ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Nova Scotia Health Authority

Halifax, NS

On-site survey dates: October 15, 2017 - October 20, 2017

Report issued: November 22, 2017

About the Accreditation Report

Nova Scotia Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in October 2017. 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

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

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

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

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

Accreditation Decision

Nova Scotia Health Authority's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: October 15, 2017 to October 20, 2017**

- **Locations**

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

1. CZ - Addictions CBS - Dartmouth
2. CZ - Camp Hill Veteran's Memorial Building
3. CZ - Cardiovascular Hearts in Motion Mumford Road
4. CZ - Cobequid Community Health Centre
5. CZ - Dartmouth Community Mental Health - Belmont House
6. CZ - Dartmouth General Hospital
7. CZ - East Coast Forensic Hospital
8. CZ - Hants Community Hospital
9. CZ - Joseph Howe
10. CZ - Newcomer Clinic
11. CZ - Nova Scotia Hospital
12. CZ - Nova Scotia Rehabilitation Centre
13. CZ - Public Health
14. CZ - QEII Abbie J. Lane Memorial Building
15. CZ - QEII Health Science Centre Dickson Building
16. CZ - QEII Health Sciences Centre Halifax Infirmary
17. CZ - QEII Health Sciences Centre Victoria General
18. CZ - Twin Oaks Memorial Hospital
19. CZ - Woodlawn Medical Clinic
20. EZ - Cape Breton Continuing Care Services
21. EZ - Cape Breton Public Health Services
22. EZ - Cape Breton Regional
23. EZ - Harbourview Hospital
24. EZ - Inverness Consolidated Memorial Hospital

25. EZ - New Waterford Consolidated Hospital
26. EZ - Northside General Hospital
27. EZ - Sacred Heart Community Health Centre
28. EZ - St. Martha's Regional Hospital
29. EZ - St. Mary's Memorial Hospital
30. EZ - Strait Richmond Hospital
31. Nova Scotia Health Authority Provincial Office
32. NZ - Aberdeen Hospital
33. NZ - All Saints Springhill Hospital
34. NZ - Colchester East Hants Continuing Care Offices
35. NZ - Colchester East Hants Health Centre
36. NZ - Colchester East Hants Opioid Treatment and Recovery
37. NZ - Cumberland Mental Health and Addiction Services
38. NZ - Cumberland Regional Health Care Centre, Nappan
39. NZ - North Cumberland Memorial Hospital, Pugwash
40. NZ - Pictou County Mental Health & Addictions Services
41. NZ - South Cumberland Community Care Centre
42. NZ - Sterling Health Center
43. NZ - Sutherland Harris Memorial Hospital
44. WZ - Chipman Building
45. WZ - Digby General Hospital
46. WZ - Fishermen's Memorial Hosptial
47. WZ - Gateway
48. WZ - Lunenburg & Queens County Community Health Network
49. WZ - Lunenburg Family Heatth
50. WZ - Queens General Hospital
51. WZ - Soldiers Memorial Hospital
52. WZ - South Shore Regional Hospital
53. WZ - Valley Regional Hospital
54. WZ - Yarmouth Regional Hospital

- **Standards**

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

System-Wide Standards

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

Service Excellence Standards

5. Acquired Brain Injury Services - Service Excellence Standards
6. Ambulatory Care Services - Service Excellence Standards
7. Biomedical Laboratory Services - Service Excellence Standards
8. Cancer Care - Service Excellence Standards
9. Case Management - Service Excellence Standards
10. Community-Based Mental Health Services and Supports - Service Excellence Standards
11. Critical Care - 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. Long-Term Care Services - Service Excellence Standards
16. Medicine Services - Service Excellence Standards
17. Mental Health Services - Service Excellence Standards
18. Obstetrics Services - Service Excellence Standards
19. Organ and Tissue Transplant Standards - Service Excellence Standards
20. Perioperative Services and Invasive Procedures - Service Excellence Standards
21. Point-of-Care Testing - Service Excellence Standards
22. Primary Care Services - Service Excellence Standards
23. Public Health Services - Service Excellence Standards
24. Rehabilitation Services - Service Excellence Standards
25. Reprocessing of Reusable Medical Devices - Service Excellence Standards
26. Spinal Cord Injury Acute Services - Service Excellence Standards
27. Spinal Cord Injury Rehabilitation Services - Service Excellence Standards
28. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	104	4	0	108
Accessibility (Give me timely and equitable services)	180	5	0	185
Safety (Keep me safe)	872	68	8	948
Worklife (Take care of those who take care of me)	197	29	0	226
Client-centred Services (Partner with me and my family in our care)	780	36	0	816
Continuity (Coordinate my care across the continuum)	163	4	1	168
Appropriateness (Do the right thing to achieve the best results)	1464	156	5	1625
Efficiency (Make the best use of resources)	84	4	0	88
Total	**3844**	**306**	**14**	**4164**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	47 (94.0%)	3 (6.0%)	0	93 (96.9%)	3 (3.1%)	0	140 (95.9%)	6 (4.1%)	0
Infection Prevention and Control Standards	37 (92.5%)	3 (7.5%)	0	30 (96.8%)	1 (3.2%)	0	67 (94.4%)	4 (5.6%)	0
Medication Management Standards	70 (95.9%)	3 (4.1%)	5	61 (96.8%)	2 (3.2%)	1	131 (96.3%)	5 (3.7%)	6
Acquired Brain Injury Services	44 (95.7%)	2 (4.3%)	0	88 (100.0%)	0 (0.0%)	0	132 (98.5%)	2 (1.5%)	0
Ambulatory Care Services	27 (60.0%)	18 (40.0%)	1	61 (78.2%)	17 (21.8%)	0	88 (71.5%)	35 (28.5%)	1
Biomedical Laboratory Services	70 (98.6%)	1 (1.4%)	0	96 (91.4%)	9 (8.6%)	0	166 (94.3%)	10 (5.7%)	0
Cancer Care	94 (93.1%)	7 (6.9%)	0	124 (96.9%)	4 (3.1%)	0	218 (95.2%)	11 (4.8%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Case Management	43 (93.5%)	3 (6.5%)	0	78 (98.7%)	1 (1.3%)	1	121 (96.8%)	4 (3.2%)	1
Community-Based Mental Health Services and Supports	39 (88.6%)	5 (11.4%)	0	94 (100.0%)	0 (0.0%)	0	133 (96.4%)	5 (3.6%)	0
Critical Care	39 (78.0%)	11 (22.0%)	0	100 (87.0%)	15 (13.0%)	0	139 (84.2%)	26 (15.8%)	0
Diagnostic Imaging Services	58 (86.6%)	9 (13.4%)	0	62 (89.9%)	7 (10.1%)	0	120 (88.2%)	16 (11.8%)	0
Emergency Department	56 (78.9%)	15 (21.1%)	0	102 (95.3%)	5 (4.7%)	0	158 (88.8%)	20 (11.2%)	0
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	107 (99.1%)	1 (0.9%)	0	152 (99.3%)	1 (0.7%)	0
Long-Term Care Services	52 (94.5%)	3 (5.5%)	0	96 (97.0%)	3 (3.0%)	0	148 (96.1%)	6 (3.9%)	0
Medicine Services	40 (88.9%)	5 (11.1%)	0	75 (97.4%)	2 (2.6%)	0	115 (94.3%)	7 (5.7%)	0
Mental Health Services	44 (88.0%)	6 (12.0%)	0	89 (96.7%)	3 (3.3%)	0	133 (93.7%)	9 (6.3%)	0
Obstetrics Services	62 (84.9%)	11 (15.1%)	0	84 (95.5%)	4 (4.5%)	0	146 (90.7%)	15 (9.3%)	0
Organ and Tissue Transplant Standards	87 (100.0%)	0 (0.0%)	0	118 (100.0%)	0 (0.0%)	0	205 (100.0%)	0 (0.0%)	0
Perioperative Services and Invasive Procedures	101 (87.8%)	14 (12.2%)	0	104 (95.4%)	5 (4.6%)	0	205 (91.5%)	19 (8.5%)	0
Point-of-Care Testing	32 (84.2%)	6 (15.8%)	0	35 (76.1%)	11 (23.9%)	2	67 (79.8%)	17 (20.2%)	2
Primary Care Services	48 (82.8%)	10 (17.2%)	0	79 (86.8%)	12 (13.2%)	0	127 (85.2%)	22 (14.8%)	0
Public Health Services	42 (93.3%)	3 (6.7%)	2	67 (97.1%)	2 (2.9%)	0	109 (95.6%)	5 (4.4%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Rehabilitation Services	42 (93.3%)	3 (6.7%)	0	77 (96.3%)	3 (3.8%)	0	119 (95.2%)	6 (4.8%)	0
Reprocessing of Reusable Medical Devices	73 (83.0%)	15 (17.0%)	0	30 (75.0%)	10 (25.0%)	0	103 (80.5%)	25 (19.5%)	0
Spinal Cord Injury Acute Services	50 (100.0%)	0 (0.0%)	0	93 (100.0%)	0 (0.0%)	0	143 (100.0%)	0 (0.0%)	0
Spinal Cord Injury Rehabilitation Services	45 (95.7%)	2 (4.3%)	0	87 (100.0%)	0 (0.0%)	0	132 (98.5%)	2 (1.5%)	0
Transfusion Services	73 (97.3%)	2 (2.7%)	0	61 (89.7%)	7 (10.3%)	1	134 (93.7%)	9 (6.3%)	1
Total	**1510 (90.4%)**	160 (9.6%)	8	2227 (94.6%)	127 (5.4%)	5	3737 (92.9%)	287 (7.1%)	13

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Acquired Brain Injury Services)	Met	1 of 1	0 of 0
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	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 (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
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 (Long-Term Care Services)	Unmet	0 of 1	0 of 0
Client Identification (Medicine Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Organ and Tissue Transplant Standards)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Unmet	0 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Spinal Cord Injury Acute 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 (Spinal Cord Injury Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Acquired Brain Injury Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Case Management)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Unmet	3 of 4	0 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Organ and Tissue Transplant Standards)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Acute Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Spinal Cord Injury Rehabilitation Services)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Acquired Brain Injury Services)	Met	5 of 5	0 of 0
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Case Management)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Unmet	0 of 4	0 of 1
Medication reconciliation at care transitions (Critical Care)	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 (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	2 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 (Perioperative Services and Invasive Procedures)	Unmet	7 of 8	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Acute Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Spinal Cord Injury Rehabilitation Services)	Met	5 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
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)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Medicine Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Organ and Tissue Transplant Standards)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Narcotics Safety (Medication Management Standards)	Unmet	1 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Unmet	6 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
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 (Acquired Brain Injury 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 (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care)	Unmet	1 of 3	0 of 2
Falls Prevention Strategy (Critical Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Unmet	0 of 3	0 of 2
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Unmet	3 of 3	0 of 2
Falls Prevention Strategy (Obstetrics Services)	Unmet	2 of 3	0 of 2
Falls Prevention Strategy (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Unmet	3 of 3	1 of 2
Falls Prevention Strategy (Rehabilitation 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 (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2
Home Safety Risk Assessment (Case Management)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	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 (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Unmet	0 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Unmet	0 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Organ and Tissue Transplant Standards)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Spinal Cord Injury Acute Services)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Spinal Cord Injury Rehabilitation Services)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

The Nova Scotia Health Authority (NSHA) is commended for its ongoing commitment to the accreditation process. This was the first on-site survey since the newly established NSHA came into existence in April 2015 as a result of the amalgamation of nine former district health authorities.

NSHA is fortunate to have a diverse, experienced, engaged, competency-based board. Since the formation of NSHA, the board has spent a tremendous amount of time building a strong and solid foundation to fulfill the governance function, while recognizing there is more work to be done to ensure public engagement. The board has a Quality and Safety Committee that is encouraged to continue to mature its mandate, structure, and performance metrics.

NSHA has 37 community health boards that are involved in identifying the health status and needs of their communities. These partnerships and relationships need to be front and centre and aligned with the public engagement strategy to mobilize effective health service planning. NSHA needs to mature and further develop these key relationships. There are many external and internal stakeholders and partners that speak highly of the organization and they are committed to NSHA's vision of "Healthy people, healthy communities – for generations." The partners encourage NSHA to ensure the public is aware of available health resources and how to access them.

NSHA has a strong and committed leadership team that fosters and enables the mission and vision of the organization. The leaders continue to evolve the organization and they need to ensure they have effective change management strategies to support the entire team. They have focused on building a new foundation for the organization; at the same time, they need to stay focused on reducing variation and increasing quality and safety consistently across the organization. Health services plans need to align with the health status and primary care priorities. NSHA is encouraged to continue to identify and report on key performance and outcome indicators. The organization needs to advance the IM/IT plan to enable clinical and administrative decision making. The organization has done an excellent job managing the resources and balancing budgetary pressures. NSHA is encouraged to continue its work with the health services plan to ensure the future sustainability of the health care system.

Despite the significant change and uncertainty that comes with a transition to a new provincial health authority, staff, physicians, and volunteers remain committed to the people they serve. A high span of control for front-line managers is a consistent theme throughout the organization. Challenges with new processes such as performance appraisals and responsive recruitment are examples of the concerns raised by front-line managers. Facility and maintenance staff are challenged with the current volume of building and infrastructure deficiencies. Mitigation strategies need to be leveraged to support staff and patient safety. It will be important for the organization to pay attention to the results of the Worklife Pulse Tool and to implement appropriate action plans. Ongoing monitoring of work life will be key to enhancing team performance.

NSHA needs a strategic vision on population health and primary health care to address scarce resources and infrastructure risk, and enhance access for Nova Scotians. NSHA needs to address security, preventive maintenance, and capital equipment needs.

Implementation of best practice varies across the organization. The organization is encouraged to further standardization. The organization is in an excellent position to apply translating research in care (TRIC). The academic mandate is evident throughout the organization.

Meaningful patient and family engagement is being realized in a number of areas across NSHA. Many patient advisors are highly satisfied with the authenticity of partnerships and the level of engagement with the organization. It will be important for the organization to clearly articulate its overall framework, structure, and process to support and advance patient and family engagement. There is evidence that very good structures and processes are in place at the provincial level; however, these are not apparent with localized projects. There are opportunities to create a provincially organized network of patient and family advisors with well-identified points of contact within the organization. A well-organized network that is oriented in a standardized way with clearly identified terms of reference and pathways for follow-up will allow the whole organization to draw from an enlarged pool of well-trained advisors with varied talents and strengths. In an effort to encourage more patient involvement, engaged patient advisors encourage the organization to celebrate and disseminate the meaningful patient engagement that is currently present.

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: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Perioperative Services and Invasive Procedures 12.11 · Obstetrics Services 9.16 · Critical Care 9.21
Client Identification Working in partnership with residents and families, at least two person-specific identifiers are used to confirm that residents receive the service or procedure intended for them.	· Point-of-Care Testing 8.2 · Long-Term Care Services 9.2
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families for a target group of clients when medication management is a component of care (or deemed appropriate through clinician assessment), to communicate accurate and complete information about medications.	· Perioperative Services and Invasive Procedures 11.6 · Obstetrics Services 8.5 · Rehabilitation Services 8.5 · Mental Health Services 8.6 · Community-Based Mental Health Services and Supports 9.5
Patient Safety Goal Area: Medication Use	
Narcotics Safety The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.	· Medication Management Standards 9.4

Unmet Required Organizational Practice	Standards Set
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
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	· Emergency Department 10.6 · Perioperative Services and Invasive Procedures 11.11 · Cancer Care 15.7 · Obstetrics Services 8.6 · Mental Health Services 8.7
Suicide Prevention Clients are assessed and monitored for risk of suicide.	· Emergency Department 10.7 · Long-Term Care Services 8.8

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)

NSHA is fortunate to have a diverse, experienced, engaged, competency-based board. Since the formation of NSHA in April 2015, the board has spent a tremendous amount of time building a strong and solid foundation to fulfill the governance function. Targets and accomplishments are monitored and organizational achievements are recognized and celebrated. The board is very active in challenging the organization to do the best it can and to remain true to the NSHA vision of "Healthy people, healthy communities – for generations." NSHA's mission is "To achieve excellence in health, healing and learning through working together," and its values are respect, integrity, courage, innovation, and accountability. The board is very diligent in examining the metrics provided by the leadership as well as opportunities for quality improvement.

The board has a great deal of trust in the CEO and the leadership team. The briefings that are brought forward by the leadership team are comprehensive and provide the information the board needs to make informed decisions and recommendations. The board works to govern, question, and support the ideas and recommendations that are brought forward by the leadership team. All major decisions go through a comprehensive process that examines quality, safety, and risk, and all decisions are carefully monitored. The enterprise risk framework and the ethics framework are key enablers in the board deliberations and decisions. The board is encouraged to continue to mature the mandate, structure, and performance metrics of its Quality and Safety Committee.

