local ethics committed that provides advice. They have a Patient Experience Advisor on several committees. this is an excellent practice and we have been encouraged that more will be added.

Challenges in the staffing workload secondary to the implementation of a new centralized scheduling system has created some pockets of decrease in job satisfaction. The staffing level and recruitment are challenging in some areas. However, it meets the job satisfaction of the staff in other areas. An opportunity for sharing staff recruitment successes between communities would be helpful.

Priority Process: Competency

There is good evidence of a well-functioning multidisciplinary team. Nurses, physicians, OT, PT, RT, RD, SW and spiritual care providers are present in most teams. The relationships are good and there was evidence of trust and respect within the teams. The spiritual care team offer support to both patients and staff and participate in rounds. Although a small group, they can enhance the patient experience while in hospital with visits and connecting with community faith leaders. They involve the ethicist as needed and they have a local ethics committee that provides advice. They have a Patient Experience Advisor on several committees. This is an excellent practice and we have been encouraged that more will be added.

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Priority Process: Episode of Care

A variety of size and complexity of inpatient adult medical units were surveyed this week. Not all areas have consistent practices from unit to unit within Horizon but are consistent on the units between shifts. Many staff indicated that Horizon is working towards consistent policies and procedures by program and this is encouraged to continue.

As we observed medical inpatients through the various locations it is evident that there are a variety of different challenges. Some areas have empty beds on a consistent basis, some are managing medical inpatient needs as they come up, some have Alternate Level of Care (ALC) using the medical beds for unusually long length of stay. Access to long term care beds has been identified as a challenge in some

communities. In these types of situations, the unit is not always equipped, trained or have the resources to provide a home like environment to meet these long stay patients.

Patients in some adult medicine wards have length of stays up to 700 days. We observed patients added to the middle of a 4-bed room, to create a 5th spot that does not have medical gases or suction readily available. A review of bed allocation and redistribution could be considered to even out the workload within the medical portfolio. It is understood distance might be a barrier but your “May not require Hospitalization” indicators are a good place to start. Maintaining and enhancing the partnership with Long Term Care and Extra Mural Programs is encouraged as their respective roles in the health care system is integral to your success in ensuring access to medical beds as the community needs them.

Space is a challenge in some units. Clutter in hallways was evident. One unit has had its only shower room closed for renovations for several weeks, leaving bed baths as an only option for patients. A patient with dementia was observed to be confused and agitated by the hallway clutter. Storage of critical equipment such as an emergency cart or isolation cart in cluttered storage rooms were observed. The nursing staff is doing the best they can in an extremely challenging physical environment.

Medication reconciliation has been enhanced in the past year with clinicians having access to the electronic health record of the province of New Brunswick, with information re: lab, DI and medications filled at any pharmacy in the province. After completing a required privacy course, clinicians can access the records on-line, which serves as a good starting point for confirming the Best Possible Medication History (BPMH) with the patient/family.

Priority Process: Decision Support

We observed inconsistent patient care plans done throughout our travels in Horizon Health Network. Some units had no care plans or patient goals completed and some had consistent care plans done with ongoing updates daily as the condition changed.

Priority Process: Impact on Outcomes

Most medical inpatient units are involved in quality improvement activities and have completed several projects recently, including a sleep project to reduce the use of sleeping medication in their patients. The results show not only a reduction in medication usage but also a reduction in falls.

Standards Set: Long-Term Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
10.3 A pleasant dining experience is facilitated for each resident.	
Priority Process: Decision Support	
13.1 An accurate, up-to-date, and complete record is maintained for each resident, in partnership with the resident and family.	!
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A strong clinical leadership team in the Health and Aging Program is commended for being the first network chosen to be a Centre of Expertise by the Horizon Health Network Executive Leadership Team.

There is a strong emphasis on person-centred care and addressing the needs of older adults receiving services. There are strong partnerships internally within the organization and externally with government and Veterans Affairs.

Priority Process: Competency

The Gentle Persuasive Approach to Care has been adopted as the model of care. The program and its staff work to create a home-like environment for the residents. Education opportunities include online learning modules, webinars, and attendance at conferences.

Team members are provided with feedback about performance in individual sessions with leaders regularly and formal performance evaluations occur annually. Team members are dedicated and work collaboratively. Teams are comfortable with ethical questions and use each other as supports when they work through ethical questions.

Priority Process: Episode of Care

The residents and their families feel treated with respect and dignity and speak highly of the staff. A commitment to actively engaging residents and families in care was evident.

Rituals have been introduced to honour the memory and military service of residents following their death. The Health and Aging Program has adopted a planned antipsychotic reduction strategy to ensure residents' safety is maintained. The program supports residents, families, and staff when residents choose to have medical assistance in death.

Priority Process: Decision Support

The hybrid resident health record is kept in a paper chart and an electronic system. The organization is encouraged to continue working on integrating health records to decrease duplication and risk of key client information being missed.

Priority Process: Impact on Outcomes

Provincial long-term care standards are followed in addition to Horizon Health Network policies and guidelines. The Resident Satisfaction Survey has been implemented and assists leadership in determining planning and quality improvement initiatives. Improvements are shared amongst the Health and Aging Program and Falls Prevention Committee to spread and standardize effective practices.

Standards Set: Medication Management Standards - Direct Service Provision

	Unmet Criteria	High Priority Criteria
Priority Process: Medication Management		
7.1	The type of alerts used by the CPOE include at a minimum: alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.	!
7.2	A policy on when and how to override CPOE alerts is developed and implemented.	!
7.5	Alert fatigue is managed by regularly evaluating the type of alerts required by the CPOE based on best practice information and by collecting input from teams.	
8.1	There is a process for determining the type and level of alerts required by the pharmacy computer system including, at minimum: alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.	!
12.1	Access to medication storage areas is limited to authorized team members.	!
12.3	Conditions appropriate to protect medication stability are maintained in medication storage areas.	
13.4	Anesthetic gases and volatile liquid anesthetic agents are stored in an area with adequate ventilation, as per the manufacturer's instructions.	!
14.1	All instructions related to medications (including medication orders, reorders, and reassessments) are recorded in a timely manner upon admission, end of service, or transfer to another level of care.	!
14.5	Steps are taken to reduce distractions, interruptions, and noise when team members are prescribing, writing, and verifying medication orders.	
14.7	A policy that specifies when telephone and verbal orders for medications are acceptable and how they are to be transcribed is developed and implemented.	!

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The management of medications throughout Horizon is well planned, well executed and well monitored. It is obvious that the pharmacy, nursing and physician teams have done and continue to do work to constantly improve the medication system. Medications are kept safely in the pharmacy and on the wards, and narcotics and controlled substances meet federal regulations.

The organization is to be commended for its Drugs and Therapeutics (D+T) committee. Not only does it represent all of Horizon it also includes Vitalité so that the decisions are implemented at a provincial level. The committee has 36 members, including 16 physicians, and a member of the public (currently vacant). The meetings are one to two days long; this highlights the commitment of the committee members who dedicate a significant number of hours to this committee.

Managing medications is a truly an interdisciplinary task and each professional group takes responsibility for its part. A good example is the maintenance of the infusion pump library; the library is maintained by the pharmacy group and the auditing and compliance is handled by the nursing group. The pharmacists are integrated in many of the treatment teams and the feedback received by the surveyors has been uniformly positive.

The Antimicrobial Stewardship Program (ASP) is another example of great interdisciplinary work. Many tools and education material are available and have been approved at the network level. However, the information penetration at the frontline level seems challenging due to limited ASP dedicated resources.

Horizon has leveraged technology and robotics in the pharmacy. The challenge is now to renew the equipment as it approaches end of life. Oral medication packagers are an example of aging equipment that has been noted a several sites. New pan-Canadian sterile and hazardous compounding standards for medication compounding are not met at most locations and significant infrastructure investment will be needed to upgrade the rooms to these standards.

As programs, such as cancer care, continue to grow there is a challenge to continue to provide safe and effective services with limited staffing resources. Some sites don't have any pharmacy presence whereas others such as ASP can't expand services due to the staffing limitations.

The pharmacy computer systems are old and do not interface with each other across Horizon. This poses a risk as information does not flow as it could, and this results in fragmented patient records. Some basic electronic decision support tools are not available to Horizon physicians or pharmacists.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
14.3 Verification processes are used to mitigate high-risk activities, with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical leadership team in Addictions and Mental Health Services has operationalized a regional approach to support the recovery model to providing care to clients and families.

Involvement of clients and families is evident, and the teams are encouraged to continue exploring innovative ways of including clients and families in service design, policy development, and resource and program evaluation at the regional and local levels.

Staff recruitment and retention have been identified as an issue for the Addictions and Mental Health Program. Various strategies have been implemented to help mitigate this issue.

Strong partnerships within the Addictions and Mental Health Services, Horizon Health Network, and external organizations are evident.

Priority Process: Competency

Interprofessional collaboration is evident with a variety of clinical backgrounds and disciplines represented within the teams. Initial and ongoing orientation are available for staff, including targeted training such as concurrent disorders e-learning module to help integrate addictions and mental health staff.

Staff are trained in various risk assessments including violence prevention and management, suicide prevention, and falls prevention. The organization is commended for implementing the new code white training throughout the region and advanced code white training for identified teams.

Priority Process: Episode of Care

A respectful and trusting relationship between clients and staff and amongst staff was evident. Clients feel well supported and find the programs and staff to be beneficial to their well-being and recovery and felt informed to provide consent and that their confidentiality, privacy, and goals are maintained. The units provide open, bright spaces and a safe environment.

Risk assessments are routinely performed and integrated into the client's plan of care. Teams communicate effectively and have established strong processes to ensure standardized pieces of information are exchanged. Strategies include huddles, change of shift handover, and admission, transfer, and discharge reports.

Priority Process: Decision Support

The program utilizes a hybrid patient health record of paper and electronic documentation in some sites, and paper at others. The organization is encouraged to continue moving towards solely documenting in an electronic health record.

This would facilitate communication across health services and allow for more seamless transitions in care. Clients and families are consulted and have input into information documented in the health record.

Priority Process: Impact on Outcomes

Client and staff safety is a priority for the program. Risk assessments and prevention strategies are aligned to help keep clients and staff safe and create a therapeutic environment. Safety equipment, such as panic alarms, are routinely utilized.

The program is commended for its operational plan of standardizing processes across the entire program. Post-discharge survey of clients assists the program to implement improvements and these improvements are shared widely amongst Addictions and Mental Health Services.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
14.3 Policies and procedures to securely collect, document, access, and use client information are followed.	!
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is very strong senior leadership with this network. Monthly meetings with the senior leadership are instrumental and directional and the recognition of team members has been appreciated. The network provides high level direction to Maternal & Newborn, Neonatal Intensive Care and Pediatrics services. The network organizes around the 3 areas. There are also two subs or working groups that include external partners, Horizon Baby Friendly Initiative and Pediatric End of Life and Palliative Care. All sites providing obstetrical services are represented.

The obstetrics department at the hospitals provide a range of services to women. The organization has provided equipment and supplies to provide ongoing quality care. There is a shortage of equipment and supplies. The infrastructure is aging. The organization has attempted to ensure the privacy of pregnant women who are delivering babies in this culturally diverse environment.

The team including physicians, medical residents, students, managers, nurses etc., all demonstrated an interdisciplinary approach to quality and safety and the delivery of care. The teams appeared committed, and very knowledgeable. The focus of the delivery of care always appeared to be the patient. The teams are engaged and motivated to perform at the highest level and take a lot of pride in their inpatient units.

Priority Process: Competency

There is an extensive education system for the team members and they are strongly encouraged to continue professional development. There is a multidisciplinary team with obstetricians, midwives and nurses who are well trained and educated and have done excellent work on several quality improvement initiatives. Staff are trained in Basic Life Support (BLS), Neonatal Resuscitation Program (NRP). The organization supports staff and physicians to advance their professional development. There is education and extensive orientation especially for newly recruited personnel. Everyone has a professional development plan. Workplace violence is not tolerated. Some cultural competency training is also provided.

There are various educational opportunities in the obstetrics program. Guidelines are reviewed regularly. Alarm updates are presented annually. There is an annual department multidisciplinary retreat.

Priority Process: Episode of Care

This program works as a well-oiled machine. The staff work well together.

There are hospital-based obstetrics services found in most primary health care providers offices. Communication links between Breastfeeding and Mother/Baby Clinic and outside agencies provide current information on prenatal classes and community supports. There is pre-pregnancy counselling by obstetrician and maternal fetal medicine specialists by consultation. There are established protocols for managing labour and mandatory consults for obstetricians and pediatricians. There are established policies in place to guide care.

Pregnancy is managed as a continuum of care. Breast-feeding rates are significant.

Hand hygiene compliance rate is greater than 90 percent and significant efforts had been made to improve this rate as it is such a major safety initiative that will assist with reducing infections.

There has been significant improvement in clarity with respect to informed consent. The policy is well written, and the information is on admission forms. Policies on the administration of Oxytocin and the actual use of it have been clarified. Monitoring of the woman and the fetus during the use of Oxytocin and the Prostaglandin is well documented.