All board members receive a comprehensive orientation as well as ongoing education. Board performance is regularly reviewed and improvements are made accordingly. The board also undertakes an annual review of the skill mix framework to facilitate and identify background, experience, and competencies needed on the board and board committees. The board has a process to review the performance of the CEO.

The board engages with the staff, physicians, patients, families, and the public through various means. Board meetings are held throughout the province and always start with a patient story. The board will be

scheduling opportunities for local members of the public to meet and discuss issues and provide input to board members when they are in a specific community. The NSHA annual report is presented at a public meeting. Board members regularly tour sites and programs throughout NSHA. Board members regularly connect with their respective community health boards and other stakeholders.

The board is encouraged to continue to move forward with its public engagement and communication strategies and to continue to look for opportunities to involve patients and families. It will be important for the board to harness the energy and input from the community and the community health boards as it moves forward with its health services planning.

The board is encouraged in its approach of keeping a population health lens on strategic planning and decision-making processes, to build and sustain an accessible and high-quality health system for Nova Scotians.

Priority Process: Planning and Service Design

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

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

There is a strong and effective strategic leadership team that has done a great job with organizational design in terms of putting in place an organizational structure that enables operations and processes to be delivered in a cross-functional manner, to foster provincial integration and line of sight. Planning and service design happens with the input of patients, families, and communities and includes a provincial Patient and Family Advisory Committee that is chaired by the members and not the organization. The committee is supported by the organization including executive management members. There are 37 community health boards that also provide input into service planning and design. Patients and families are also on committees for infrastructure design and new builds.

The organization uses Safer Health Care Now! bundles and evidence-based research and puts these into practice. Community members are trained on how to do research at a micro-level to increase awareness about health choices and health status.

The NSHA mission, vision, and values were created with the previous nine district health authorities. This is a strategic way to foster ownership of the provincial health authority.

The organization is encouraged to implement its primary health vision with a focus on the determinants of health and health status. The organization is commended on its extensive provincial diversity and inclusion framework. This is remarkable and should be considered as a Leading Practice. Geographical networks have been established that include network fact sheets to enable conversations with communities. These are updated as needed.

Equity consultants are resourced to each Zone which demonstrates the organization’s commitment to seeing all people. The organization is committed to developing and strengthening their relationship to achieve its vision.

The organization is only two years into its transition and it is transforming some provincial programs in a planned approach. NSHA is encouraged to continue to decrease variance when evaluating all programs and services across the organization to increase quality and safety. This organization is well positioned from a leadership and a planning and service design perspective to continue to lead the large complex transformational change that has been embarked upon.

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)

The leadership and finance teams are commended for the progress that has been made in relation to the amalgamation of resource management processes and systems. While the team is still working on standardizing processes related to financial resource management across NSHA, a consistent process for the development of annual operating and capital plans has been implemented. The organization is commended for implementing a five-year planning cycle that has allowed it to have transparency into areas of future need and opportunities for resource (re)allocation, and to plan accordingly.

Criteria for resource allocation have been developed and are consistently used across the organization. While external and internal stakeholders are engaged in the resource allocation decisions, there may be an opportunity for NSHA to consider further engagement with broader communities, stakeholders, patients, and families in its decision making and prioritization processes.

Operating savings have been achieved over the past number of years, allowing NSHA to achieve a balanced budget. However, challenges related to increased clinical activity and resources required to maintain aging physical infrastructure have put a strain on the organization's ability to balance the operating budget. NSHA is encouraged to continue its work related to health services planning, engaging the Department of Health and Wellness and implementing some of the system redesign initiatives that have been identified to ensure the sustainability of the health system.

The capital asset request process is well developed for the allocation of capital resources for infrastructure and clinical equipment projects. Prioritization criteria are well established and there is a methodology to engage key funding stakeholders in the process. NSHA is challenged with the level of capital resources that are available to refresh and rejuvenate major capital clinical equipment and infrastructure assets. The organization is also challenged by the obsolescence of some of its information technology systems. With so many disparate systems in operation as a result of the merger of the former district health authorities, investment will be required to rejuvenate and standardize the systems and leverage the benefit of consolidation. The organization is encouraged to continue to investigate alternate methods of resourcing to address the gaps in funding.

NSHA has a robust method to educate its leaders throughout the organization on how to manage and monitor their budgets. The organization should be proud of the various tools that have been prepared and implemented to ensure financial literacy across the organization. The integration of financial resources with the clinical care teams has created a collaborative culture where everyone is focused on the quality of care to the patient, client, and/or resident while always keeping an eye on the financial performance of the organization.

Priority Process: Human Capital

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
10.13 An exit interview is offered to team members that leave the organization, and the information is used to improve performance, staffing, and retention.	

Surveyor comments on the priority process(es)

A dynamic, energetic, and knowledgeable team leads and supports human resources functions at NSHA. The team is organized to support staffing and recruitment, talent and organizational development, workforce planning, performance and operations, employee relations, health, wellness and safety, interdisciplinary practice and learning, and transformation and change.

The team has developed a people and organizational development framework. The next step in this process is to consult with employees to identify three to five key priorities, actions, and measures that will lead to the NSHA people and organizational development plan. This plan will guide and focus NSHA in supporting the staff, physicians, volunteers, and learners and will be aligned with the organization's strategic direction.

As the team moves forward in developing new policies, procedures, and human resources processes for the new NSHA, it has been following the policies from the legacy organizations. This has ensured a solid foundation for the organization. Some of the recent changes include a new workplace violence policy and program, new processes for the completion of performance appraisals, and the development of an exit interview process that has yet to be implemented. The team has also developed several initiatives to support and enhance a healthy workplace and a culture of workforce safety. NSHA has also worked in partnership with the IWK Health Centre to develop a provincial diversity and inclusion framework focused on culturally relevant and appropriate care for clients; training and education for NSHA staff, physicians, volunteers, and learners; having a diverse workforce; and engaging vulnerable and marginalized populations.

The team has identified concerns about the span of control and pressure and demand on the front-line managers because of the many changes that have occurred in building the new NSHA, such as the implementation of new policies, procedures, and processes. This concern was validated during the on-site survey. It will be important for the organization to monitor the number of initiatives that impact front-line managers and seek their input when implementation plans are being developed. During the on-site survey, concerns were expressed about the significant amount of time it takes to recruit into a vacant position using the Success Factor system. Significant delays are impacting the ability to have appropriate staffing in some clinical areas.

It was also identified that the new performance appraisal system is not always user friendly. It is suggested the organization follow up with staff and managers to obtain their feedback and their suggestions for improvement. The organization needs to ensure the completion of performance appraisals as identified in policy, and to pay attention to the findings of the Worklife Pulse Tool and implement appropriate action plans. Ongoing monitoring of work life in the organization will be key to enhancing team performance.

Recruitment and workforce planning needs to remain a high priority on the organization's agenda, particularly as it relates to hard-to-recruit areas such as family physicians. Physician workforce plans have been developed until 2025. The team is also implementing key strategies for replacement of family physicians to ensure continuation of service, particularly in the rural communities. With the significant gaps in access to family physicians, patients and families have expressed concern that they don't feel safe or comfortable in raising a concern for fear of losing their physician. They also don't know the complaint process when it relates to a physician concern. The organization is encouraged to ensure the public is aware of how a concern can be raised without repercussion.

The team is working with multiple IT systems specific to employee time capture and health, safety and wellness needs. Moving to one reporting system would streamline processes.

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		
12.4	The risk management approach and contingency plans are disseminated throughout the organization.	!
16.10	The results of the organization's quality improvement activities are communicated broadly, as appropriate.	!
Surveyor comments on the priority process(es)		

The organization has a quality framework with varying degrees of action planning throughout the organization. Some quality improvement teams are in place and some are still forming to align with the new provincial organizational structure. The safety information management system (SIMS) was implemented this year and includes training to enhance reporting and data analysis. The organization has invested in decision support analysts over the past two years and this is enabling performance management and evidence-based decision making which is impressive.

Patient and family advisors sit on committees and teams to enhance the patient experience. The organization is encouraged to evaluate the impact of this engagement. The organization has key performance patient safety indicators on its website, including handwashing rates that are also reported to the Department of Health and Wellness. The organization is in early days of cascading indicators and outcome indicators to the point of care that align with executing strategy. A patient experience survey has been done and the information is being used to positively impact the patient experience.

The organization is encouraged to continue with its provincial rollout plan on medication reconciliation to decrease variance and increase safety. The organization has set up Required Organizational Practice teams across the province to enhance consistency, teamwork, and capacity and foster the spread of a systems approach to quality and safety.

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)

NSHA has implemented structures and processes for clinical, organizational, and research ethics support. Research ethics is provided by the Nova Scotia Research Ethics Board (REB) while Ethics NSHA addresses clinical and organizational ethics inquiries.

Since the creation of NSHA, the organization has established clinical and organizational ethics support throughout the province at the local and Zone levels. It has also established an ethics leads group that provides guidance and oversight to all NSHA health care ethics activities, includes clinical consultation and organizational ethics consultation, education, policy development, and review. Recent policies that have been reviewed relate to the use of seclusion, emergency use of blood products, and searches in mental health. NSHA also collaborates with the Dalhousie University Department of Bioethics and with Department of Health and Wellness and the IWK Health Centre as part of the Nova Scotia Health Ethics Network. As part of building ethics capacity, NSHA has recruited community volunteer members to sit on local and Zone ethics committees. The Ethics NSHA would like to see more front-line staff involvement at the committee level. Key performance indicators are regularly monitored.

The REB ensures that research protocols meet current safety, scientific, ethical, and privacy standards. Processes and procedures are in place to ensure the review process follows laws, policies, standards, and guidelines governing research. The REB has the authority and resources to review all research projects that will be conducted within NSHA facilities and programs. The REB has processes in place to ensure timely review of requests. The team also incorporates processes for random audits on high-risk research, and it has a research educator who supports continuous quality improvement within the REB. The team also monitors performance indicators. The board is encouraged in its efforts to continue to move forward in harmonizing the REB process with all the universities.

NSHA is commended on its commitment to supporting health care and research ethics activities. It will be important to ensure resources are in place to sustain this important work. There is a need for continued awareness of ethics support at the front line.

Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
7.6	Input is sought from stakeholders on a regular basis to evaluate the effectiveness of their relationships with the organization.	
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)

The leadership team has created a strategic organizational structure for the communications functions. This will continue to enable integration, reduce variation, and enhance communication across NSHA. The team has a solid communication plan which it is starting to implement.

To increase staff and public confidence, the team needs to continue to close the loop and tell the stories of how NSHA has executed strategy. It is suggested that the team start showing real time data on things like flu immunization uptake; this can create some healthy competition and visual management as well help to get ahead of the story. The team is committed to making a difference and is going down the right path.

Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures		
3.2	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	!
3.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	!
3.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!
3.9	The operating/procedure room has a restricted-access area for the sterile storage of supplies.	!
Surveyor comments on the priority process(es)		

NSHA operates many sites across the province, including 41 hospital sites in rural and urban communities. The physical infrastructure varies significantly by age and condition. The building infrastructure and asset management (BIAM) team is responsible for ensuring the physical environment is safe for staff and patients, clients, residents, and families. Clinical teams report that they are often required to work around infrastructure challenges to deliver quality patient care. BIAM is challenged in addressing infrastructure issues due to the levels of historic infrastructure investment. With an estimated deficiency of $85 million of urgent infrastructure needs (as per the auditor general of Nova Scotia, 2016) for hospitals in Nova Scotia, the BIAM team is generally only able to focus on demand and corrective maintenance issues. While there is variability in the level of preventive maintenance across NSHA, the team reported that on average only 10 percent of resources are able to be applied to preventive maintenance.

Variability in the physical environment is significant. For example, the Colchester East Hants Health Centre in Truro is new (approximately five years old), well maintained, and very clean, with several outdoor spaces for patients, families, and staff. Patients, families, and community partners were invited to participate in the planning process for this newer facility. Staff comment that the design supports improved efficiency and workflow.

In contrast, the Halifax Infirmary and Victoria General sites are challenged with regard to the physical environment. There are regular leaks and occasional floods at these sites which occupy a great deal of the

infrastructure team's time. This creates other challenges in the team's ability to address other critical issues at the sites. For instance, the team articulated that due to the age of infrastructure, the necessary air exchanges and monitoring of air quality to the operating rooms could not be assured. While this issue continues to be a challenge, the clinical teams reported that the infrastructure team is very responsive to urgent requests.

NSHA is commended for its approach to address the critical infrastructure needs given the resources that are available to address core issues. The VFA Facility Condition Assessment that has been undertaken allows the organization to prioritize areas requiring the most urgent investment. The teams are commended for the integration of infection prevention and control, emergency preparedness, BIAM, and environmental services that allow the organization to respond to these challenges. Regular audits of high-risk areas and reviews of infection control outbreak data and infection rates allows NSHA to proactively respond to existing or developing infrastructure issues. The organization is encouraged to continue its efforts to redevelop and rejuvenate the most critical sites. The QEII redevelopment project is absolutely necessary to ensure that safe, quality patient care can be delivered at this site and NSHA is urged to undertake this work expeditiously.

The organization does not have a single work order system; therefore, there is no consistent approach to logging or requesting support for issues requiring maintenance across the health authority. The team is investigating an opportunity to invest in a province-wide work order system that would link to the finance systems and provide the business intelligence related to service, demand, and preventive maintenance needs. NSHA is encouraged to continue this work to better identify opportunities to allocate resources across the organization.

The team reports some challenges related to the recruitment and retention of skilled trades in the facilities department; these vary by site and Zone. NSHA is encouraged to investigate opportunities to share resources across Zones to better leverage skilled assets where they are most needed.

The facilities team has implemented several environmental initiatives to mitigate the organization's environmental impact. Numerous examples were provided of initiatives focusing on recycling promotion, reduction of waste, reduction of water usage, and energy consumption. NSHA is encouraged to continue this great work and to spread the learnings across all of its sites.

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
14.3	The all-hazard disaster and emergency response plan is aligned with those of partner organizations and local, regional, and provincial governments.	!
Standards Set: Public Health Services		
13.6	A plan for informing the public about public health emergencies is established and followed in collaboration with partners.	!
13.7	The public health emergency response is tested as part of broader all-hazard disaster and emergency response plan drills.	

Surveyor comments on the priority process(es)

NSHA's emergency preparedness team is a newly formed group that has been focusing its efforts on the development of the team and establishing the strategic priorities of the program. Much of the focus has been on recruitment and consolidation of services from the former district health authorities to the new NSHA program.

Team members are a diverse group of professionals with varying background and expertise. They have formed what appears to be a very strong partnership with internal teams such as the building infrastructure and asset management, infection prevention and control, occupational health and safety, public health, and clinical operations. The team is encouraged to continue to build these relationships to further enhance the ability to respond to emergency situations.

Given public health's leadership presence in emergency preparedness, there is good communication and response on issues related to outbreaks and pandemics. The organization is encouraged to provide additional education and training on the public health emergency preparedness plan as public health staff in the central, Eastern, and Northern Zones indicated a lack of awareness of the plan and were not clear on what their roles would be in the event of an outbreak. The public health teams in the Central and Northern Zones report that many key staff positions are vacant, which would limit their ability to respond to public health communicable disease emergencies. The organization is encouraged to fill these positions as soon as possible. Even with the human resources challenges, there is prompt detection of, response to, and containment of disease outbreak, as evidenced by the response to the measles outbreak.

The emergency preparedness team also works closely with a number of external stakeholders such as Nova Scotia Power, IWK Health Centre, Department of Health and Wellness emergency management, and municipal governments, among others. NSHA is encouraged to continue to strengthen these relationships as they will augment its ability to prepare for and respond to broader emergency events.

NSHA and this broad team are commended for their success in responding to the numerous (more than 80 events in 2016/2017) medium and large-scale emergencies that included code oranges, infrastructure failures, floods, chemical spills, critical system failures, urgent IT repair shutdowns, power outages, mass gatherings, adverse weather events, and fires within the facilities. NSHA has used these very challenging occurrences to refine and enhance the emergency response plans and strategies to react to future events.

Based on the learnings from these events, the team has established an incident management system to standardize responses across NSHA. The organization is encouraged to continue to roll out the implementation of this system across the health authority to further clarify the roles and responsibilities among the Zone emergency preparedness teams, cross-Zone team responses, and provincial response to emergency situations. As part of this system, the organization is encouraged to investigate technology that could be used across the province to assist NSHA with a more rapid mass alert notification process to deploy the emergency response. Currently, the processes vary across the organization. The team has also conducted an inventory of the all-hazard response plans throughout the organization and is encouraged to begin the process of standardizing a plan for the entire NSHA.