The program in Horizon has approximately over 4500 births a year. Most deliveries are done by obstetricians and with each one looking after and doing their own deliveries. There is a pilot demonstration site midwifery program at the Dr. Everett Chalmers Hospital which started in November 2016. Extensive change management was needed to get this program going. The first baby born to the program was in November 2017. There are now 4 midwives in the program. Midwives have helped to broaden the delivery of care. There may be plans to implement this program throughout the rest of Horizon.

There is a flash sterilization policy. Flash sterilization is not used on the obstetrics unit. There is a critical overload policy that has allowed the reallocation of resources to where the need is greatest.

There is a high turnover of nurses and occasional high acuity medical patients are placed on the obstetrics unit because of capacity issues on the medical inpatient beds.

There is a policy for disagreeing with the plan of care. There are numerous community partnerships to ensure that the babies get home.

Documentation of information is monitored and audited.

There is a Home Phototherapy Program that is a leading practice with Accreditation Canada. This has been recently implemented throughout Horizon.

Priority Process: Decision Support

The team has medical records that are up-to-date and accurate. Compliance with two client identifiers is excellent and the team has access to guidelines at the point of care.

There are numerous pamphlets both paper and electronic that assist the patients with the delivery of care. Some of these include, preventing infant abductions, blood glucose in newborn babies, prenatal and postnatal hospital-based services, discharge instructions and jaundice and your baby.

Some computers at various sites are being left unattended without signing off. The organization has different software (All script, Peri-watch) and paper methods to document but none interface with the others. This is not unique to obstetrics. The different documentation software does not interface so the user must move from one to the other (and look at the paper chart) to get the full picture. At various sites computer workstations are being left open and unattended in-patient care areas for varying durations of time. Privacy issues need to be considered.

Priority Process: Impact on Outcomes

There are several quality improvement initiatives that have been implemented. Safety incidents are reported, and appropriate action and recommendations are taken. Additional work is ongoing on initiatives to reduce the number of stat caesarean sections. The emergency caesarian rate is about 32% like other jurisdictions in Canada. The organization is working to improve the skin to skin contact rate which is at 53 percent. Skin to skin contact is supported and monitored.

Several indicators are being monitored: percent low risk C sections, overall caesarean section rate, breast feeding initiation rate, percent breast feeding exclusively at discharge, patient pain survey, medication reconciliation, Braden scale, Morse falls scale and hand hygiene rates.

In the pain survey it was identified that clients with unplanned c section had the highest rates of uncontrolled pain and there is ongoing work with anesthesia to explore this issue further. There are occasional delays in cleaning patient care areas.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.1	There is a process to respond to requests for services in a timely way.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is strong leadership and adequate numbers of physicians and nurses for providing surgical care services. The surgery teams at all the visited sites have strong clinical skills and are committed to high-quality medicine. The staff are very much engaged and supportive of improving the care of the patient. Goals and objectives were identified as per the network. The process of developing and communicating those goals and objectives was variable.

The surgery leadership receives and reviews site-specific information regularly. Greater visual display of quality improvement and safety charts may encourage health care practitioners to be more aware of the progress that the unit has made in improving care for its patients. The safety huddle boards have assisted in driving the focus towards better quality and safety. The location of those huddle boards is variable and depends on the physical space of the units. The teams are encouraged to do a deeper analysis of the information provided in the column “How are we Doing” to determine actionable items that can improve care.

All surgeons are given about one day per week of surgical operating time and the surgeon is free to use that time as he/she sees fit. The organization needs to continue to focus all healthcare providers on the strategic priorities as there are various methods being used to deal with the allocation of surgical time and what surgical procedures are performed. There are cancellations of surgical cases regularly at various sites. The causes are numerous and include surgical allocation time, schedule over run, staff recruitment and many others. This significantly impacts surgical patient flow.

Surgical patient flow in the organization is significantly affected by bed availability. If inpatient beds are not available for day of surgery patients, their surgery may be canceled even if the patients have traveled some distance with some patients experiencing two or more cancellations. Cancer surgeries are also impacted.

A better allocation of surgical time to ensure that the most needful of surgical intervention are prioritized should be considered.

Surgical priority is determined by the surgeon within their allocated surgical time. Non-medically required cases are completed despite extensive wait periods for medically required cases. Review of surgical cases to ensure surgery is consistent with evidence-based practice is recommended.

Priority Process: Competency

The operating room (OR) team responsible for the surgical care of the patient is a multidisciplinary team that is well trained and educated. The teams’ function like family. Their primary purpose is to ensure safe, high quality, surgical care for their patient. Staff have personnel files containing their credentialing, privileging, educational, competency assessments and performance activities. Staff had orientation which are performed in a standardized manner. An increase in recent violent acts both in acute and community has resulted in further education and training on workplace violence and improving communication. Furthermore, the recent shooting in Fredericton resulted in enhanced ethics education and training.

There are students of various disciplines being educated and trained on the various sites. There is a very close relationship between the hospitals and the universities. The extent of education permeates all levels of the organization.

Priority Process: Episode of Care

Work processes are enabled. The organization has optimized the patient’s journey by streamlining the process of care.

The surgical journey starts with the patient in the clinic or emergency department or unit where the surgeon makes the diagnosis of a condition that requires a surgical intervention. All patients are seen preoperatively by anesthesia and appropriate information is shared with the patient and documented. Informed consent is appropriately done.

The operating theaters have operating suites that are of adequate size. Not all the surgical suites are being utilized at present. The operating suites are well resourced with anesthetic and surgical equipment. Requests for new or additional equipment is considered by the team leaders and subsequently referred to senior leadership. The organization may wish to consider maximizing the utilization of the surgical resources (surgical staff, equipment, scheduling).

Antibiotic administration within 60 minutes prior to surgical incision is apparent and is performed by the anesthesiologist. A comprehensive surgical checklist is used in the operating theater.

There is a small whiteboard in the operating room at Dr. Everett Chalmers Hospital. It is used for scheduling. The organization may want to consider using electronic whiteboards that may help with managing the operating theaters, scheduling, patient and provider communications, perioperative nursing and surgical counts. A digital surgery tracker can significantly improve the communication within the operating rooms.

A new licensed practical nurse scope of practice has been introduced in Horizon. The licensed practical nurses have just completed the first skill of their training which is the Medication Pass. Other skills are to be completed within the next year.

Patients who present after hours and on weekends for surgery and are brought to the operating theater do not usually have their old charts accompanying them. This has resulted in inadequate previous information for the surgeon and anesthesiologist.

Anesthesiologists are concerned about the assembly of glide scopes in the operating room. These scopes are often not completely reassembled after being cleaned but are still put out for use. It is recommended that the scopes should be fully reassembled and tested when placed back into service after cleaning. An unassembled piece of emergency equipment is not very useful in an emergency.

Some services have done excellent work in developing standardized procedures and patient information sheets (orthopedics). There is still working to be done to standardize tray sets, procedures, post-operative instructions and patient information sheets for other surgical services.

Temporary charts are created for recent patient admissions until the information is scanned into the computer system. This can take quite some months. Patients who access the surgical service frequently can therefore have several temporary charts which do not have numbers. As a result, physicians can be challenged as to obtain all the patient's relevant information as there may be many temporary charts for one patient.

There are environmental constraints in assuring confidentiality in both holding and recovery areas in some surgery suites.

While there are mechanisms to expedite urgent surgeries such as those for cancer, there are significant delays for regularly scheduled procedures including cataracts and orthopedic surgery. Patient flow is negatively impacted by lack of availability of beds.

Priority Process: Decision Support

Educational resources and tools are available for the team to perform their professional work. There is online education as well as clinical rounds and education opportunities.

The information system and other communication modalities is robust. Staff able to provide input horizontally and vertically with regards to required resources and tools for care delivery. Computer access in day surgery has continued to be an area for improvement. Medical records are being digitized which require access by computer. However, there may not be enough computer terminals in some day surgeries that are easily accessible to nurses and physicians to review old records, laboratory results, and consultations. The more difficult it is to access a computer then the less likely someone will try to access a computer thus leading to an increased likelihood of missing information.

Guidelines for Cases on the Operating Room Added List have assisted in managing case acuity especially after hours. The type of emergency is listed and the surgeon wishing to advance their case must discuss the case with the surgeon they intend to precede. There are consequences for non-compliance and the process is reviewed on a quarterly basis.

Priority Process: Impact on Outcomes

All staff are required to have basic cardiopulmonary resuscitation certification. Code blue training is done by the team in the operating theatre during normal working hours. Code blue training is done by the hospital code blue team after hours and on weekends.

Several key performance indicators such as rates of falls, seriousness of falls and trending of the number of days without falls are monitored. The measures are seen and acknowledged by the front-line staff.

There is excellent collaboration between the primary physicians and the interdisciplinary team on the surgical units. There is a commitment to excellence in patient care. Staff on the acute surgical units are aware of the VTE guidelines, Braden scale, falls program, and medication reconciliation and there is evidence that these guidelines are implemented. The team has access to community care resources and ensures comprehensive plans are put in place to ensure a seamless discharge.

The organization is encouraged to continue to work with physicians and staff to standardize processes based on evidence informed guidelines such as standardized surgical trays, and criteria for surgery.

Priority Process: Medication Management

There is an adequate supply of medication for the procedures done in the operating rooms. The contents of the medication carts are standardized across the organization though there are small differences within the anesthesiologists' carts at each site depending on the practice of the anesthesiologist. Medications are labelled and are delivered to the sterile field using an aseptic technique.

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

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

The organization has met all criteria for this priority process.

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

The Point of Care (POC) Program is accredited by the Institute for Quality Health Management (IQMH). The Organizations Point of Care Program continues to evolve. The program has improved patient safety with the additions of urine dip stick analyzers which have been implemented to help staff consistently perform testing using appropriate procedures.

The POC Program provides training for all operators and currently uses a variety of reporting mechanisms. The organization would benefit from a more consistent practice for reporting point of care results. Some point of care results is reported manually on a separate form while other test results are recorded in the nursing notes. Instruments that are interfaced with the lab and hospital information system would provide a more consistent reporting approach and help prevent reporting errors.

Staff could review where controls and urine specimens are stored after testing. Refrigerators should be monitored for temperature, specimens and controls should not be stored with patient drinks or food.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Public Health		
2.1	A process is followed to regularly access and monitor surveillance data to identify and investigate emerging and immediate public health threats and trends.	!
2.5	Surveillance information is disseminated to the organization's leaders, partners, and the public in a timely way.	!
2.6	There is a process to evaluate the surveillance system and make improvements.	
3.5	The resources needed to achieve public health goals and objectives are identified.	
3.12	Utilization reviews are regularly completed to ensure resources have been used appropriately.	
10.8	Equitable, evidence-based screening programs are provided or promoted.	!
11.1	The population's immunization coverage is monitored at regular intervals by reviewing immunization data.	!
12.9	Protocols to trace the source and contacts of communicable diseases or toxic exposures are followed and appropriate control measures are implemented.	!
14.5	The data system, i.e., hardware and software, is evaluated annually and upgrades to improve the access, quality and use of health data are planned and implemented.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A multidisciplinary team approach is used. There has been significant change in several public health leadership positions due to retirements. Evidence of how team members support each other was evident during the survey along with the commitment to public health and population health.

The public health teams have good working relationship with the regional medical officer of health. The team is encouraged to continue to work closely with the regional medical officers of health to clarify and strengthen Horizon's public health staff responsibility and accountability to medical officers of health particularly as they relate to communicable disease control and vaccination.

Priority Process: Competency

Staff are well trained with specified competencies for the areas that they are responsible for. There is a formal system of rotating coordinators every five years for personal developmental opportunities as well as strengthening the overall team. Opportunities are provided for development. Team members are supported in their collaborative work with community partners, clients and communities.

Priority Process: Impact on Outcomes

Numerous examples were observed of how the team makes effective use of information from the community needs assessments and the New Brunswick Health Council in strategic and program planning.

The team evaluates their programs through process measures largely as outcome measures and are limited in availability due to limited resources to be able to collect the required information. Partners and communities are included in the design of evaluation activities. The results of initiatives in one region are shared with other regions in the spread of programs.

Specific issues that Horizon is encouraged to work with New Brunswick Health and the Office of the Chief Medical Officer of Health are a comprehensive program evaluation of the Healthy Families Program.

There is also a need for better population level information on vaccination status. With the multitude of different providers, there is currently no effective system to capture all the information although work is apparently occurring on a new electronic information system.

Priority Process: Public Health

A number of examples were observed at a regional and community level of how the findings of community needs assessment are being acted on at a local level. The information is used to identify population health inequities and to engage with potential communities to address the issues. There is a commitment to the determinants of health.

The Caring Way - My Community in Action is an example of a capacity building approach that focuses on building on a community's existing strengths that can have a significant impact.