The NSHA emergency preparedness team has a robust SharePoint site that allows the organization to track all exercises and events. The site also allows the team to track trends and learnings from previous events and to highlight areas on which to focus future opportunities for improvement.

The organization is encouraged to continue to provide ongoing education to staff, service providers, and especially patients, clients and families related to emergency preparedness. Given the size of NSHA and the number of sites, there are challenges in providing a consistent approach in the uptake and readiness for events. This can result in some variability. Drills of emergency response plans are delivered at the site and Zone levels which can also result in some inconsistency in process, readiness, and understanding of the plans. NSHA is encouraged to continue with its strategies to enhance the education of emergency response plans and to continue to promote drills and debriefings as appropriate.

NSHA has focused on some business continuity planning, primarily in areas associated with key events such as the Canada Post work interruption, Bell Aliant cellular phone outage, and the provincial measles outbreak. While there were excellent learnings through the response to these processes, the organization is encouraged to continue to refine its business continuity plan. This will require significant effort, but the process will become easier as the organization standardizes clinical and business operating procedures across programs and Zones.

Priority Process: Patient Flow

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
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**

Surveyor comments on the priority process(es)

NSHA has embraced and fully understands patient flow to be a health system issue. There is a clearly demonstrated organizational accountability and investments in flow have been made at the site, Zone, and provincial levels, with many roles dedicated to dealing with capacity management and flow along the continuum of care within sites and systems. Each site has been creative using its resource base with its roles; however, it may be beneficial to create a standard role that looks at flow at the front-line level.

There are many pockets of excellence throughout the Zones and areas where more improvements need to be made. However, regardless of their tireless work and investment, emergency department (ED) overcrowding and bed capacity continue to be major issues that put patients and families at risk when care is not accessible in a timely fashion. This is especially problematic at some of the larger sites and at the lead site (QEII) due to its tertiary/quaternary status in the system, with all referring sites being dependent on ED capacity to accept their patients. There are region-wide overcapacity protocols, code census protocols, and surge and repatriation protocols to help the situation. Transition spaces are created when needed, and there are also clear no-refusal priority patient populations that are effectively triaged such as cardiac, stroke, trauma, and plastics as well as all Canadian Triage and Acuity Scale-appropriate patients. However, for some of the non-tertiary populations access can be a day-to-day challenge for the referring sites, and delays in transfers are very dependent on the volume in the ED at the QEII, which potentially puts the patients and health care providers at risk in an system that is not set up to care for the acuity of the patient.

Flow is recognized as a priority issue for the Zone and many strategies exist; however, the current health care system has many gaps. Some of these issues such as limited access to primary care in some communities, limited mental health and addictions resources and beds, as well as an excess of alternate

level of care patients in acute care beds, along with other health system issues make flow challenging for the sites and programs to deal with day-to-day capacity.

Each site visited has made flow a top priority and is commended for this. A region-wide electronic bed management system allows for a clear and transparent view of the “state of the house." All sites are accountable not only within their Zone but also at the Zone level and they report in every Monday morning. Each site also has interdisciplinary bed/flow meetings, which, depending on the size of the site, can vary from once a day to twice or up to three times a day at sites like the QEII and Dartmouth General Hospital, depending on the situation and state of the house.

Many sites have embraced flow and have participation at all levels and from all disciplines; however, there are some sites where physician participation is not yet fulsome enough to have a positive effect on daily flow within the site. This lack of engagement and unwillingness of some physicians to round, assess, and discharge their patients in a timely fashion is directly impacting the sites’ ability manage flow daily. The Zone has been very creative in dealing with its long length of stay patients and is ready to roll out a new provincial overstay patient policy that will enable NSHA to effectively discharge patients who no longer require acute care services but who are blocking beds due to their reluctance to be discharged.

The Zones is commended on the development of the solid foundational building blocks that support the structure and processes of flow within the Zone and site. Discussions with flow leaders identified some suggestions that could help, such as:

• Create a long length of stay benchmark, perhaps 20 days, so they can focus on specific discharge strategies for the long length of stay and complex discharge patient populations.

• Have a site-focused weekly meeting regarding all long length of stay patients that includes external stakeholders such as continuing care, palliative care. etc., so they can have a focused discussion on discharge with actionable outcomes.

• Continue the Home is Best journey in the Zone, as well as palliative care and dying in the home as strategies.

• Implement successful pilot programs that are currently in place at many sites, such as the EMS-led offload delay care program at Dartmouth General Hospital.

• At the QEII daily bed huddles, incorporate a running list of requested transfers in and repatriations out, so site flow manages can refer to the list in their day-to-day work and always have a pulse on areas of high need as they oversee bed placements.

• Clearly spell out the physicians’ roles in patient flow and safe transitions of care from hospital to community. It may also be advantageous to have senior medical leaders in the flow portfolio to work on physician engagement, so that all physicians are accountable within the flow process.

In addition, many of the charge registered nurses, unit coordinators, and supervisors have many roles in their job descriptions, including flow. This means they can be challenged by differing priorities during the day and, depending on the situation, this can impact their ability to manage flow and complex discharge planning while dealing with operational issues. It is suggested that dedicated flow coordinator positions be implemented or that case management leaders who deal with flow have this as their sole responsibility on each floor. This could be piloted first in the busier, more challenging areas such as medicine. Having this dedicated role will allow flow to be prioritized without compromising other daily activities in the units. It is also suggested that a robust analysis and bed mapping exercise be undertaken in the Zone.

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		
8.2	If the team does not have access to the resources needed to safely clean and reprocess diagnostic devices or equipment at the point of use, the team sends them to the medical device reprocessing department or an external provider.	!
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!
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.	!
8.9	The team follows the organization's policies and procedures and manufacturer's instructions for cleaning and reprocessing diagnostic devices and equipment.	!
Standards Set: Perioperative Services and Invasive Procedures		
4.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	!
Standards Set: Reprocessing of Reusable Medical Devices		
1.1	Information about service volumes is collected at least annually from all areas in the organization that require reprocessing services, and is shared with the MDR department.	!
1.2	Information collected about services offered and their volumes is used to determine the range of reprocessing services and how they are delivered.	!
3.2	The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
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.	!
5.4	The team involved in reprocessing medical devices is prepared for the functions it performs through education and training in a formal medical device reprocessing training program recognized by the health care setting.	!
5.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
7.9	Policies and SOPs are regularly updated, and signed off according to organizational requirements, as appropriate.	!
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
8.9	Workplace assessments of the MDR department are regularly conducted for ergonomics and occupational health and safety.	!
9.2	Point of use cleaning of a device or equipment is performed as part of the decontamination process and occurs immediately after use and prior to decontamination in an MDRD and following manufacturers' instructions.	!
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.	
15.1	There is a quality improvement program for reprocessing services that integrates the principles of quality control, risk management, and ongoing improvements.	
15.2	Information and feedback is collected about the quality of services to guide quality improvement initiatives with input from stakeholders and team members.	
15.3	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities with input from stakeholders.	

15.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	!
15.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	
15.6	Quality improvement activities are designed and tested to meet objectives.	!
15.7	New or existing indicator data are used to establish a baseline for each indicator.	
15.8	There is a process to regularly collect indicator data and track progress.	
15.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	
15.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	

Surveyor comments on the priority process(es)

Central procurement management is transparent and organized. There is a consistent, well-thought-out, process-based, five-year plan to purchase new equipment that is to a large extent based on patient risk. Although there are financial challenges, a robust and functional equipment replacement program is in place. There is a fast-track program and emergency funds to replace critically needed prices of equipment when the need arises.

The biomedical service has an effective system to manage inventory, preventive maintenance, and repair histories for the equipment it is responsible for throughout the Zone. In some departments, shared service contracts with the vendor are in effect. The team is responsive and works hard to maintain its expertise on the many pieces of equipment that require its attention. Initial assessments, repairs, and preventive maintenance are well documented at the sites that were visited. In addition to the strong working relationship that exists between biomedical engineering and central procurement management, partnerships have also been established between biomedical engineering and many of the vendors. A rigorous response to equipment alerts and recalls, with a primary focus on patient safety, is in effect.

Biomedical engineering recognizes that some variation in standards, processes, and procedures remains across the province and it is in the process of standardizing these. This is a work in progress. In a

collective effort from all Zones, there is an ongoing effort to develop standardized key performance indicators and these initiatives will result in better outcomes for patients.

Physicists play an important role in the quality control and quality assurance of much of the equipment in the radiotherapy department at the Victoria General Hospital.

Medical device reprocessing is performed by supervisors and staff who are conscientious and engaged. There is strong leadership from the managers and team leaders and staff work well together as a team. Staffing levels are generally adequate and staff report their workload is reasonable.

Ongoing professional development, education, and training opportunities are available to team members in the medical devices reprocessing department (MDRD). Reprocessing technicians attend regularly scheduled in-services and they are encouraged to attend conferences when possible. Some have become certified by CSA Group or the International Association of Healthcare Central Service Material Management and others are working toward that goal. There is an education nook in the staff lounge at Victoria General Hospital and staff members use the resources in this library to keep current with their practice.

Team members are recognized for their contributions. At some sites, employees are recognized by their supervisors and peers by having their names displayed on a staff shoutout board, a star board, or a good job board and this recognition is appreciated by the staff.

An initiative called bridging the gap is in place at the Halifax Infirmary, where staff from the OR and the MDRD spend time in each other’s departments. This benefits both groups as they learn to appreciate the work and the challenges that members of each team face, and it has led to increased levels of cooperation between the two departments.

Endocavitary ultrasound probes are being reprocessed in many of the ultrasound departments by diagnostic imaging staff who were trained by MDRD educators who have taught them to disinfect their devices to the same standards as those used in the MDRD. Ongoing competency assessments are conducted by educators from the MDRD.

Records show that the MDRDs at some sites (Halifax Infirmary, Victoria General Hospital, Dartmouth General Hospital) are cleaned by housekeeping, but there is significant room for improvement with respect to the cleanliness of the floors.

The Cape Breton and St. Martha's Regional Hospitals, quality improvement initiatives are discussed at MDRD meetings but key performance indicators and dashboards have not been developed. There is no quality board for staff or the public. This has been identified as a provincial initiative. Key performance indicators have not been established and indicator data are not being collected and reviewed at the South Shore Regional Hospital.

Some of the pages in the tray binders at the Victoria General Hospital and Halifax Infirmary are not dated and many that are dated have not been reviewed in years. In addition, many of the pages have not been initialled or otherwise signed off by the person responsible for writing or reviewing them. A well-organized set of policy binders with well-written standard operating procedures are available for staff at Valley Regional Hospital. However, they have not been updated for several years.

Medical devices used in the OR at the QEII Halifax Infirmary site are pre-cleaned in the OR but there was evidence of gross blood that was left on several instruments after they had been pre-cleaned. Adequate soaking and cleaning with friction had not been used to remove this bio-burden. In these cases it would have been useful to coat the instruments with a gel spray to keep them moist until they can be properly cleaned in the MDRD.

At Yarmouth Regional and the Valley Regional hospitals there are storage cabinets in the endoscopy suite and wooden pegboards and work counters in the clean side of the MDRD that are made of particle board or laminate. There are also workstations, furniture, and bookshelves that are made of porous fabric and materials at Yarmouth. These work surfaces and storage units do not meet standards and represent a level of risk for the perioperative program and the hospitals.

Ultrasound probes at Cumberland Regional Hospital are reprocessed in the patient examination room. The reprocessing room in the ultrasound department of Yarmouth Regional Hospital is spacious, clean, and single purpose, and there is proper ventilation and drainage. However, cleaning and decontamination occurs in the same room and a one-way flow from dirty to clean was not observed.

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:

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.

Organ and Tissue Transplant

- Providing organ and/or tissue transplant service from initial assessment to follow-up.

Point-of-care Testing Services

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

Transfusion Services

- Transfusion Services

Standards Set: Acquired Brain Injury Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

Leadership teams from the Nova Scotia Rehabilitation Centre (NSRC) in Halifax and the Harbourview Hospital in Sydney Mines participated in a joint leadership discussion group, providing the following insights into the acquired brain injury (ABI) program.

NSRC and Harbourview Hospital provide provincial and regional, respectively, rehabilitation services in Nova Scotia. Although NSHA has not defined rehabilitation services provided in Nova Scotia in the context of a program or a network, both leaders expressed interest in collaborating and sharing best practices between the two organizations/locations. There appears to be a willingness among the leadership to develop a provincial rehabilitation strategic plan for Nova Scotia. This is encouraged, as it aligns with NSHA's articulated provincial focus on the aging population with complex conditions and on the desire to maintain frail seniors in their homes.

There is an opportunity to develop a rehabilitation strategic plan in conjunction with a provincial physician resource plan for rehabilitation services (with an emphasis on physiatrist resources), with consideration of innovative models for resourcing rehabilitation services to meet patient needs across the province. This is already being done via telehealth and could be further expanded or done via development of community-based specialist practices. NSRC already provides telehealth across the province for inpatients and outpatients. The opportunities presented by this and other technologies may permit expansion of rehabilitation support, such as providing remote consultations and assessments where physician, especially physiatrist, resources are lacking.

With respect to the programs and services offered by the ABI unit at NSRC, demographic data and information about community needs are collected and used by the leadership of the unit to identify and develop services for target populations and to understand service and staffing levels that are needed. An example is a report prepared for the Traumatic Brain Injury Research Partnership that cites growing concerns for traumatic brain injury in Nova Scotia due high-risk industries as well as the military, sports, motor vehicle accidents, and falls. The strong interdisciplinary, collaborative, and patient-centred focus of ABI team members at NSRC indicates that this team is uniquely positioned to provide expertise in building capacity beyond NSRC walls and across the full continuum of prevention, education, rehabilitation, and post-injury service delivery and research.

The ABI program team's understanding of the population served enables it to develop goals to guide the efforts of the leadership and the quality team, specifically to:

- Increase intensity of care
- Evaluate effectiveness and efficiencies of practices
- Build healthy team skills and relationships
- Decrease length of stay

In the context of Accreditation Canada's focus on patient- and family-centred care, the team is encouraged to develop tactics to evaluate effectiveness and efficiencies of practice, in partnership with

and with input from patients and families, as well as community and other stakeholders. Articulating and documenting this strengthens the goals and makes the partnership explicit.

Priority Process: Competency

NSRC is a tertiary rehabilitation centre serving the people of Nova Scotia and the Atlantic provinces. The centre offers an interdisciplinary team approach in four key clinical subprograms. It has 66 inpatient beds, a range of outpatient clinics (such as multiple sclerosis, amyotrophic lateral sclerosis, neurology, acquired brain injury, musculoskeletal, amputee, spina bifida, orthotics, spasticity, stroke, and transition clinics), telehealth services, a day program, and an outreach service for acquired brain injury patients. The team comprises physiatrists, hospitalists, nurse practitioners, nurses, occupational therapists, physical therapists, dietitians, psychologists, recreation therapists, and social workers as well as orthotics/prosthetics, spiritual care, and vocational counselling services.

The centre's leadership has worked hard to develop academic training opportunities across disciplines that serve the centre well in terms of career laddering. This, in turn, supports recruitment and retention of clinicians. The centre is commended for its academic partnerships, which have virtually eliminated the need in the last two years to close beds to address vacancies in hard-to-fill positions.

Research is also an important component of the centre's mandate. There are many examples of interdisciplinary research; a project exploring pain self-medication was highlighted during the on-site survey. And the 2017 Shears Lecture in Physical Medicine and Rehabilitation, held at NSRC, brought in an internationally recognized expert in concussions and headache to provide the keynote address, in addition to related presentations by local researchers.

The ABI program at NSRC provides an interdisciplinary team approach to the care and treatment of traumatic and non-traumatic (including stroke) brain injuries. The program's approach to care and treatment includes the 7th floor ABI unit, the ABI day program, an ABI outreach team, and ABI outpatient services. The ABI program has a strong leadership team to support front-line team members. A standardized orientation program includes a general NSHA orientation day, a discipline-specific component, and an ABI component to ensure new staff receive a consistent and comprehensive orientation. Cultural competency training is provided and cultural beliefs and practices are incorporated into care planning. A dedicated rehabilitation clinical nurse leader provides day-to-day operational leadership to the nursing staff in the provision of collaborative patient care. A matrix reporting relationship exists for clinical staff members who report to both program and discipline/practice leadership. The team is positive about the hospitalist model and rounds and the support from physiatrists.

Family members are an integral part of the team and there are opportunities for families to room-in to learn and participate in the care routines for their loved one. An interdisciplinary clinical leader reports to the program manager and works closely with the team and program managers, professional practice coordinators, physicians, nurse leaders, and other team members to promote patient-centred, interdisciplinary collaborative care.

Although team members on the ABI unit at NSRC have opportunities for informal feedback on their performance and are recognized for their accomplishments, formal documented evaluations that could inform performance plans and personal and professional development are not regularly conducted for all staff on the unit. The unit manager is encouraged to explore with NSHA's human resources leaders whether documented performance conversations (frequent informal performance conversations already do occur, but are not documented) adhere to NSHA's policies related to performance appraisal. This approach has been successfully adopted in many organizations where span of control is large.

Staff working on the ABI unit provide strong testimonials of the strong team culture on the unit. One noteworthy comment reflected the overall mood that permeated all interactions with staff during the on-site survey, "I have found my clinical home here. It's never boring. I love working with this team."

Priority Process: Episode of Care

NSRC is congratulated on the renovations that were funded by the Revitalizing Rehabilitation Campaign. These include a fabulous new therapeutic pool; the upgrade of four elevators that, based on feedback from patients, families, and staff now include an oversized open/close button located at the rear of the cab to assist patients in wheelchairs; changes to the main entrance; paving of the parking lot. In addition, two new activities of daily living suites are under construction with targeted completion in the new year. One suite will be high tech, the second will be similar to a typical home or apartment. These capital plant changes reflect significant improvements to the aging physical infrastructure of the centre and permit opportunities for increased engagement and collaborative programming with the Halifax community. The NSRC pool, for example, is used by the centre’s inpatients and outpatients as well as by the YMCA for a community program four evenings each week. The centre has developed the community YMCA partnership with consideration of maximizing use of the space while ensuring safety is paramount in the contracted relationship.

The ABI unit has secured funding and is in the process of installing 24/7 secure swipe access to the units (stairwells and after-hours elevators). Cameras have been installed at points of entry and exit, and an electronic patient wandering system and staff duress/panic buttons have been funded and hardwiring is underway. Although some upgrades have been made to the outdated and badly deteriorated cabinetry in the patient rooms and dining areas, there is an urgent need to replace counter tops that are unsightly as well as being significant "germ trappers."

There have been significant positive changes to NSRC infrastructure; however, more is needed to address, as noted above, patient safety and infection prevention and control concerns. Added to this is concern among leaders and staff about the implications of the development of a single campus of acute care in Halifax that will see the closure of Victoria General Hospital in approximately seven years. The underground/basement tunnel between NSRC and Victoria General supports essential services for NSRC, including patient meals, diagnostics (imaging, including barium swallows), respiratory therapy and code teams, IT services, and evening pharmacy services.

Medications were observed being dispensed from the Pyxis medication system and taken to the patient, where the blister packages were opened and administered on location, checking two patient identifiers and the medication administration record.

The ABI team led the work of NSRC in partnering with patients to develop a checklist guide for patients that follows the episode of care (upon admission, during your stay, as you near discharge, the day of discharge, after discharge). The guide meets the program goal of providing consistent care and messaging at key transitions. The Your Journey through Rehabilitation documents (one version for patients/families; a second for care staff) are the result of a staff and patient engagement project that identified the need for a checklist to prepare patients for discharge. The patient version provides space to add notes and the care staff version prompts key discipline staff to provide consistent (where appropriate) and customized information for each item on the checklist.

Patients and families report that the ABI team works hard to incorporate their feedback at every stage of the planning for their care, including in defining their goals for care and discharge. As noted, patients are provided with the Your Journey through Rehabilitation checklist, as well as a Let's Talk about Stroke Guide that informs patients and families about potential needs to enhance care planning. Patients and families in the program are invited, encouraged, and involved in identifying topics for education sessions.

Compliance rates with medication reconciliation being completed within 24 hours of admission is monitored via inpatient chart audits. Evidence of medication reconciliation on admission and discharge was noted. Medication reconciliation on transfer appears to have been consistently implemented in the ABI program, with the best possible medication history (BPMH) being verified by physicians or nursing. Discrepancies are noted on the medication reconciliation form. The percentage of falls assessments completed within 24 hours and Braden scale completion rates on admission are also monitored by the quality teams. In addition, a falls prevention pamphlet is given to all patients on admission; this augments the signage posted throughout NSRC. The centre's CNE produces a monthly newsletter, provides a comprehensive orientation for new nursing staff, and offers topical lunch-and-learn sessions that are open to all team members.

Although the patient record is paper based, the ABI team provides a comprehensive initial assessment using an interdisciplinary assessment tool developed by the team. Standardized documentation tools are used for transfer of information between care areas and between shifts and are documented on the patient's chart.

A family support group is open to families even after their family member has been discharged and an inpatient ABI education series is open to families even if the patient chooses not to participate. Feedback from a family survey led to the change in the title of the Thursday patient education program to include "families" in the title, as families reported they were not aware that they were welcome to attend. Following discharge, time-limited community support is offered to patients and families through an outreach team.

Priority Process: Decision Support

A centralized intake and prioritization system is in place across NSHA. This is the first line of triage for patients referred to NSRC. Clinical assessment data and information from standardized assessment instruments are submitted to the Canadian Institute for Health Information (CIHI) and information is used to compare performance with other tertiary rehabilitation facilities (based on peer groups) across Canada on metrics such as average wait times for programs, number of admissions/discharges, average length of stay, and change in function based on functional independence measure scores. Robust indicators tracked by the team are presented in the form of a scoreboard for review by NSRC quality and ABI quality teams.

The ABI team's model of care is based on the evidence-based review of acquired brain injury and the evidence-based review of stroke rehabilitation. These evidence-based therapeutic frameworks guide care planning for patients with ABI and stroke.

NSRC teams worked with patients and families to develop an inpatient survey instrument. This short tool has 14 items that yield quantitative results, with the opportunity to collect narrative/qualitative comments. While response rates have been high, a limitation of the tool is that the items have not been validated and as such may not measure what is intended. For example, several of the items are double-barrelled. The ABI unit team is encouraged to consider fielding instruments with demonstrated validity and reliability that offer opportunities for benchmarking with centres that provide similar case mix and/or services. No benchmarking is currently possible; as such, sharing or learning from the best practices of others is not possible, and it is unclear how to interpret scores. Finally, it is important for the rehabilitation and ABI quality teams that review the results of the survey to recognize that respondent n sizes are low, making margins of error high. A more targeted open-ended question that asks respondents to name one thing that would improve the service/program may yield more actionable feedback.

Priority Process: Impact on Outcomes

The ABI unit is commended for its engagement of patients and families in day-to-day care planning and research. The ABI annual luncheon and presentation session for upwards of 150 former patients and families is a wonderful example. Evidence-based gap analysis conducted by stroke and traumatic brain injury working groups has led to using stroke best practice guidelines to develop a standardized screening tool for mood and depression screening that nurses complete with all patients on admission.

ABI unit leaders and staff monitor a robust list of indicators, many of which are posted on quality boards and reviewed by the rehabilitation and ABI quality teams to inform local quality improvement initiatives. The safety information management system (SIMS) is the corporate patient safety reporting system used to report errors and safety-related incidents. Staff report it is an improvement over the previous PSRS platform and that they can submit both identifiable and anonymous reports. Total incidents that occurred during the period are reviewed by the rehabilitation and ABI quality teams (harm, no harm, near misses), as well as any SIMS incident with a harm rating over 4, categorized as falls; pressure ulcer prevalence; medication reconciliation incidents; hand-hygiene compliance; methicillin-resistant

Staphylococcus aureus, vancomycin-resistant enterococci, and C-difficile transmission rates; and catheter-associated urinary tract infections. In addition, chart audits are completed on inpatients to verify if the BPMH, and falls and Braden scale assessments were completed within 24 hours of admission. Data on specific indicators are submitted to CIHI via the National Rehabilitation Reporting System that includes average wait times for the program, number of admissions and discharges, average length of stay for each program versus peer groups, and change in function based on CIHI FIM scores.

Post-discharge surveys are distributed to patients and response rates, overall satisfaction rates, and satisfaction with involvement in decision making are monitored. See comments on the patient survey instrument in the ABI decision support section.

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
3.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
6.1	There is a process to respond to requests for services in a timely way.	

6.2	When scheduling services, set criteria are followed and input is gathered to ensure clients with the most urgent needs are seen first.	
6.6	The length of time clients wait for services beyond the time the appointment was scheduled to begin is monitored and work is done to reduce that time as much as possible.	
8.2	The assessment process is designed with input from clients and families.	
9.4	Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.	!
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
13.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
14.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
14.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
14.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
14.6	Safety improvement strategies are evaluated with input from clients and families.	!
14.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!

15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Participation of clients and families, partners, and the community in service design is not evident at all locations. The organization might consider developing a structured approach on this matter to obtain benefits such as those seen in the renal program. The same goes for the definition of service-specific goals and objectives, which, for example, are well developed for the renal program at the central level but aren't clear for staff and management at the local level. This is an important opportunity to implement a widespread space co-design approach involving clients, families, and other partners.

Priority Process: Competency

Teams are highly motivated and engaged. A well-structured orientation process is in place and opportunities and tools for knowledge refresh and continuous education are present via face-to-face sessions as well as a very complete e-learning platform. Staff feel they receive the necessary training for care delivery and the safe use of equipment, in alignment with the organization model.

Commitment toward staff and client safety is evident in activities such as widespread training on workplace violence. The organization is encouraged to consider the process of a regular performance evaluation of team members which at some sites has not taken place in several years. Lack of evaluations

could affect levels of staff engagement as well as opportunities to recognize achievements and improvement opportunities. At some sites, physicians seem to function separately from the rest of the team, which creates an environment where the team does not collaborate as a complete unit. Regular evaluation of team collaboration and functioning is strongly suggested.

Priority Process: Episode of Care

The on-site survey focused on the renal dialysis units at Cape Breton Regional Hospital, Inverness Consolidated Memorial Hospital, Colchester East Hants Health Centre, QEII Health Sciences Centre Dickson Building, and Yarmouth Regional Hospital. As well, the orthopedics assessment clinics were assessed at Valley Regional Hospital, Aberdeen Hospital, and the QEII Health Sciences Centre Halifax Infirmary site.

The renal dialysis program is a shining example of providing excellent centres is small sites that otherwise would be only offered in larger centres. Despite being hours away from Halifax, chronic renal disease patients are very well served. A clear framework and protocols are supported by engaged teams, good equipment that is being further improved with new dialysis machines, and telehealth consultations that are highly appreciated by clients.

It was reassuring to see the passion and client-centred approach exhibited by nursing staff from the chronic kidney disease clinic.

Dialysis services are very well supported by a collective team from pharmacy, dietary, infectious disease, and renal nurses. Patient feedback is excellent and their confidence in the team is noteworthy. The unit is also well supported by a very committed team from the biomedical service. The collective expertise is most impressive.

Despite some members of the leadership team being relatively new, they are focused on raising the bar. An example is a concerted effort along with infection prevention and control to increase the hand-hygiene rate. The units are expanding their quality committee and encouraging patient advocacy. The patient satisfaction survey guides many improvement initiatives and feeds the planning process.

There is a clear sense of pride in the building and the program.

The orthopedics assessment clinics focus on non-surgical management and health optimization and "pre-hab" (an eight-week/two-day per week lifestyle, education, and exercise program). Standardized assessment instruments and tests are used to establish baselines (functional, physical, mobility, strength, pain, etc.). Follow-up is done via phone calls from the clinic nurses 48 hours post-surgery, and at two-week or six-week clinic visits with continued follow up at three, six, and twelve months as needed. The strong interdisciplinary teams are passionate about their work and the opportunity for innovations as the provincial health authority explores opportunities to better manage and reduce surgical wait times for hip and knee replacements in Nova Scotia. Staff engagement is evident. As one client said, “No man ever treated me any better than this doctor, he explains everything.”

The implementation of a solid wait list management strategy is strongly suggested, not only for surgeries but also for assessment consultations that can take six to eight and even more than 20 months with specific surgeons. Some sites have found a central intake is an opportunity to better analyze consultation wait lists. Another initiative to address wait lists is the one at Valley Regional Hospital, where the Accreditation Coordinator has developed a clinic program that triages patients referred from GPs in the north west Zone to orthopedic surgeons. Recently, GPs were sent a letter from the hospital, indicating that if referrals were sent to the clinic (rather than to individual surgeons) that the wait list for surgery could be reduced by making available the first available surgical slot. A surgery readiness improvement initiative is being tested at the QEII Halifax Infirmary site.

Flow in the clinics is limited by space and there was some indication that flow through the diagnostic imaging area for x-rays has room for improvement at sites such as Aberdeen and Valley Regional Hospital. Valley Regional and the clinic team are encouraged to consider a flow project (perhaps using Lean methodology) to explore opportunities to streamline the x-ray flow. Space is always a scare resource.

It has only been four months since these clinics have been aligned under perioperative services across the province. As they are new, it is strongly suggested that in due course the program explore linking with the Canadian Institute for Health Information (CIHI) to understand the national plans for PREMS/PROMS measurement pre/post total hip/knee arthroplasty, using both generic and condition-specific PROMS that will permit national benchmarking. CIHI is leading a hips and knees pilot in this area; Dr. Eric Bohm in Winnipeg is leading this work.

Pain is measured, but not using a standardized tool, and there is no coordinated approach for pain management, which becomes even more critical when clients have to wait months and even years for surgery.

Clients are screened for falls, but this is not identified on the chart in a visual way such as by using a sticker.

The team is encouraged to develop a formal approach to engage patients for input and partnership to develop the program. The VHC holds a graduation ceremony for the hip and knee patients who complete the pre-hab program. Each patient receives a Certificate of Completion and is given their theraband. This is a very special activity for these patients, who finish the program having optimized their health and rehabilitation potential prior to surgery. This program also provides a concrete intervention while patients wait for their surgery. This ceremony is an example of patient centredness. After graduation patients know their exercise routines and can continue at home or at a gym.

It is suggested that any instructions or teaching in the clinic setting could benefit from teachback methods and return demonstrations to confirm that patients have understood and mastered the instructions and exercises. Patients and families very much appreciate the information available at the My Surgery website. One person said it is “one of the most positive things I’ve ever seen.”

Priority Process: Decision Support

Technology and information systems support the process of care delivery as well as the monitoring of care processes which are used for planning purposes. A new electronic clinical record will be implemented for the renal program, developing even further the capacity for standardization and data analysis.

Record-keeping practices and resources ensure the privacy of client information.

Priority Process: Impact on Outcomes

The two assessed programs are at different stage of development related to improvement planning and the assessment of quality initiatives. These are more developed at the renal clinic in Halifax where there are designated team members for quality and patient safety as well for data analysis. The orthopedics program is encouraged to continue working to define measurable improvement objectives and initiatives that will help, among other things, to better define the key performance indicators to monitor in order to identify opportunities for improvement. The renal program would benefit from ensuring that all sites are aligned and adopt the regional improvement objectives and the key performance indicators, which aren't always known to the sites away from Halifax.

There is a culture of reporting patient safety incidents supported by a user-friendly online reporting system. To help prevent recurrence and make improvements, data are analyzed with input from clients and families at the Kidney Patient Advocacy Committee in Halifax, which is remarkable. The other sites as well as the orthopedics assessment clinics are encouraged to emulate this practice.

Treatment guideline selection as well as the mitigation of high-risk activities involving clients and families is a practice that needs further development.

The organization is encouraged to consider developing an easy and practical structured process and culture to test improvement initiatives and provide feedback to staff and clients, and to spread improvement interventions that have worked.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Laboratory		
5.4	The team is made up of a sufficient number of qualified team members who are able to carry out the required volume of laboratory services, day-to-day operations, and any other responsibilities.	
6.3	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
6.4	The team's competency is assessed following a new staff member's orientation and on a regular basis thereafter.	
6.6	Each team member's performance is evaluated in an objective, interactive, and constructive way.	
7.2	The laboratory has sufficient space to carry out laboratory services.	
7.7	The environmental conditions of the laboratory's storage space protect the integrity of its samples and supplies.	
11.2	The team has access to SOPs that are applicable to the activities it carries out.	
11.3	The team updates its SOPs every two years or more often if required.	
20.1	The team follows SOPs to transport samples to and from the laboratory in a safe and confidential manner that is in line with applicable laws and regulations.	!
29.10	The team follows a process to regularly collect indicator data to track its progress.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Laboratory		

Laboratory service providers at all sites and levels are commended for their commitment, enthusiasm, and proactive approach that has resulted in considerable progress in the journey to standardize practices across the province. The accomplishments to date are quite impressive.

The laboratory team is very well organized with clear lines of responsibilities. There are dedicated resources for quality and safety to guide the quality management system. Pathologists and other specialists are readily available to provide consultative services to clinical programs and education to

residents, students, and staff. There is a shortage of medical laboratory technicians (MLTs) that should, in time, improve with all the efforts being taken. At cape breton regional, core lab MLTs are working 12-hour shifts to deal with the current situation. The senior technologists are commended for their willingness to cover the shifts on an occasional basis; these are opportunities to maintain their competency and help their team. Cross-training in core labs has also been effective in reducing some staffing pressures. More consideration could be given to medical laboratory assistant (MLA) full scope of practice, including loading of samples on equipment.