The communicable disease tracer looking at management of animal bite exposures and rabies post exposure prophylaxis identified some quality issues with attending physician risk assessments that did not support the rabies Performance Excellence Program (PEP) the physician provided. Considering the cost of rabies PEP and risks associated with administration of blood products (Radiologically Inserted Gastrostomy) the team may want to consider incomplete documentation by the physician as a patient safety incident and follow it up.

The team also identified the special food distribution service as an activity that did not fit with the Public Health team's goals. Consideration should be given to transferring this food distribution service either internally or externally. Approval of client eligibility rests with pediatricians and clinical nutritionists and Public Health is functioning as a distribution centre.

Current communicable disease surveillance systems do not provide timely recognition of disease outbreaks. This is in part due to their paper-based nature. Horizon's surveillance capacity should be reviewed to ensure that it is sufficient to support its public health responsibilities.

Potential resource issues were identified with other public health programs. For example, it is not clear if the number of nurses supporting the Healthy Learners Program is sufficient to support the implementation of the program across all schools. It would be beneficial if better estimates of staff resource requirements for implementation and spread of programs were available.

There is good protection of the cold chain for those areas that Public Health is responsible for. Public Health is encouraged to work with the Office of the Chief Medical Officer of Health to look at cold chain protection in other areas such as physician offices and Community Health Centres. During a site visit to a CHC, while there was the appropriate lab grade fridge with an alarm. There was no evening or weekend monitoring of the alarm unlike the process in public health. There was also no backup power supply or detailed plan for loss of power.

The team is also encouraged to share some of its initiatives that have been evaluated with other jurisdictions including with Accreditation Canada’s leading practices.

Standards Set: Rehabilitation Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership at Stan Cassidy Centre for Rehabilitation (SCCR) is strong, evidence-based and committed to the population, families and community outreach.

Rehabilitation services are provided at five (5) Community Health Centres, eight (8) Community Health Clinics, 12 Hospitals, and the SCCR. The Neuro Network helps develop quality initiatives and goals. Huddles are held weekly to engage staff in opportunities for improvement and to “close the loop” on suggestions and feedback. There are many key partnerships and networks such as the NB Stroke Network, Horizon Pediatric Network, Horizon, and Aging Network, to name a few.

The research enterprise is strong and presently there are 25+ research trials that clients/families can be part of to advance their function and reintegration into the community. The organization has a 'smart room' that is used for training of clients prior to going home to use everyday devices to allow for independence. The partnership with the foundation allows for the funding of these innovative programs, and provides support to clients and families financially (up to 500) in the purchase of equipment if there is a need.

The collaboration between physicians and the team is palpable and a model for other areas with Horizon to emulate. There is a genuine sense of camaraderie and the desire to work together to remove barriers

to achieve optimal outcomes for clients/families.

The culture is incredibly positive, and the turnover rate is very low within rehabilitation, which was echoed on the floor with staff indicating pride and joy in their work. An example of the culture was nursing staff supporting one another in hand hygiene by using the code words “Code Sparkle” if they see a colleague not complying with hand hygiene best practice. Staffing levels and skill mix and maximizing the full the scope for Licensed Practical Nurses (LPNs) has been initiated in Saint John and the ONTRACC approach is being rolled out across Horizon Health Network.

When staff were asked across the areas what they were most proud of there was an overwhelming sense of pride in their work, team collaboration, genuine caring for each other, the closeness of the physicians and team working together, everyone feeling they had a role which included non-clinical staff, a sense of professionalism and special purpose. One staff indicated while working abroad the only reason they would return to NB was to work at the SCCR. The sense of pride in work and joy in work at the SCCR is visible and should be cultured, learned from and scaled to other sites.

Several families were interviewed, and all sang the praises of all the staff and the quality of care as well as the input they had in their care. In particular families felt safe that their loved ones were receiving exceptional care, they were partners and informed at all stages and in one families quote 'worth the 1. 5-hour drive' to witness care.

Priority Process: Competency

Staff receive Horizon orientation as well as unit-based orientation. The completion rates of performance appraisals are variable, because of the span of control of some managers. As an example, SCCR the performance appraisals are 100 percent and in some other areas a little lower.

Some of the areas have staff that are certified in their specific fields (e.g. rehabilitation nursing, non-destructive testing, certified) whereas in other areas the certification is sought individually. Identified was the education budget for professional growth was eliminated several years ago due to financial pressures which has created some moral issues at the front line for ongoing professional education. Leaders recognize this and are trying to find other opportunities to support their staff. Additional education has been provided to staff regarding security guard support and code white responses for workplace violence risk.

Identified was a need to ensure consistent Non-Violent Crisis Intervention (NVCI) training more consistently across the areas to provide front line staff with the skills to de-escalate in ways that ensure staff and patient safety. As the population continues to become older and more complex, this will be required to ensure safe care. Very focused on safety in all aspects, doors, alarms, violent patient management with respect. It is very commendable.

Credentialing occurs for professional health disciplines on an annual basis and ensured at the Performance Review. Horizon has shortened its appraisal forms to streamline the process and Clinical

Resource Nurses are provided some support. The workload is monitored and augmentation to baseline staffing is supported when there is rationale and need.

Horizon across the sites has various methods of documentation (electronic, paper, hybrid) with different processes would benefit from a harmonized system that allows for information flow between sites and functional areas.

Priority Process: Episode of Care

Criteria for admission to the rehabilitation unit includes patients being out of the ICU for 24 hours and being clinically stable, to safely provide care. Patients and family members are involved in care to the extent possible and desired. There is clear criterion for both inpatient and outpatient referral, with KPI's monitored to manage access times. Referrals for rehabilitation require physician request and 'self referrals' are not possible given the limited resources and increase in need.

Inpatients rehabilitation has a several days admission process, with clear goals and objectives set with clients and families to allow for an understanding of the role. Discharge conversations begin immediately to anchor the journey and family meetings allow for opportunities to discuss challenges, concerns and celebrate the successes. Outpatients have a different process with 3 levels of 'triage' and ensuring that care is provided based on acuity, outcomes, and need.

All ROP's were met with evidence within the charts to prevent falls, ensuring the identity of clients before medications are administered, pressure injuries, transitions and infusion pumps (where applicable). Standardized assessment tools are used, and patients are familiar with safety elements such as wearing a yellow arm bracelet if determined to have a risk of falling and they are clinically managed very well. Medication reconciliation and management is excellent. Evident in the conversations with staff and family is the passionate desire to keep clients/families safe while ensuring best outcomes through evidence-based practice.

Research activities and opportunities are expanding, and both staff and patients find this exciting. A poster and documentation recently updated clarifies the rights and responsibilities of patients. Patients report having their identification checked consistently and know who to approach in patient relations patient complaints or concerns.

Stan Cassidy Centre for Rehabilitation has a 'Cafe Paris' service that meets weekly with staff for conversational French to bolster the proficiency of staff to meet the needs of the francophone community. The program has been incredibly well received and clients/families valued that their first language of choice is met. More than 40 percent at SCCR are intermediate/advanced fluent in French.

Priority Process: Decision Support

There is variation in the uptake and availability of clinical information systems, with paper-based and paper and electronic hybrid approaches. Although technology gaps have been identified, there is a need

to complete the strategic plan for information technology and advance the efforts towards an electronic record. Patients can view their records and are supported by the health records department to arrange for a physician to review the documentation with them as needed.

As some care is provided by Medavie, the Extramural Liaison at the hospital is able to access the needed patient information in order to establish care requirements for home support in the community. This would be further enhanced with an electronic record for the province.

Staff were aware of the process for families to access health records and comfortable in sharing the process in ways which are understood for clients/families. The health record is accessed through Health Data Records with a full consenting process. In paediatrics the consent process is anchored in privacy and health information, and clear process where custodial or Power of Attorney situations arise.

Policies are reviewed every three years as a Horizon practice but may wish to consider having policy review more frequently based on the policy nature and sensitivity especially if anchored in legislation. Also cited by staff, was the length of time for policy approval from the executive leadership, which created unintended downstream impacts.

Priority Process: Impact on Outcomes

Standardized guidelines and order sets are available on Skyline for staff. Clinical Practice Committees and Councils are in place, along with patient advisors. The Project Management Office has helped with quality improvement projects. Several key performance indicators are tracked in order to assess length of stay, falls rates, and hand hygiene rates. Indicator information is posted on communication boards for staff.

The length of stay has been noted as longer than peer groups and Horizon is working on the layered and complex situations such as pediatric community rehabilitation needs, which are not managed by Medavie as with adults.

They collect output information and can look at their results on the Intranet dashboard site. Their accounting and accessing of KPI's is impressive. All clinicians use outcome measures and they have a vast array to select from including FIM, SCIMS, Berg, MMT, TUG, COPM, and Gas Goals to name a few. A large initiative was undertaken in 2015 at the SCCR on outcomes including a great and white literature search, environmental scan, connections to CanChild and McMaster, research networks to catalogue and evaluate outcome measures for use. This has allowed for the organization to understand pan-nationally and internationally the standards of meaningful measurement to track change and assist with program and service delivery design.

At Miramichi and Moncton there is an awareness that there is "research" being undertaken under the bigger Horizon umbrella (some of which their data contributed to) but do not feel they get enough information about those initiatives. At SCCR there is a very strong research presence with over 25 clinical trials and partnerships to advance adult neuroscience research, and paediatric research.

There is enthusiasm with the inclusion of patient experience advisor roles and opportunities to develop further research capacity across the sites.

Standards Set: Substance Abuse and Problem Gambling - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
14.4 Verification processes are used to mitigate high-risk activities, with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There are four (4) detox programs in Horizon. Three are in the community and one (in Miramichi) which is in the hospital. There are three (3) others in the Vitalité region.

Strong partnerships and networks across mental health and addictions are noted. The staff feel supported through the use of a Clinical Supervisor/Supervisee pairing model, where candid discussion and clinical decision making, and ideas are shared between a more experienced clinician and a novice.

The Miramichi detox program is both part of the hospital and managed conjointly with inpatient psychiatry.

Awareness of the program comes from past users. The waitlists are long but well organized.

Ideally, programs would like to be multidisciplinary. Some programs only have nurses. Use of LPN and RN teams over shifts is working very well.

The physical environments may not be ideal, but they are clean and welcoming - using minimum space to the maximum.

Client voices are heard loud and clear, be it group topics, murals to be put on walls, and relaxed rules.

Priority Process: Competency

Specific education and skills, such as the first responder and R2MR (Road to Mental Readiness) are provided to staff working in detox. An education committee and an endowment specific to mental health help to support staff wanting to pursue professional development. As well, secondments are used to provide opportunities to staff to gain and share expertise.

Staff complete the Mental Health and Addictions Certificate as well as other required training. There is an obvious culture of no judgmentalism and care for detoxing clients.

There are no recruitment or retention issues, at least 20 people apply for each vacant positions. French is spoken on every shift.

Priority Process: Episode of Care

According to detox staff and leadership, “every door is a good door” in terms of access and response to client needs. Access has improved considerably over the past few years because of one centralized phone number and intake for all services.

Clients report being actively involved in their care and at one detox centre were involved in naming their new recovery group program, “a new chapter”. At another, they wanted a mural on the wall and access to a DVD player to watch a movie.

Right from admission, clients are not judged, offered help and encouraged to make decisions for themselves. No technology is allowed. Visitors must be identified. While there is much respect for client decision making, detox has strict rules that must be adhered to. Discharge will occur, but they have a "never give up" philosophy.

Patient cultures are respected, for example allowing a smudging ceremony (with safety considerations in place, such as going outside with supervision).

A patient representative is available to field complaints if a local level approach is not successful and the issue is not resolved without escalation. Friends of Addictions Services also offer their services to the detox program. A Patient Advisory Group also operates monthly at one detox centre, these are people with lived experience who offer advice to the program.

As well, there is an Indigenous Liaison position at the hospital in Miramichi who is used extensively.

Clients report feeling safe, respected and well cared for. They can describe the identifying wristbands,

including those used for falls prevention and allergies.

The use of non-violent crisis intervention is used to de-escalate any potential threats, and secure door access, personal alarms, and hand-held radios offer staff additional safeguards. There is some variation in treatment protocols to meet individual client needs, however there are plans underway to standardize at a provincial level in the future. Safety is key for staff members as well.

Transition plans are enacted with strong support from community partnerships and networks.

Detox offers a variety of programs focused on recovery in many forms:

- Every Friday at one detox program a program called ROAD is offered - past clients return and talk with present clients. This meeting is often 40 + people.

- There is a spirituality group, three education and support groups every day that are mandatory.

- There are worksheets and goals sheets to complete, plans for the day are posted on a board for all to see.

This service is excellent.

Priority Process: Decision Support

Staff can access policies and procedures using the Horizon Skyline electronic system. This has just started. Most files are still in hard copy.

Careful attention regarding disclosing client information is noted, particularly at the detox facilities, where clients sign a specific consent if family members can receive any information about them.

File information is well organized. Clients can review their file according to policy.

Priority Process: Impact on Outcomes

For detox, there are still individual and specific care plans and processes. There are hopes to look at provincial guidelines where possible to standardize care/order sets for more common conditions/patient needs.