The laboratory orientation program and competency assessment for staff is very comprehensive and well documented. There is a gap in the education and training on how to work respectfully and effectively with clients and families with, for example, diverse cultural backgrounds, religious beliefs, or sexual orientation. It is suggested that this be made part of the organization's orientation program.

Overall the laboratory spaces are adequate, secure, clean, and well maintained. There are space issues in the Valley Regional laboratory that need to be addressed from a safety standpoint. Ergonomics and air quality issues have been improved in many of the laboratories. At the Colchester site, handwashing stations are lacking. Splash shields need to be used when uncapping blood specimens at Colchester and Cape Breton Regional. At the QEII Victoria General site, Histology staff are now wearing powered air purifying respirators to manage formalin fumes.

The laboratories are very well equipped and equipment is well maintained according to all standards. The organization has invested a great deal in robotics at the Victoria General site for much greater efficiency and ability to manage the high volumes of tests. At Cape Breton Regional it was noted that not all maintenance records are complete. Periodic intra- and inter-lab comparison studies on instruments need to be performed. The goal to standardize equipment and contracts across the province will take a great deal of time. In the meantime, some equipment will need to be replaced and contracts are expiring. Purchases may be held up pending decisions to standardize and this is a risk. A plan needs to be developed for this interim state.

Much work needs to be done with the laboratory information system (LIS). Having a single system (or systems that can interface) where results can be easily transmitted across Zones will reduce risk and duplicate testing, among other benefits. In pathology at Victoria General, if a consult is requested from another Zone and the results differ from the original diagnosis, the report does not get back to the ordering physician. Also, staff at the Victoria General laboratory are transcribing reference laboratory results into the laboratory information system. The organization is encouraged to discourage this practice.

A commitment to continuous quality improvement is evident at all sites. A contract with independent health facilities has been established to improve ordering, collection, and transportation of specimens. Turnaround times and wait times are monitored and improvements have been made. The pathologists at Colchester East Hantz are encouraged to work together with the histo-technologists to improve reporting and monitoring of errors at each station. This information can be used to build indicators, provide feedback to teams, and enhance quality. The consolidation of pathology services in the province has

resulted in a reduced turnaround time for reports. The Woodlawn Clinic pilot project for booking phlebotomies is successful and very client focused.

The quality assurance program is solid. Of note is the anatomical pathology quality assurance program adopted by the pathologists. A Pathology Medical Quality Assurance Committee has been established, with policies established and indicators developed, monitored, and reported. The program is based on both Canadian and American quality assurance recommendations for interpretive pathology. The molecular laboratory at Victoria General recently achieved Institute for Quality Management in Healthcare accreditation.

A review of the incident reporting processes for high volume, pre-analytical errors such as hemolysis, clotted specimens, NSQ specimens etc. is suggested. Currently, all issues are reported in the safety information management system (SIMS) and also in the LIS. Much time and effort could be saved by not double reporting. The LIS is the most efficient and effective way to report and track these types of errors and reports can be easily obtained for monitoring and improvement needs. The SIMS system is meant for reporting issues which resulted in or could have resulted in harm to a person or other unusual occurrences.

The work toward standardization and control of documents continues across the province. A great deal of work has been done to get to where it is today. Unabridged documents can be found in almost every laboratory. Job aids are used some sites, where paper copies of only pertinent procedures are available and all other documents are electronic. This minimizes the task of maintaining up-to-date hard copies. Document control is a challenge and takes years to fully implement.

Standards Set: Cancer Care - 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			
9.3	Radiotherapy only: A radiation oncologist and medical physicist are accessible to support the team at all times when services are being delivered.		!
15.1	Each client's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family.		!
15.4	Standardized assessment tools are used during the assessment process.		
15.7	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	15.7.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
	15.7.2	The approach identifies the populations at risk for falls.	**MAJOR**
	15.7.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	15.7.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
24.4	Technologies, systems, and software are interoperable.		
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
25.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.		!
25.5	Guidelines and protocols are regularly reviewed, with input from clients and families.		!

27.9	Data are collected on treatment-related toxicity outcomes.	
27.11	Client-reported outcomes are collected and reviewed as part of the cancer program's quality improvement initiatives.	
27.15	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
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.	!
6.5	Systemic therapy only: An organizational standard format is followed when ordering, labeling, and administering systemic cancer therapy medications.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Delivery of cancer services at NSHA has undergone significant change, along with the rest of the organization, in the past two years. The transition from Cancer Care Nova Scotia to the Nova Scotia Cancer Care program has resulted in many challenges for staff and administrators but, to their credit, there has been no negative impact on the quality of patient care.

New leadership is in place with the appointment of the new medical leader, a dyadic relationship with an administrator, executive directors, and directors across Zones, as well as facilities and professional groups.

A fruitful discussion about the challenges and opportunities was held with the program leadership.

Staff are dedicated, caring, and committed, and patients are loud in their praise of the staff and the care being provided.

Required Organizational Practices (ROPs) are understood across the site and are well implemented. Staff indicate that the ROPs have become a standard way of taking care of patients. This is a tremendous culture shift and ROPs have now become standard operating procedures.

The program leadership team has spent considerable human capital to engage staff, patients, and families across the province. Many meetings have been held. Leaders acknowledged that cancer incidence and outcomes appear to lag compared to the rest of the country, but were unable to identify specific tumour types or subpopulations where the problems were greatest.

The team identified the poor uptake of screening programs by the population, especially colorectal screening. This would seem to be an obvious starting point.

The team identified many areas for possible investment to assist in the delivery of care. These include computerized physician order entry (CPOE) and Aria for Medical Oncology. Despite the widespread use of pre-printed orders for chemotherapy protocols, there is still too much handwriting and transcribing with the resultant risk to patient safety.

At the same time, there are many changes that could be made that do not require additional financial resources but will require changes in the way work is done. The team is encouraged to move to a disease site primary care nursing model, in keeping with the organizational focus on the patient as the centre of care. Although it will be disruptive to work habits and styles, the organization is encouraged to undertake this without delay.

The department of radiation oncology is seeking a new head. It is suggested that appropriate next steps be taken if this is not moving forward. Perhaps a new model of leadership in radiation oncology could be considered.

Greater effort needs to be made to have interdisciplinary and intraprofessional clinics and rounds. Too many clinics are physician centric and patients must make too many visits to get a complete care plan developed.

Priority Process: Competency

There are highly competent and caring staff at all sites.

There is some variation on the conduct of performance appraisals. The organization is encouraged to eliminate these variations.

Priority Process: Episode of Care

Any deficiencies identified by individual sites

Priority Process: Decision Support

Modifications to current practice would yield strong results.

Priority Process: Impact on Outcomes

Individual sites and tumour groups are encouraged to focus on outcomes and adapt accordingly. They are also encouraged to particularly consider patient-reported outcomes.

Priority Process: Medication Management

Medications are generally well managed across all sites, with variations identified.

Standards Set: Case Management - 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		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
6.3	Clients and their families are assisted in accessing essential services 24 hours a day, seven days a week.	!
7.11	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

The continuing care teams have created excellent partnerships in the community to better serve the clients. These collaborative partnerships across all Zones are valued and maintained despite the challenges of the restructuring that is taking place.

The focus and emphasis on the importance of the relationships with the clients and their families is evident. Continuing care staff are engaged and demonstrate how the client is at the centre of the services they deliver. Feedback is solicited either directly from clients and families every day or via committee participation and is considered valuable for service structure review, space issues, or dissatisfaction and follow-up.

Clients and families receive a great deal of information when service begins, demonstrating openness and transparency. The information starts with a welcome package which is informative and helps to inform clients and families about the organization.

Priority Process: Competency

New staff are invited to participate in an elaborate orientation process. This process is described as detailed and lengthy, with presentations providing general information about the organization as well as detailed information about the site, the service/program, and other information necessary for new employees to fulfill their mandate. The most interesting element of the orientation is the mentoring and shadowing aspect. The new employee is assigned a mentor over a number of weeks for modelling of professional interventions, actions, and behaviours. New employees also have opportunities to ask questions and develop their knowledge base. The organization is encouraged to maintain this type of orientation process for all its employees across all Zones to embed an understanding of the objectives of the services being offered.

The program does an excellent job ensuring all of its professional staff offer evidence of membership in professional order and colleges and follows up appropriately when necessary.

The continuing care leadership is highly concerned about the growth and development of its staff and ensures an ongoing openness to allow staff to participate in internal and external training opportunities. This is very much appreciated by the staff. The organization is encouraged to support staff training needs in an ongoing way, as highly trained staff offer exemplary and high-quality service to the clientele.

There are numerous flyers and notifications about preventing workplace violence in continuing care. The staff feel the importance of this concept via the support they receive in their programs to ensure their well-being.

Staff remark positively about the consistent recognition from leadership about their contributions in the workplace. It appears that no positive action from a staff person, whether to clients or colleagues, goes unnoticed. This recognition is an important measure that helps maintain a positive organizational climate.

The organization is encouraged to conduct regular performance reviews for all staff, to contribute to their development and skills. It does not appear that performance reviews are being undertaken systematically across the organization.

Priority Process: Episode of Care

The leadership and staff in continuing care are focused on the Home First approach that emphasizes the important efforts to work with clients, families, and the community at large to maintain people at home for as long as possible. This approach, which is evidence based and person centred, adheres to a philosophy for seniors with significant needs to remain at home. The approach is one whereby clients and families are very engaged in the development of a care plan and services to support a successful return

home over the standard approach of the past which tended to automatically direct these individuals solely to long-term care. The leadership and staff believe in this new approach wholeheartedly and it is reinforced by a significant and meaningful program and services to ensure its success. Continuing care has been working very hard to reduce wait lists across the board. Since 2015 the number of clients waiting for home support, nursing home, and residential care facilities has declined dramatically as a result of the new approach implemented within the service.

There are no barriers to access case coordinators in the hospital and community. Where barriers develop the program makes significant efforts to reduce or eliminate them.

One highlight is the hospital to home (HAL) initiative that facilitates early discharge from hospital. VON coordinates (or provides) grocery shopping, housecleaning, and transportation home to bridge the first few days until other arrangements can be made.

There is also a rapid assessment team in the emergency department to facilitate discharge home. Services can often be put in place very quickly and a hospital admission averted. One of the hospital coordinators also attends daily bed huddles to help solve flow issues.

Access to Intake is available seven days per week but in the evenings messages are left for the next day. While some resources may be available by phone, there are after-hours limited services available.

In continuing care, reducing wait times is an important objective. Teams make tremendous efforts to ensure people wait as little as possible. Community care workers in the central Zone were trained in the "start with heart – respond with heart" model that ensures a respectful and dignified model of service delivery. The organization is encouraged to consider expanding this type of training to more members of its staff.

Clients and families do not appear to be asked to participate in research activities.

Staff are aware that they can consult members of the Ethics Committee for support with an ethical dilemma, but they do not appear to be aware of the existence of the ethics framework that is in place.

Staff are very conscientious about ensuring clients and families are aware of their rights and responsibilities as they engage in service provision. Information of this nature is provided in the welcome kit offered to all new clients. Staff direct any dissatisfied clients to contact the phone service that accepts feedback about client issues and ensures someone follows up on expressed concerns.

The continuing care team is very sensitive to issues related to palliative care and end of life. Assigned staff are focused specifically on this population in the community.

The safety risk assessments are well done and ensure the well-being of clients and staff.

Priority Process: Decision Support

The continuing care teams appear to make good use of technology for service delivery. An example is the use of Skype to hold meetings with long distance partners and colleagues in the Zones instead of travelling. This is a good use of technology to improve efficiency and save time. The organization is encouraged to further develop the use of technology to benefit more efficient service delivery.

The organization does not yet have a one patient/one chart electronic model. A few models exist depending on the type of setting. The organization is encouraged to pursue a one electronic chart model to minimize risk and ensure greater access across the sites. However, Seascape is used in continuing care as the main electronic chart for this service.

Staff are well aware of the PHIA system regarding confidentiality of the chart, access to information for clients, and regulations for chart retention and destruction. Continuing care staff ensure that clients are made aware of the necessary information as well when requests are made.

Priority Process: Impact on Outcomes

Over the past 12 to 24 months, continuing care has taken important steps to reduce wait lists in home assistance and long-term care admissions. These efforts, particularly in light of a large senior population, are quite meaningful. The organization is encouraged to maintain these important efforts to strengthen the Home First program and manage wait times in the best interest of the population served.

Continuing care has worked hard to ensure a consistent review and analysis of potential unmet needs for clients in an effort to improve its services. Many quality improvement initiatives are in place including tracking response times, wait lists, home assistance hours, and chart audits.

In cooperation with the Department of Health and Wellness, additional continuing care priorities are being implemented including developing further continuing care strategies, helping spouses remain together while living in long-term care, expanding benefits to caregivers, and further improving access to long-term care for those seniors who are no longer able to remain at home. The organization is encouraged to embark on these vitally important objectives.

Continuing care is seeking to build a research program as a future improvement initiative. This project will further benefit the population to help create innovative proposals for care in the future.

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			
4.9	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
8.9	The client's informed consent is obtained and documented before providing services.		!
8.10	When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.		!
8.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.		!
9.5	Medication reconciliation is conducted in partnership with clients and families for a target group of clients when medication management is a component of care (or deemed appropriate through clinician assessment), to communicate accurate and complete information about medications.		ROP
	9.5.1	The types of clients who require medication reconciliation are identified and documented.	**MAJOR**
	9.5.2	At the beginning of service, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, health care providers, caregivers, and others, as appropriate.	**MAJOR**
	9.5.3	Medication discrepancies are resolved in partnership with clients and families OR communicated to the client's most responsible prescriber, and the actions taken to resolve medication discrepancies are documented.	**MAJOR**
	9.5.4	When medication discrepancies are resolved, the current medication list is updated and provided to the client or family (or primary care provider, as appropriate) along with clear information about the changes that were made.	**MINOR**

9.5.5	Clients and families are educated about how to share their complete medication list with health care providers within the client's circle of care.	**MAJOR**
9.11	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.	!

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

Leadership teams across the Zones are passionate and dedicated. They have made evidence-based practices and integration their focus. They have embraced change and are commended for the work they have done on model change. Trauma-informed care, harm reduction, and recovery focus are a few of the changes noted. The addition of mindfulness training and dialectical behaviour therapy are also noteworthy.

Leaders from all Zones are meeting together to begin standardizing practices. Projects are being developed to decrease duplication, which is an excellent use of resources. There is still some duplication (e.g., treatment planning templates, information sharing tools) and all leaders are encouraged to be aware of these duplicate efforts.

The co-leadership model for clinical and administrative is working well and it is suggested that this be spread to all areas.

Client- and family-centred care has been embraced by the leaders and having clients and families on quality teams is a great step forward. The organization is encouraged to continue to find ways to involve clients and families in program design and use of resources. Clients expressed interest in working in partnership with the organization.

Integration of mental health and addictions is seen in many areas. Staff are co-locating and training for all staff in concurrent care is evident across the community locations. Client flow is notably improved in the areas that have integrated.

Mental health promotion activities are growing since health and wellness staff have been dedicated to this area.

Priority Process: Competency

Staff are competent, multi-skilled, and open to learning new ways of providing treatment for clients.

There is an excellent orientation process that staff appreciate, as many are coming to a new setting. The buddy system works well.

Staff receive many types of mandatory training, especially around the area of safety. They are provided with education on a formal basis as well as computer-based learning. Clinical educators have been introduced which are a real asset. The educators are encouraged to be creative for adult learners and continue to share education modalities and content. Staff are encouraged to do self-learning and have been supported financially to attend conferences and formal education programs. Training on new models of care has been a focus, which is excellent. Cross-training is occurring for both mental health and addictions staff as they integrate services and continue to strive for a system where “any door is the right door.”

Collaboration within the team and with clients and families is evident in all areas. Many staff feel they have more supportive teams now that the focus on family involvement has increased considerably and client flow among programs (inpatient, community, stakeholders) has improved as more partnerships are developed.

Performance evaluations are completed regularly except in the western Zone. Staff who have used the new format that incorporates feedback from peers and managers say this has validated and improved the process. Regular communication on objectives and support is appreciated by staff.

Priority Process: Episode of Care

A true team approach is used by the passionate staff group in the mental health and addictions community programs, and respect for the clients can be seen throughout the programs. Clients are very pleased with the service and express gratitude that the program is there for them, especially in times of great need.

The CAPA choice model is a client-focused design that is used widely in the child and adolescent programs. Some adult programs (Dartmouth, for example) are using components like Choice for the intake program. This allows for client choice in appointments and clinicians and clients are very invested in the process. Child and adolescent community service used the whole program and saw a demonstrated decrease in the waiting list. It may be advantageous to share this with other adult programs across the Zones.

Client and family input is sought in most areas at the individual care level. Many excellent examples of partnership were demonstrated. It would be useful to share stories of how to partner in one of the communication methods, like the Ted Talks.

There are strong beginnings to the partnership with clients and families as their feedback is sought to design changes in the service. Many of these suggestions have been built into quality improvement projects. There is a need to continue to teach staff about this philosophy and then present some of the excellent examples from around the province, such as the co-facilitation of the Family Matters group in Dartmouth and the discharge form that was created at St. Martha's Hospital.

Clients and families are not provided with information on how to file a complaints report in Cumberland. The organization is encouraged to focus on sharing practices across the province. Cape Breton has not standardized an informed consent process. Many sites have this in place and Cape Breton is encouraged to address this gap quickly.

Access to care has improved with the integration of services and new models of care. The team is commended on the courage it has taken to change the norms. Fishermen's Memorial Hospital withdrawal management is an excellent example.

Clinical outcomes for clients is an area that needs to be strengthened, to ensure the right treatment is offered. The GAIN system is used on admission in some areas; however it does not offer a comparison on discharge. This would be an excellent research focus area for the future.

A comprehensive individualized plan of care is not completed with the client in all areas. Some programs are developing new tools to accomplish this and they are encouraged to implement it in the near future. The tool could be used with the client and a copy given to the client to enhance client-centred care.

Wait list management has improved in Dartmouth but wait lists have increased in Truro. It is important to continue to find ways to allow greater access by looking at resource allocation as well as creative ways of offering pre-service to clients through groups or other modalities. The creation of a centralized intake system has improved access considerably by offering intake appointments and prioritizing the wait list.

The program is commended for the work that has been done to offer standardized groups in the community programs. Clients have had input into design and themes. This is great work and the clients and families appreciate this modality.

An extensive wait list exists for the Colchester East Hants opioid treatment and recovery program. Two hundred clients can be serviced at this location. Clients are often in treatment for over a year, which has caused a bottleneck and has reduced access as demand increases. Currently there are 78 clients on the wait list. The program has developed a proposal for expansion in a neighbouring community which has been accepted.

The medication reconciliation process is not completed in all service areas. The services that are doing medication reconciliation are doing it well and the program is encouraged to implement this process at all sites in the near future.

Priority Process: Decision Support

Programs have standardized information on health records. Much attention is paid to completing information in a timely manner. This has improved communication flow among members of the care team during transitions of care.

Staff appreciate the support and education on information systems.

Charts are a combination of paper and electronic records, which vary greatly in the programs. At times there are up to three areas that hold client information (paper chart, electronic scanned material, and binders for medication records and care plans, etc.). This is an area of potential risk. The provincial project on one record/one person is a great goal but timelines need to be put in place. Consolidation of records may need to be looked at if the timeline is too great for the full electronic record.

While there is a formal process to access records, it could be more client friendly. The organization is encouraged to look at ways to provide clients with copies of information that they have a part in developing, such as treatment plans, consents, contracts, or transition summaries. This would create more transparency and partnership for the client and decrease barriers to attaining information.

Priority Process: Impact on Outcomes

The teams are very aware of safety and risk issues. Many strategies are used to highlight safety with clients and staff, such as hand hygiene, panic buttons, redesign of space, and beginning a group for “affected others” that was designed by families.

Having a dedicated quality staff in each Zone is a definite asset. These staff are passionate and seen as a great improvement in the organization.

Quality councils in each Zone have client and family representatives who have begun to bring a new perspective to the projects. Staff commented on how refreshing the clients and families are to have in the group. Many projects have occurred and are occurring to improve care. For example, the stop smoking project now uses nicotine replacement therapy in an evidence-based way with pharmaceutical expertise. The central Zone received an award of excellence this year for its work on patient-centred emotional wellness supports, which is commendable.

Client surveys and focus group feedback has been used in many areas, such as in the design of a discharge transfer form that clients complete in partnership with staff and are then given a copy, a redesign of waiting rooms, and the development of specific community groups.

The program is encouraged to provide key information to programs based on the improvements on which they are working. Measurement and indicators are being used in most areas; however, more education on simple measurement is suggested.

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.6	Education and training are provided on the organization's ethical decision-making framework.	
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
6.1	Standardized criteria are used to determine whether potential clients require critical care services.	
7.12	Ethics-related issues are proactively identified, managed, and addressed.	!
7.14	Clients and families are provided with information about how to file a complaint or report violations of their rights.	!
8.2	The assessment process is designed with input from clients and families.	
9.2	Other units or facilities are provided with the expected discharge dates for clients who will be repatriated so those units or facilities can plan for a timely transition.	!
9.10	A protocol is followed when conducting a daily interruption in sedation.	
9.21	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
9.21.4	Information shared at care transitions is documented.	**MAJOR**

9.21.5	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**
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		
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
15.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
16.4	Safety improvement strategies are evaluated with input from clients and families.	!
17.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	

17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The critical care program is a provincial NSHA program. Critical care has been working on a more regional model for several years, but there were issues with implementation and change management. With the recent formation of NSHA, the program has begun to look at opportunities for early wins, such as identifying standard order sets and the development and implementation of an organization-wide scorecard. Current metrics are quite high level and tend to be focused on process. Critical care is encouraged to develop more patient outcome indicators.

The Colchester East Hants Health Centre critical care unit was newly built, as part of the new hospital, five years ago. The unit was able to address many of the legacy issues it faced.

The Dartmouth General Hospital critical care unit is about to undergo a number of renovations that are scheduled to be completed by 2019. The renovations will modernize the unit and address a number of clinical and operational issues.

The critical care unit at Victoria General is old. It has recovered from the flood of 2015; however, infrastructure issues remain.

Priority Process: Competency

The Halifax Infirmary and Victoria General critical care units, which make up the QEII critical care component, are best thought of as one unit on two sites. They are fully integrated with regard to clinical policies, procedures, and most operational issues. The physicians work at both sites and there is some sharing of nursing staff.

QEII critical care has developed and implemented a very successful mobility program for critical care patients. There is excellent uptake. Patients are encouraged to be up and about as soon as it is clinically

safe. The program is tied to venous thromboembolism, pressure injury prevention strategy, falls program, and delirium best practices, and a significant decrease in delirium and a reduced number of intubated days has been noted. The Dartmouth General Hospital critical care unit has adopted a modified version of the program and has demonstrated significant success over the two years it has been in place. There are ongoing discussions to bring the program to other NSHA critical care units.

The team uses an urgent admission pause for all patients admitted to the QEII site. This allows all team members to participate in the transfer process and ensures key information is gathered and communicated to team members. This is an excellent communication tool and an important initiative to involve patients and family members. NSHA is encouraged to adopt this program at its other critical care units.

An ethicist at the QEII is available to assist with difficult patient care decisions and family discussions. Staff at the Cape Breton Regional intensive care unit (ICU) feel they need additional information on ethical resources and decision making, as well as additional support in coping with the moral dilemmas that arise in critical care. There is sporadic availability of an ethicist at the more remote sites; however, they are always available by phone.

There are few new graduate nurses applying to the ICU at the QEII and it is difficult to recruit experienced nurses. It was determined new graduate nurses would benefit from a formal onboarding process and so the resource nurse position was established. This position has been invaluable in helping new graduates feel comfortable working in ICU while maintaining safe patient care. The community sites are better able to hire new graduate nurses. Many places have good onboarding and orientation programs for new nurses. New graduates are encouraged and supported to take the critical care course. Many critical care units recognize the need to hire new graduate nurses to meet their staffing requirements and have done a good job of ensuring robust onboarding and orientation programs.

The ongoing education of nurses has been a priority for all the critical care units. The QEII, with the current move to NSHA, has placed a temporary hold on ICU education for nursing staff with a renewed focus of providing additional education to nursing staff in other ICUs across the organization. The annual education and recertification is comprehensive and covers key clinical and occupational health and safety areas. All units track compliance with mandatory education courses; Valley Regional Hospital uses a passport for each nurse which is very helpful to the staff and manager.

St. Martha’s Regional Hospital is very progressive. The day after the new chief of internal medicine started at St. Martha’s, a new echocardiogram treatment modality was implemented. The Ladies' Auxiliary provided the funding for the machine, while the director provided interim staffing support. Patients were immediately able to get their echocardiogram performed and read at St. Martha’s without having to go to Halifax.

Wait times for the cardiac catherization lab in Halifax are a bit frustrating for many of the community critical care units. Outpatients can wait up to two weeks or more, and inpatients can also wait for extended periods of time.

Priority Process: Episode of Care

The clinical programs on the QEII campus are different at each site and patients are admitted to the ICU according to the services they require. The Halifax Infirmary site has 15 beds; however, it is funded for 12. One of the unfunded rooms is used for low fidelity simulation with the scenarios focused on communication and team building. All health care providers are encouraged to participate in the regularly scheduled sessions. The other two unfunded rooms are used for storage.

The Victoria General site has 11 beds; it is funded for 10 and operates an average of nine. It had a significant flood in September 2015 that resulted in the closure of the critical care units and other inpatient units. The critical care unit was initially planned to remain closed after the flood; however, the clinical need was significant and six beds were initially opened. This has gradually grown to nine beds.

There is a process underway to look at the critical care units across the organization to determine their appropriate level (Level 1, 2, 3). Admission criteria will be developed for each level of the critical care unit.

The teams at the Halifax Infirmary and Valley Regional Hospital work hard to determine the expected date of discharge; however, clear and consistent communication of this information is sometimes challenging, especially when patients are to be transferred to another facility. Many of the community sites are not using whiteboards at the bedside. The organization is encouraged to standardize this practice across all critical care units.

NSHA critical care quality improvement is in its early stages. The critical care team is establishing a Quality Council and one of its first projects will be to develop and implement a standard set of orders for all critical care units. At the present time, individual sites have their own order sets, but they are not consistent site to site. The Quality Council will have its first meeting in November 2017. It will have patient representatives as part of its membership. One key area of opportunity is to improve the ability to collect and use data in a consistent and meaningful way. Not being able to do this has limited the team's ability to move forward with some of its clinical activities and performance measures.

Medication reconciliation is done very well. There is integrated participation by pharmacists, pharmacy assistants, nursing staff, and physicians. At the Victoria General critical care unit, there are two separate practices to withdraw medications from the Pyxis system. If the nurse only requires one medication, they do not need to bring the medication administration record (MAR) to the Pyxis system and they do not need to use two identifiers. If the nurse is required to withdraw two or more medications, the MAR is brought to the Pyxis system. The team is encouraged to unify this process to ensure the MAR is used through all steps of the medication management process regardless of the number of medications being withdrawn from the system.

The critical care units in the community are dependent on the emergency department for over capacity.

The inpatient units in many of the sites will use the critical care unit for off-service patients. There are some issues with long stays due to long-term ventilated patients, and also patients who require overnight BiPAP who the medicine program will not take on the inpatient units, though it does accept patients from home with their own BiPAP machines. Funding for home BiPAP can take many weeks to come through which results in long stays in the unit. There are ongoing issues at a number of community sites with long-term ventilation of patients, primarily related to the lack of a home or long-term care ventilator program.

The critical care unit in Sydney is making significant gains regarding transitions of care. It has developed a transition of care form that is supposed to be signed by both the receiving and transferring nurse. At the present time, only the transferring nurse is signing the form.

Critical care research is centred at the Halifax sites. There is a desire to move research to the outlying communities; however, there needs to be a change in the physician model. Limited research is done at the community sites. If there is research being conducted, patients and families are given the opportunity to participate in appropriate studies.

Valley Regional Hospital uses a unique tool for journaling for patients and families. It has been helpful for patients to understand their critical care stay.

The heart health program, and specifically the coronary care unit (CCU) at QEII, remains site specific. Heart health has not been designated a regional program. The CCU at the QEII is a 12-bed unit with 10 beds used for CCU patients (post-cardiac procedures, ventilated, aortic balloon pump patients), one bed for ST-elevation myocardial infarction (STEMI) patients, and one bed for cardioversions and electrophysiology (EP) ablations. Post-cardiovascular surgery patients go to the cardiac surgery intensive care unit.

There is limited sharing of information between CCUs across the NSHA and between the CCU and MSN-ICU especially in the areas of common clinical guidelines. The CCU is currently using a locally developed database, but has plans to move to the APPROACH database within the next several months.

Priority Process: Decision Support

Patients and family members are included in the daily rounds of patients at QEII, Valley Regional Hospital, and Colchester East Hants Health Centre. Family members have the opportunity to hear the discussions of the health care team and provide input. They are included in the decision making of the team and are active participants in the care delivery. The families are seen as valuable members of the health care team. At the community sites, there is limited input by families in the formal care of patients. Family members are encouraged to be active participants.

The critical care leadership at Cape Breton Regional recognizes that the clinical service is in its infancy in obtaining input from clients and families. There are plans to obtain patient and family input and the team is encouraged to continue with this process. Families and patients consistently state the care received is great, and they can outline their involvement in care and planning.

Priority Process: Impact on Outcomes

There is a need to develop a standardized process to select clinical guidelines and these will be developed through the critical care quality council. There is a plan to use patients and family members in the process. This is in its infancy at the present time.

The ability to collect data in real time and then use it for just-in-time clinical care is limited. Data systems need to be more robust. The critical care team will be addressing this issue as part of the initial activities of the Quality Council.

There is limited infrastructure with regard to the interfacility patient transfer network. In many cases, physicians are required to call around to various ICUs to identify an accepting physician and an available bed. Once a bed and accepting physician is identified, transportation of the critically ill patient becomes an issue with limited ground and air transport options.

The critical care team documents patients' do not resuscitate (DNR) status; however, it is inconsistent as to where this is kept in the chart. This makes it difficult to find in a hurry. The team is encouraged to adopt a "green sleeve" or similar type program to help better locate the patient's DNR and advance directive documents

Priority Process: Organ and Tissue Donation

The provincial organ donation program has been transferred to NSHA. The QEII has a robust organ and tissue donation program. Two of the physicians are involved in national programs and there is ongoing research in the area. They are a leading example of quality and compassionate care in this area.

The more community-based programs are following the previous provincial guidelines; however, they generally feel less comfortable managing and organizing organ donation patients. They are very grateful for the assistance of the guidelines and telephone support. Many of the smaller communities have had audits undertaken to ensure there were no missed opportunities. In many cases, the community sites do well identifying potential donor candidates. Ongoing education sessions for staff will be restarted in January 2018.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
3.10	The team evaluates and documents each team member's performance in an objective, interactive, and constructive way.	
4.3	For nuclear medicine, the team designates separate waiting areas to segregate clients who have been injected with radioactive substances from other clients.	!
4.4	The client service area includes a space for screening clients which respects confidentiality issues prior to their diagnostic imaging examination.	!
4.5	The client service area is equipped with a private and secure space for clients to change.	!
6.7	The team annually reviews and updates the Policy and Procedure Manual.	
9.7	The team responds to stat orders within a timely manner.	!
11.12	The team uses diagnostic reference levels to optimize radiation protection of adult and pediatric clients.	
11.13	The team follows appropriate policy and procedures for each diagnostic imaging technique.	
17.6	The team reviews its diagnostic reference levels at least annually as part of its quality improvement program.	
17.8	The team uses results of the utilization management review to educate referring medical professionals and diagnostic imaging providers on the appropriate use of diagnostic imaging services.	
17.9	The team designs and tests quality improvement activities to meet its objectives.	!
17.14	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		

Priority Process: Diagnostic Services: Imaging

The diagnostic imaging (DI) program has transitioned very well from the nine districts to the NSHA. The directors and chiefs are optimistic about their ability to improve access to care, system efficiency, and quality of care. The program is fortunate to have access to medical physicists and researchers whose work can stimulate innovation and opportunity.

Medical and administrative executive leadership are working well together across Zones and are maximizing their contributions by taking on different quality improvement projects and sharing the benefits with each other; projects include standardizing contrast media for CT, standardizing the MRI patient safety checklist, and requisitioning and commencing a peer review program. The DI program leadership has intentionally chosen to investigate and implement some projects that do not require funds.

There is some evidence that projects that are started do not come to fruition. The research on CT diagnostic reference levels has not yet been rolled out to the local imaging departments and the briefing note recommending an audit of local site intracavity probe reprocessing did not get done. The DI executive team may wish to establish accountability agreements.