Safety walks are conducted as part of quality improvement and patient safety initiatives.

Key performance measures are mostly outputs (numbers of admissions, elopements, etc.). While these are good, it is suggested that considering success factors for clients might be a good idea. These could include goal attainment scales or success as defined by the client, achieved or not.

The recovery model is clearly followed and could also be measured for success.

Staff are highly attuned to safety right from intake (even though there have been very few incidents (4) where police had to be called over a 17-year period. Cameras are at the entrance, there is 24-hour coverage with two people always for example.

Standards Set: Telehealth - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A small team providing a key service "over small and large distances". Clinical leadership within the service and collaboration in all aspects are evident.

The team make-up and sourcing of new staff is thoughtfully done, to gain staff with a background and understanding of clinical needs, as well as the ability to learn telehealth technology.

This ensures the provision of a quality service. All program requests, needs, resources and sustainability are assessed prior to commitments.

Priority Process: Competency

Staff support for each other, training and relationship building within and outside the department is important.

Capacity is deliberately built amongst staff including public speaking to share key messages and accomplishments.

Work has occurred to standardize processes such as booking across the organization and to ensure clients

are both informed of reason for visit and feedback opportunity. The team works with the site leads to ensure consistency and processes are followed/supported.

Priority Process: Episode of Care

Episodes demonstrated the roles of both the service and the participating sites or programs. There are both individual responsibilities, dual responsibilities, and client expectations.

The program has taken care to ensure that sites are able to support the program requirements as needed and works to resolve any concerns raised by stakeholders (the sites or clients/families etc.).

Consent, relationships, and cooperation are essential. Client feedback was positive with an opportunity suggested that at times it would be helpful to add face to face visits blended with Telehealth when weather permits (to keep connections/provider relationships strong).

Priority Process: Decision Support

Telehealth is an optional opportunity for clients with many of the programs, and for some, it can be lifesaving. Options for care are shared with patients and families and wishes to participate in Telehealth, not participate, or end participation are respected.

The legislation is followed. Policy and procedure requirements are in place and assessed or revised on an ongoing basis as new evidence, information or feedback is surfaced.

The Video Conference User Group is an important part of information and program support that contributes to the success of the service.

Priority Process: Impact on Outcomes

The program has been collecting routine data over time. There is an opportunity to review the rationale for current efforts and work toward meaningful QI tracking and reporting in keeping with the program efforts of today. This will increase data quality, and relevance. Given the profile and ability of the Telehealth team, site leads and programs, this would be valuable not only for Horizon Health Network but other networks and authorities.

Participation in a research project with client participation and university co-leadership may be of interest for this highly engaged and mature department. This is suggested given the national interest in what the Horizon Health Network program and providers have been able to accomplish.

Service awards, article involvement and speaking at conferences all demonstrate commitment and high ability of the small team. Most recently the team should be recognized for two staff members speaking at two different sessions at the 2017 Atlantic Learning Exchange on Health Quality and Patient Safety. This is something much larger departments seldom accomplish. Well done!

Standards Set: Transfusion Services - Direct Service Provision

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

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services
Horizon Health Network Transfusion service demonstrates evidence of trained staff who work as a network to provide transfusion services to residence of New Brunswick. There is a collaborative approach between laboratory and patient care areas. The Transfusion Department is accredited by the Institute for Quality Health Management (IQMH).

Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: May 24, 2017 to July 27, 2017**
- **Number of responses: 14**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	N/A
3. Subcommittees need better defined roles and responsibilities.	64	14	21	N/A
4. As a governing body, we do not become directly involved in management issues.	0	0	100	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	21	7	71	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	7	93	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	14	86	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	43	0	57	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	8	92	N/A
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	N/A
12. Our ongoing education and professional development is encouraged.	0	0	100	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	0	100	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	N/A
17. Contributions of individual members are reviewed regularly.	14	21	64	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	14	7	79	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	8	15	77	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	7	0	93	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	21	21	57	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	7	0	93	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	0	7	93	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	33	33	33	N/A
27. We lack explicit criteria to recruit and select new members.	75	25	0	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	9	9	82	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	N/A
31. We review our own structure, including size and subcommittee structure.	0	10	90	N/A
32. We have a process to elect or appoint our chair.	11	0	89	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	36	64	N/A
34. Quality of care	0	29	71	N/A

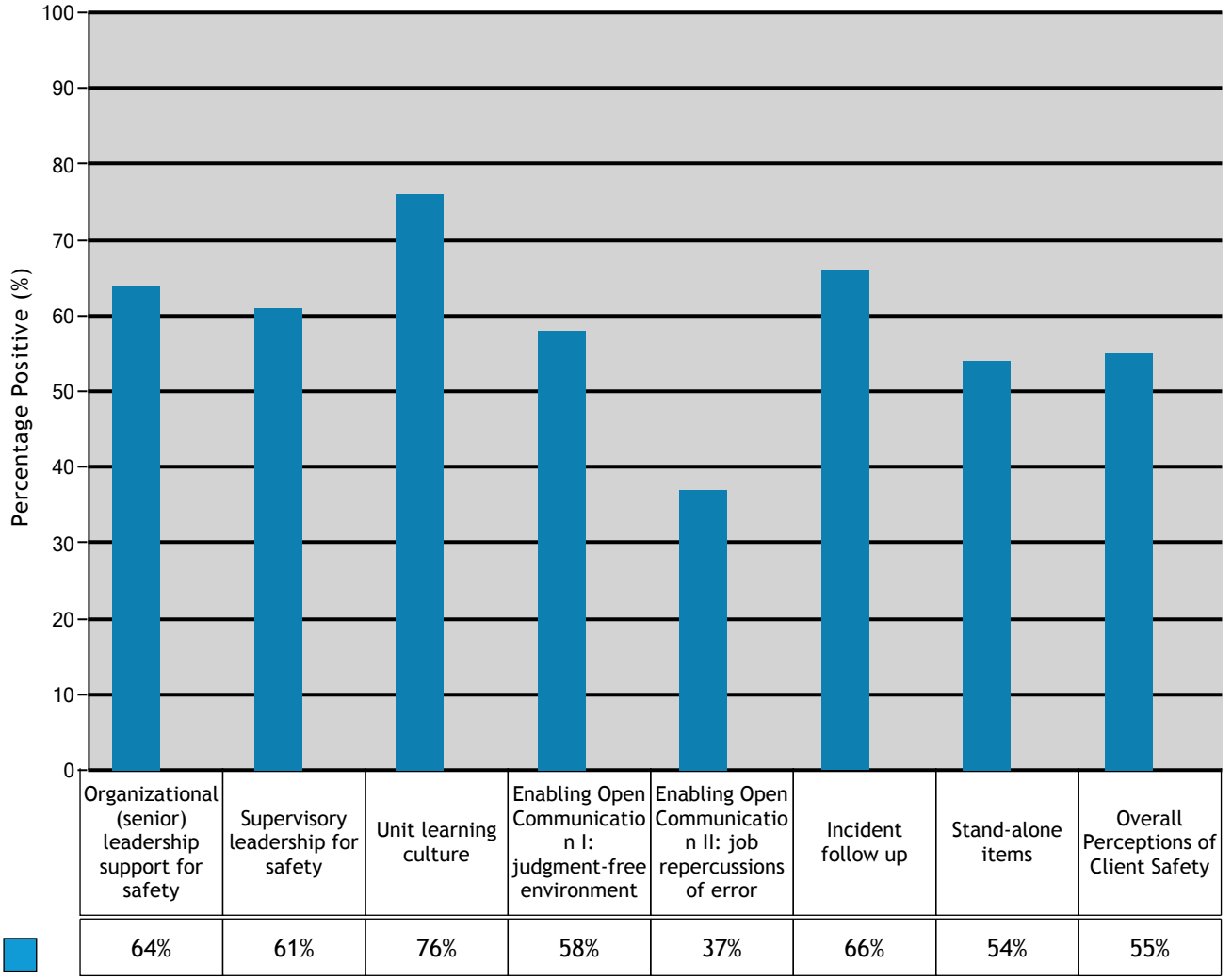
Canadian Patient Safety Culture Survey Tool

Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations with the Patient Safety Culture Tool, an evidence-informed questionnaire that provides insight into staff perceptions of patient safety. This tool gives organizations an overall patient safety grade and measures a number of dimensions of patient safety culture.

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife. Accreditation Canada provided the organization with detailed results from its Patient Safety Culture Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address areas for improvement. During the on-site survey, surveyors reviewed progress made in those areas.

- **Data collection period: October 19, 2015 to November 27, 2015**
- **Minimum responses rate (based on the number of eligible employees): 367**
- **Number of responses: 3218**

Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	64%	61%	76%	58%	37%	66%	54%	55%

Legend

Horizon Health Network/Réseau de santé Horizon

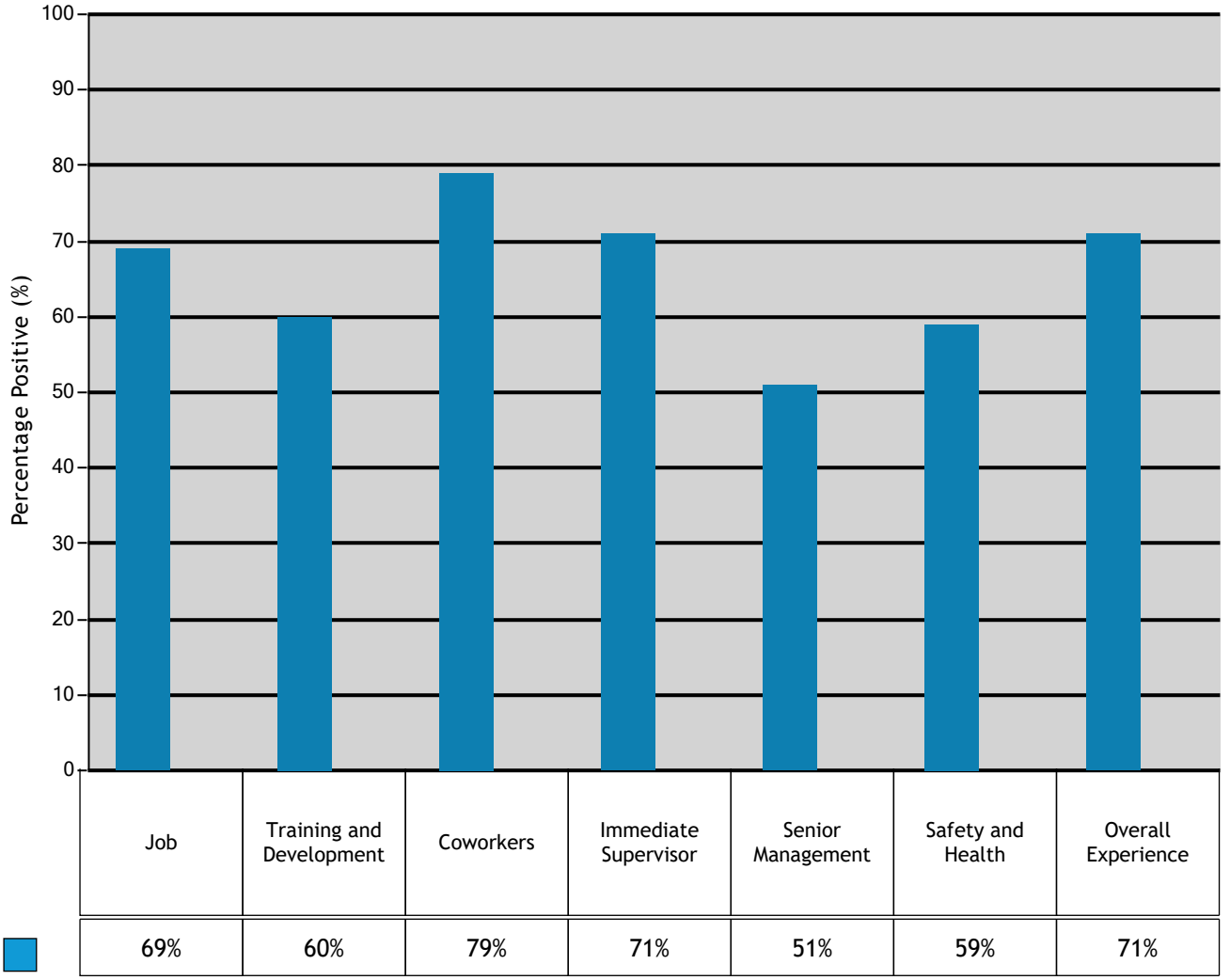
Worklife Pulse

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

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

The organization used an approved substitute tool for measuring the quality of worklife but did not provide Accreditation Canada with results.

Worklife Pulse: Results of Work Environment



Legend

Horizon Health Network/Réseau de santé Horizon

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

Health care accreditation contributes to quality improvement and patient safety by enabling a health organization to regularly and consistently assess and improve its services. Accreditation Canada's Qmentum accreditation program offers a customized process aligned with each client organization's needs and priorities.

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 15 business days.

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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