Intracavitary probe reprocessing is done in medical device reprocessing (MDR) or in DI across the Zones. In Truro, DI-based reprocessing meets the standard, including the best practice of clean storage in a cabinet. Several other DI-based reprocessing operations do not meet the standard as they all have the decontamination and cleaning cycles in the same room. There is also an opportunity for education on health care–associated infections for the DI staff, to engage them in understanding the importance of safe practice. One option to explore is the hybrid solution where during business hours MDR reprocesses and after hours the sonographer travels to MDR and reprocesses the probes there. One site visited does not have an MDR so establishing a safe reprocessing environment somewhere in the hospital could be considered. Best practice and manufacturer's recommendations suggest that probes should be hung vertically to maintain the integrity of the cables; ultrasound probe storage cabinets are commercially available.

The local DI departments are full of knowledgeable, engaged, and collegial staff and radiologists. They appear to enjoy their interaction with patients, families, and each other, noting that they know many of them as neighbours, friends, and family. Clinicians in some of the EDs are pleased with the level of service and access to radiologists. A lack of after-hours access to ultrasound and MRI services in at least one ED is problematic for the physicians.

Accessibility to advanced imaging and interventional radiology is an issue with wait lists in excess of eight months in some locations. The NSHA DI executive is working on identifying and measuring the inputs that influence this situation. Current capacity could be optimized with existing resources while waiting for new MRI and other equipment to add substantive capacity. It will be important to empower Zone directors and chiefs to actively manage their wait lists.

Department managers are feeling the impact of the change to one authority the most. The time it takes to gain approval and onboard a replacement staff member is too long, resulting in negative impacts to service delivery, staff morale, and patient and clinician satisfaction. Many operating process changes and in some cases a perceived loss of autonomy add to a level of stress for the front-line leadership in local DI programs. It may be helpful to consider a distributed model of leadership at the local level. There is variation in application of this concept now across the Zones. Leadership roles such as technical specialists, team leaders, senior technologists, and quality management technologists, etc. support the manager in day-to-day patient flow and problem solving.

Nova Scotia has led the provinces in establishing a single image repository that will soon be augmented by a single provincial cache. These two information management tools support radiologists' ability to provide timely, high-quality consultations. Operational process improvements on the DI team's list include booking and patient notification, scorecard development, off-site reporting, no shows, reminder calls, and harmonization of policies and procedures. The DI team could consider adding a critical results policy and practice to this list.

The DI team is focused on developing its quality management framework by introducing a scorecard. This prospective view will inform future quality improvement projects and capitalize on the rich benchmarking opportunity afforded through collaboration across Zones. The DI team appears well positioned to support NSHA's stated goal to shape one system together.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
4.1	Required training and education are defined for all team members with input from clients and families.	!
4.11	Education and support to work with clients with mental health and addictions are provided to team members.	
6.8	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
12.12	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
7.3	Clients are offloaded from EMS and an initial assessment is conducted and documented by a nurse or other medical professional in a timely way.	
8.3	A triage assessment for each client is completed and documented within CTAS timelines, and in partnership with the client and family.	!
8.4	A triage assessment for each pediatric client is conducted within P-CTAS timelines, and in partnership with the client and family.	!
10.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated. 10.6.1 A documented and coordinated approach to falls prevention is implemented.	ROP **MAJOR**

	10.6.2	The approach identifies the populations at risk for falls.	**MAJOR**
	10.6.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
	10.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	10.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
10.7	Clients are assessed and monitored for risk of suicide.		ROP
	10.7.1	Clients at risk of suicide are identified.	**MAJOR**
	10.7.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
	10.7.3	The immediate safety needs of clients identified as being at risk of suicide are addressed.	**MAJOR**
	10.7.4	Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.	**MAJOR**
	10.7.5	Implementation of the treatment and monitoring strategies is documented in the client record.	**MAJOR**
10.11	Priority access to diagnostic services and laboratory testing and results is available 24 hours a day, 7 days a week.		!
Priority Process: Decision Support			
14.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.		!
Priority Process: Impact on Outcomes			
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.		!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.		!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.		!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.		!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.		!

18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
18.10	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

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

A new provincial leadership structure has been in place for the past two years with both an operational and a medical lead who report directly up to the vice president of integrated health services. Each Zone has appointed leaders in the emergency department (ED) and structures and process are in place to support emergency care, strategic planning, and integration within the Zones. A new strategic plan is in place and strategies to roll out to the Zones are underway. All of the sites are currently undergoing reviews of resources and roles and the leaders are applauded and encouraged on this difficult journey within the Zones.

Patients and their families are involved at the point of care and this was observed to occur in a respectful, caring, and compassionate manner at all sites. There is evidence of client and family involvement as per the quality framework at many sites; however, most of the sites' journeys with client and families has not yet evolved to include resource allocation, service delivery design, or ED hiring and staffing. As the cultural shift evolves with patient and family engagement the sites are encouraged to include patient and family partners in these areas.

Most of the sites visited have passionate communities that support their local hospitals and through their individual foundations have donated funds for construction and redesign, such as a generous donation to the ED at the Cobequid Community Health Centre after the tragic death of a family member. The family felt that privacy could be improved with walls between the stretcher bays and worked with the site on this initiative so other families would not have to endure the same situation. This is a clear demonstration of patient and family involvement in creating a better environment for providing care.

At Valley Regional Hospital the development of a video conferencing consult/assessment with a child psychiatrist at the IWK Health Centre for teenagers with mental health issues presenting in the ED and the involvement in the development of a crisis response team are examples of role design with input from the team, community partners, and patients. Most sites are involved in NSHA's province-wide Home First Committee to support frail seniors in the community to wait for long-term care placement rather than an alternate level of care bed; this is also an example of the involvement of the ED leadership at a provincial level to develop and pilot a program with patients before spreading on a large scale. While a

number of innovative partnerships and initiatives to improve on discharge practices for ED patients have evolved and continue to do so, there are still opportunities to continue to address alternate level of care avoidance through the department.

A new human resources system called Success Factors has been implemented to standardize hiring practices. Many of the managers state that this has created a very lengthy process for hiring and can be challenging as they try to staff their departments effectively. Each ED has a different formula and complement for ED staffing and the regional leaders are encouraged to work with the sites to help standardize roles and staffing ratios where needed. Many of the EDs in the region have a culture of collaborative teamwork and quality engagement with active physician involvement, demonstrating a passion and commitment to providing safe, high-quality emergency care for patients in the communities.

The flow section provides a more detailed review of organizational flow challenges that affect the EDs.

Priority Process: Competency

Within the ED there is a strong commitment to the highest level of education and training and professional development at the site and regional levels. All nursing staff have specialty emergency training and mandatory annual updates occur every fall. All staff have their educational passport and learning path and compliance is very high. ED staff are all certified in advanced cardiovascular life support, trauma nursing core course, pediatric advanced life support, and basic cardiac life support.

The majority of staff interviewed are a bit overwhelmed at times with the number of online modules; however, they know it is part of their role and commitment to stay current when working in the ED. Staff at small rural sites also comply with the ED training and feel that they need to be prepared for everything as the resources at small sites can at times be challenging. Most sites accommodate staff to do their online education either at work or at home. There is a comprehensive orientation and a mindset of developing staff to their fullest potential. The QEII also hosts annual education days for the province and the engagement of all sites is fulsome.

Within NSHA there is a robust simulation training philosophy and most EDs have either comprehensive simulation centres embedded at their sites and departments or have access to the provincial simulation training bus that goes around the province. This commitment to ongoing education and team training is exemplary. Most of the major EDs have fully certified emergency physicians, with specialty-trained rural family practice physicians at some of the smaller rural sites. There are also fully certified EMT staff embedded in many of the EDs around the province to augment care and support the ED teams. Many of their roles are embedded in the code teams. This creative solution to support the ED is something other provinces could adopt. Other areas such as palliative care and educational outreach are robust and many staff are proud to provide this care closer to home in their sites.

Some sites note there are gaps in the access to education around mental health and addictions. This was raised as a concern by many staff as mental health and addictions issues are rising and resources and access is limited in the province. The organization is encouraged to make this an area of focus for ongoing

education and training. The same can be said for violence prevention and training in some of the smaller sites, where staff feel at times unsafe in caring for certain patient populations. As mental health incidents in the rural communities increase so does the need to review violence prevention training and risk analysis due to limited security resources and staff at the sites. Many staff rely on the RCMP and emergency medical services (EMS) for support after hours, and feel unsafe at times in providing care in rural areas.

Priority Process: Episode of Care

The ED staff at most sites are extremely proud of their daily accomplishments in their departments. All staff, physicians, clerks, EMS, allied health team members, social workers, and nursing staff collaborate and work cooperatively to ensure patients receive the best, most timely care possible. Many sites struggle with overcapacity due to admitted inpatients in the department and work in collaboration with the flow leaders to tackle the challenge on a day-to-day, hour-to-hour basis. The majority of patients, regardless of age, are appropriately triaged following Canadian Triage and Acuity Scale standards; however in the smaller sites this process is deficient due to lack of nursing personnel. Offload delays are a common problem at the larger sites such as QEII, Dartmouth General Hospital, and Cape Breton Regional Hospital. Dartmouth General is piloting EMS-led offloading projects to help with flow and allow the ambulances to be quickly redeployed to the field. Once this pilot is evaluated, if successful it is suggested that it be adopted at other sites to mitigate risk to patients who are not assessed and receiving care in the halls.

At the QEII, medicine and psychiatric services are embedded in the ED to facilitate dealing with these patients due to increased demand. As mental health issues and demands for care increase it is suggested that this be piloted at other sites such as Dartmouth General, to decompress the ED at the QEII. Many sites feel that access is limited for the mental health population due to overcapacity at the QEII, and they are forced to discharge some patients back into their communities which puts the patient at risk. At the QEII there is a research project engaging patients and families that asks them for their expectations of the visit to the ED. This research will evaluate why the patients come to the ED and will eventually help with access and flow as a root cause analysis is done and strategies to provide primary care outside of the ED are developed. All of the busy and congested EDs have created some sort of streaming process that has helped with flow in the departments.

At the QEII translation services are available via an iPad app. It is strongly suggested that this new and efficient technology be made available to all sites. The ED physicians' commitment to develop themselves and their teams (learning sessions, simulation and team training, annual education) is evident. The teamwork displayed at all sites is excellent. The research within the ED are known for publishing evidence-based best practice nationally and worldwide and is commended on their commitment to setting the standard for best practice.

Medication reconciliation has a positive uptake and all sites comply with this Required Organizational Practice. Resources vary from site to site with regard to this practice, with the busier sites having pharmacy technicians doing medication reconciliation in the ED. As a whole the EDs also comply with falls

prevention; however, one of the smaller sites was not able to demonstrate knowledge of the NSHA Morse Falls Risk Assessment Tool and was not able to easily locate the tool on the organization's intranet. The organization is encouraged to educate registered nurses on the falls risk assessment process. At the same site there was also no evidence to support the uptake for the registered nurses regarding the organization's suicide prevention policy or screening and assessment tools and processes. Again the organization is encouraged to do formal education and implementation of the standard NSHA suicide screening and assessment tools. Standard communication tools are used and formal handover is done when the patient is admitted to the ward. If the patient is admitted to the OR, ICU, or a high acuity unit, the handover report is done on paper and in person. If the patient's acuity is lower and they are admitted to a general ward, the report is faxed to the unit with a follow-up phone call for questions regarding the patient. All staff observed at the sites complied with using two person identifiers in the ED.

Access is limited at some of the sites for both diagnostic imaging and laboratory during hours of operation. Although point-of-care testing is embedded at most sites, some of the rural sites still lack access to this. Care plans for patients in the EDs are guided by standard order sets and evidence-informed clinical protocols

Priority Process: Decision Support

There is a hybrid patient chart (paper and electronic), with some results online such as laboratory and diagnostics. There are standardized ED documentation forms in the province and many standard admitting order sets available depending on service and site. The new regional ED assessment form has falls prevention as well as suicide assessment embedded within it, and compliance was high in the charts reviewed.

EDIS is up in the majority of Central Zone sites and there is a plan to go region wide with this. It is used robustly within the sites that have access to it and it allows the teams to have a view of the activity and acuity of the department. Interdisciplinary charting practices are used and patients and families can access their charts through the proper process and in a timely fashion on request.

Priority Process: Impact on Outcomes

Within the region there are standardized evidence-based guidelines that support ED care. These are easily accessible online and are used by staff. All of the ED indicators are region wide; however, not all sites are using data and indicators in their departments. The QEII is a research hub for emergency medicine and is a leader in the country in this area. While all sites do not actively participate in research, with the new regional structure there is an appetite to roll out more research to the sites that would like to participate when appropriate. Staff conduct safety huddles daily at many of the sites, and review the metrics to develop actions to address issues. Staff are recognized and they share ideas for new improvements. At Dartmouth General there are staff dedicated to calling and following up with patients who left without being treated, to see if they require support or to mitigate issues or problems.

Most sites have patients and families on their quality committees, although all sites do not have patients and families as part of the development and review of protocols. Some of the patient- and family-centred care standards would be appropriate to be a focus of the overall organization and/or the Zones with capacity to take on a few of these standards and develop an approach for other Zones.

Evidence-informed practice is evident, but without direct input from patients. The region and the sites are encouraged to continue this journey with patients and families and further embed them in this priority work when appropriate.

Priority Process: Organ and Tissue Donation

There are clear and established protocols and policies, education, and training for organ and tissue donation within the region and province. Although the majority of care for organ and tissue donation is in the intensive care units, the EDs understand their role. They feel comfortable with the organ donation program and processes and feel supported when death is imminent and they have identified potential donors.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.12 A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency	
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

Zone palliative care programs were visited at Cape Breton Regional Hospital, QEII Health Sciences Centre (QEII), and Aberdeen Hospital. Palliative care has been established as a provincial network. A palliative coordinator has been recruited to oversee the ongoing development of the program and develop a palliative care strategy. There is also plan to develop the first integrated, the network that would promote the philosophy of palliative and end-of-life care in all settings and services, in collaboration with patients/families, staff, physicians, partners, and stakeholders. A strategic planning session will be held in November 2017.

The integrated approach to service provision is commended. Close links between the inpatient unit, the outpatient clinic, and consultation teams in the community and hospital were observed in the three centres visited. Co-location of most staff facilitates the flow of information and continuity of care for patients. Community-based hospices are in the planning stages. The program and future network members are encouraged to build on the integrated approach, promote a full continuum of care, and define the roles of each component as they collaborate to build a cohesive province-wide service.

At the provincial level, there are three working groups, each with public and family advisors. For example, the Capacity Building Working Group is developing programs for caregivers based on the lived experience of patient advisors. In addition, the group has developed a competency document to build specific knowledge and skills of people who work with palliative patients and families. Over 50 people have been involved as well as 15 course providers and 21 colleges. This work is being spread nationally and has been presented at recent conferences. The group is encouraged to begin implementation, perhaps using a collaborative approach across Canada with willing partners, with evaluation.

Partnerships with provincial and local palliative care societies and hospitals or palliative care foundations have greatly facilitated the quality of palliative care and environments for patients and families. Foundation funding was used to fully renovate units at Cape Breton Regional and Aberdeen. Public education is also supported by the palliative society, including the upcoming “Death Cafés.” First Nations, Caregiver Nova Scotia, auxiliaries, VON, long-term care providers, and emergency health services (EHS) are also key external partners. Valuable internal partnerships have been developed with oncology units and/or clinics, cancer patient navigators, continuing care coordinators, and emergency departments.

A dedicated group of specially trained volunteers is an important component of each team. These volunteers provide individualized services to patients and families according to their wishes. These may include art classes, music, baking, companionship, access to alternative therapies such as massage and reiki, visits, and pet therapy.

Many educational materials for patients and families have been developed (e.g., Preparing for Death and Dying) by individual palliative care services, with family input, and are now being adapted for use throughout NSHA. The development of the resource After the Loss of a Loved One was led by the Nova Scotia Department of Health and Wellness in collaboration with clinicians and stakeholders. Resource libraries on the inpatient units are available for patients and families.

Required resources are identified at the Zone level. An inventory is being conducted of all hospice and palliative care services in the province and will be reviewed according to utilization data and population needs for both operational and capital funding. In some Zones the model of care is being reviewed to ensure resources are allocated appropriately among settings. In some cases, staffing hours have been reallocated and/or business cases developed for new resources based on the model.

All programs have a broad interdisciplinary team. The team at Cape Breton Regional Hospital includes a music therapist who works with patients on CD legacy projects and facilitates “comfort choir” volunteers from the community as appropriate. At Cape Breton and Aberdeen the team would benefit from the addition of psychology and spiritual care services and at Aberdeen, the services of a bereavement coordinator.

The QEII program is in an older building. The bathrooms in the patient rooms and the shower room are not wheelchair accessible. The team has done a good job of making the unit as home-like and functional as possible. The presence of the community coordinators on the unit has contributed to continuity of care and flow of information.

Priority Process: Competency

Team education needs are identified by team members, families, and patients on an formal and informal basis. Feedback mechanisms such as the satisfaction surveys invite feedback on skills, information sharing, dignity and respect for patients and families, and bereavement services.

Adoption of the Pallium LEAP education program facilitates the ongoing use of evidence-based education for staff and physicians. LEAP facilitators are or will be trained at each program (on their own time). Facilitators then provide tailored education to staff and physicians, others in the hospital, and long-term care representatives.

All patients and families interviewed reported a very patient-centred, collaborative, and caring culture in all palliative services. Staff and physicians are regarded as trusted friends and equals in their palliative care journey. Positive comments were also made about the volunteers, activities, and food.

Staff are also very satisfied with their roles and consistently noted teamwork and positive relationships with leaders and physicians as reasons for their commitment to working in the programs.

Bereavement support is provided for team members and volunteers by their leaders and colleagues as well as through an annual retreat.

On the inpatient units, there are several options for patient and family space for private conversations, overnight stays, and spiritual support. Patient rooms are also used for First Nations groups who appreciate the support for their cultural traditions at end of life.

At the QEII, there is a collaboration with Dalhousie University to offer a training program for medical students and residents as well as a two-year subspecialty program for physicians across Atlantic Canada.

Priority Process: Episode of Care

Inpatient units respond to requests for inpatient admission in a timely way; however, there have been significant increases in demand for consultations on other inpatient units and in the community over the last few years. Increased demand associated with diseases other than cancer has also been noted. Teams are encouraged to track these trends across the province and share strategies.

The Cape Breton Regional Hospital team has developed Allow Natural Death protocols (AND) to replace Do Not Resuscitate, with positive responses from patients, families, and staff. Goals of care are addressed by all teams on admission. In partnership with the Department of Health and Wellness, the Palliative Care Association, and retired teachers, there is an initiative to enhance public communication on advance care planning and adopt the “green sleeve” system in the home.

The implementation of the province-wide EHS special patient program is commended. Registration in the program has enabled hundreds of individuals in the community to remain at home and has reduced the

unnecessary use of emergency departments. Paramedics have been trained to provide palliative care and support in the home and access information in the home from other providers such as palliative care consultants and VON.

There is a focus on clinical service quality improvement but less on formal research projects. There is extensive involvement in undergraduate and graduate education in all disciplines.

Bereavement programs at Cape Breton Regional and QEII are well developed and contribute to follow-up care for families as well as evaluation of the quality of services in the program. At Aberdeen, inpatient nursing staff contact families by letter and offer assistance. All programs hold nondenominational memorial services at which families and staff participate.

Priority Process: Decision Support

Due to the integrated nature of the programs, the need to access information from multiple paper charts for each patient poses a special challenge to team members who need easy access to assessments, consultations, and clinic and home care. Many elements of documentation are not standardized across NSHA at this time. Access to information on previous admissions and tests at other hospitals through the SHARE system and information from the drug information system is well used for medication reconciliation.

The development of a standardized home chart has been identified as a need at the provincial level to facilitate communication between providers, patients, and families. In addition, moving to a common palliative care referral form is encouraged to continue, starting with a pilot in the North Zone.

Priority Process: Impact on Outcomes

The provincial Palliative Care Quality Council began in April 2017 with a major stakeholder session. The council's membership includes a patient advisor. Local QI teams also include patient advisors. Aberdeen's patient advisor has been on board for the longest period of time and has been actively involved with a number of initiatives.

Improving the definition and documentation of substitute decision makers has been identified as a priority quality improvement project. It is suggested that front-line staff be supported to identify local improvement opportunities and use standardized processes to address them (e.g., plan-do-study-act, in collaboration with patients and families).

Evidence-based guidelines have been developed at the Zone level and will be reviewed for provincial standardization and spread. These include the Central Zone policy on palliative sedation and expected death at home. At the provincial level, teams are encouraged to continue to work together within Nova Scotia and throughout Canada to develop or adopt key guidelines and protocols while supporting local innovation and culture.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
1.3	The resources needed to support the IPC program are regularly reviewed.	
5.5	Team members and volunteers are required to attend the IPC education program at orientation and on a regular basis based on their IPC roles and responsibilities.	!
6.1	Clients, families, and visitors are provided with information about routine practices and additional precautions as appropriate, and in a format that is easy to understand.	!
9.1	The areas in the physical environment are categorized based on the risk of infection to determine the necessary frequency of cleaning, the level of disinfection, and the number of environmental services team members required.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Since the bridging survey, NSHA has made significant improvement and progress in goal and priority setting for the infection prevention and control (IPAC) program across the four Zones. Providing safe and quality patient care is a priority for this team and it is successfully demonstrating this with its actions. Key strategies for advancing safe care in the prevention of infections have been as a result of transparent and measures taken by the IPAC team with regard to outbreaks.

The IPAC program has a well-defined corporate organizational structure with clear roles and responsibilities, as well as accountabilities for quality and patient safety initiatives. As identified in the quality improvement plan, the IPAC program has been focusing on building teams and enhancing and standardizing the program. Four goals were identified as a priority: having a high functioning and effective IPAC program, reducing rates of health care–associated infection, observing and sustaining hand-hygiene compliance, and using research findings to inform and drive quality improvement. The IPAC team is commended for its collaborative efforts thus far in achieving the first goal. As a high-functioning team, it successfully planned provincially and implemented locally with its very first provincial surveillance reporting. The IPAC program conducted an environmental scan of all the indicators, reviewed evidence best practice, conducted risk assessments, engaged with all stakeholders including a patient representative, and reported its very first provincial standardized quarterly data.

To achieve the remaining goals set by the organization, further exploration is needed with regard to medical leadership and oversight of the IPAC program. Although the site did meet the criteria with regard to having access to a qualified IPAC physician to provide input to the IPAC team, the current designated 0.1 FTE physician for the central Zone only will not support meeting the three remaining long-term goals. The physicians need protected, dedicated time for IPAC support, academic, and research to be more proactive and co-develop the IPAC program. Most sites state that they rely on internal medicine for physician support locally (volunteering their time, or done on the side of their desks) making it difficult at times of outbreak to obtain continuity and long-term support. Some physicians have expressed interest and have experience in infectious disease outside the central Zone. This might enhance physician retention to have incentives for those interested in infectious disease which could effectively support sites locally. A co-leadership model could be explored.

Another factor to consider in goal setting is the IPAC resource allocation. With the increased focus on infection control following the SARS outbreak and increasing rates of antimicrobial resistant organisms, the roles of infection control practitioners have expanded as have the requirements for depth of knowledge, which NSHA is fortunate to have. The IPAC infection control (IC) nurses are very dedicated, independent, qualified, and competent in all Zones. The organization has not performed a review of IC resources to ensure sites are appropriately resourced since the amalgamation. The IC nurses are intuitive and creative, but the activities to be performed in IC are numerous, varied, and complex. IC nurses are embedded in the day-to-day operations of the units. Their visibility and involvement have contributed to great cohesive relationships with front-line staff and interdisciplinary teams. Due to their vast coverage and portfolios, the focus can be more reactive vs proactively preventing infections, thus more focus could be given provincially. With aging infrastructure and its failures and renovation projects growing across the province, this will need to be revised.

Another challenge is that many IC staff are close to retirement age. The organization is encouraged to evaluate its succession planning to maintain the skill set and expertise for IPAC. NSHA IC staff-to-bed ratio is significantly above norm, averaging 1 IC per 200 beds. Staffing recommendations must take into account not only the number of occupied beds within a facility, but also the type of care provided, characteristics of the patient population, the specific needs of the facility, and geographic distances between sites. As per the Association for Professionals in Infection Control and Epidemiology, for an IC program to be effective, there needs to be a ratio 1 IC per 100 to 120 beds regardless of setting. Further review is required to ensure the best possible standards of safety for all those who receive services within the region. Staff recruitment and retention is difficult for environmental services staff, particularly in the remote and rural areas, and so the organization is encouraged to further explore a provincial resource strategy.

Significant efforts have been vested in standardizing all provincial policies, signage, and reporting. The organization is commended for the informative new NSHA intranet IPAC web page. Resources are easy to find. The IPAC policies and procedures are evidence informed, aligned with current regulatory requirements, and comprehensive. Staff know about the IPAC manual, policies, and procedures, but many have not yet reviewed the changes and are still transitioning. Designated infection rates and practices are monitored and reported publicly in compliance with the Patient Safety Act. Staff at all sites

expressed gratitude for and satisfaction with the new infectious diseases signage. The rollout has not been completed at all sites but is ongoing. The organization is encouraged to ensure that all sites have a clear understanding of the changes, policies and have implemented standard universal screening at triage for methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococcus (VRE) across all sites to avoid further outbreaks.

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			
3.6	Education and training are provided on the organization's ethical decision-making framework.		
3.15	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			
8.8	Clients are assessed and monitored for risk of suicide.		ROP
	8.8.1	Clients at risk of suicide are identified.	**MAJOR**
	8.8.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
	8.8.3	The immediate safety needs of clients identified as being at risk of suicide are addressed.	**MAJOR**
	8.8.4	Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.	**MAJOR**
	8.8.5	Implementation of the treatment and monitoring strategies is documented in the client record.	**MAJOR**
9.2	Working in partnership with residents and families, at least two person-specific identifiers are used to confirm that residents receive the service or procedure intended for them.		ROP
	9.2.1	At least two person-specific identifiers are used to confirm that residents receive the service or procedure intended for them, in partnership with residents and families.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			

15.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from residents and families, teams, and partners.	
15.3	There is a standardized process, developed with input from residents and families, to decide among conflicting evidence-informed guidelines.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Long-term care programs at Harbourview Hospital, Camp Hill Veterans Services, Soldiers Memorial Hospital, and Sutherland Harris Memorial Hospital were visited.

Long-term care programs in all sites have a strong foundation for further development of patient- and family-centred care (PFCC). At the individual resident care level, there is evidence from staff, residents, and families of exemplary collaboration and a culture of resident- and family-centred care throughout the resident's journey, including end of life. Family and/or Resident Councils are in place at all sites and have potential for further consultation on policy issues and major projects. Examples of successful collaboration include patient, family, and stakeholder involvement in the design of the Canadian Foundation for Healthcare Improvement (CFHI) e-collaborative Better Together at Harbourview Hospital and the community outing risk assessment at Camp Hill Veterans Services. Patient advisors are being added to Zone quality improvement teams. Teams from all sites are encouraged to share their experiences and innovative ideas with each other to advance PFCC to the next level.

All sites have developed goals and objectives based on their own priorities. Most are centred on quality and safety, including the Required Organizational Practices. Other objectives are related to future planning for services and enhancing communication within teams.

Many partnerships are fostered between sites and external organizations including the Alzheimer Association, community groups, schools, the military, the Legion and many more. These partnerships improve care, patient flow, and quality of life for residents.

Although there are challenges associated with aging buildings such as equipment storage and long hallways, all teams have made special efforts to create attractive, home-like environments using comfortable furnishings, art, and décor. Donors, staff, and family members have contributed to improving physical environments for residents including lounges, gardens, music rooms, and a palliative care room. All sites were observed to be very clean and well maintained.

Priority Process: Competency

A rich assortment of mandatory education and professional development opportunities are provided and appreciated by the staff who were interviewed. A variety of online and in-person options are available.

Highlights include equipment safety, medications, managing responsive behaviours, and end-of-life care.

There is a strong focus on orientation and ongoing education for team members. It is suggested that the sites jointly review and compare current approaches to promote standardization and share best practices.

Infusion pumps are only used at Camp Hill Veterans Services and Sutherland Harris Memorial Hospital. On these sites, education is provided on a regular as well as just-in-time basis, using instruction, demonstration back, and testing. Feeding pumps are used at all sites according to policies and procedures but do not fall under the Required Organizational Practice.

A collaborative approach to care with the residents and families as full partners was observed everywhere and very positive comments were made by all residents and families. Residents feel like respected and informed members of the facility family.

There is no evidence of evaluation of the effectiveness of team functioning at the Zone level and particularly at the Camp Hill and Harbourview sites. It is suggested that a consistent strategy be identified to review team functioning at least annually, perhaps in conjunction with education sessions or surveys. Feedback from residents and families needs to be included.

Awareness of the ethics framework was not observed at all sites. More education and awareness is required at Sutherland Harris Memorial Hospital.

Priority Process: Episode of Care

Continuing care coordinators and, in the case of eligible veterans, Veterans Affairs Canada staff, gather information for intake and refer to facilities for admission. Camp Hill Veterans Services is working with Veterans Affairs to develop a plan to address the expected decline of veteran admissions. One current strategy is to use some beds for alternate level of care/restorative care.

Patients and families report feeling comfortable reporting any complaints, concerns, and commendations. Most were aware of the bill of rights and responsibilities that is provided in a welcome package and posted on every unit.

There are low rates of antipsychotic use throughout long-term care. Camp Hill teams are commended on being part of the CFHI collaborative to reduce their use and have achieved a reduction from 17 percent to 12 percent. Site educators have developed a series of dementia education programs with Level 1 provided to all new staff in the building and available to volunteers and family members.

There is a low rate of admission to acute care and, where admissions are required, there are early returns the long-term care site. This is facilitated by good medical coverage, staff expertise, and availability of IV therapy, either through VON or on-site staff. The effectiveness of transitions to acute care is evaluated through staff calls to the acute units and family feedback. More formal evaluation is suggested, including evaluation of transitions between long-term care facilities, in collaboration with placement staff.

Residents are engaged in a very broad range of activities, according to their assessed preferences and capabilities. There has been a focus on enhancing the dining experience and food quality, as confirmed in interviews with residents. A dedicated group of volunteers at each site assists with feeding, art, music, outings, pets, and many more activities. Chaplaincy services are also highly appreciated on the sites where they are part of the team.

A high level of physician engagement and team collaboration was noted. Some physicians have identified special areas of interest including medication review and admissions to acute care.

The suicide risk assessment tool and processes have been developed but have not yet been rolled out in long-term care sites. Staff are aware of the impending implementation but have not yet been educated. In the meantime attention is paid when depression is identified as an issue.

The use of two identifiers for dispensing medications was observed in all sites except Sutherland Harris. The team at this site is encouraged to consult with other sites, Accreditation Canada, and the Institute for Safe Medication Practices (ISMP) for the development of strategies.

Priority Process: Decision Support

There is risk associated with the heavy reliance on multiple paper charts and some instances of duplicate documentation. At Camp Hill, MDS 2.0 comprehensive assessments are entered electronically and resident assessment protocols are generated; however, the care plan is created manually and outcome measures are not readily available to teams to track quality and progress. The organization is encouraged to explore the implementation of MDS 3.0 as it becomes available with full electronic care planning in all long-term care sites.

The teams and leaders are commended on the many audits undertaken to promote and improve the quality of documentation. Further attention to streamlining and standardization is encouraged.

Priority Process: Impact on Outcomes

All sites participate in student education for many disciplines. Although there is less of a focus on participating in research initiatives beyond current quality improvement projects, there is great potential for addressing research questions in long-term care, perhaps as part of a group or with academic faculties.

Quality boards have been introduced recently and a range of quality indicators and initiatives are displayed. Quality staff and teams are encouraged to show unit and site data to motivate staff to improve even more. The boards could then be used more effectively for quality and safety huddles. Focused education for front-line staff on simple plan-do-study-act techniques is also encouraged.

The organization is commended on conducting the first province-wide resident experience survey in the spring of 2017. Results are being shared with residents, families, and staff. Action plans are being developed by quality improvement teams and sites based on the quantitative and qualitative data. The presence of patient advisors on the quality improvement teams will enhance the planning and decision-making for next steps.

Evidence-based guidelines are not developed or reviewed on a consistent basis at all sites. Long-term care sites are encouraged to work together on guideline development.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
9.4	The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.		ROP
	9.4.2	Stocking the following narcotic products is avoided in client service areas: • Fentanyl: ampoules or vials with total dose greater than 100 mcg per container • HYDROmorphone: ampoules or vials with total dose greater than 2 mg • Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas.	**MAJOR**
	9.4.3	When it is necessary for narcotic (opioid) products to be available in select client service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.	**MAJOR**
12.3	Conditions appropriate to protect medication stability are maintained in medication storage areas.		
12.6	Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas.		!
13.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation, and are segregated from other supplies.		!
16.2	Appropriate ventilation, temperature, and lighting are maintained in the medication preparation areas.		
18.2	Medications are dispensed in unit dose packaging.		!
Surveyor comments on the priority process(es)			
Priority Process: Medication Management			

Pharmacy services are led by a dynamic and energetic leadership team that includes a senior director and physician co-lead. The leadership structure has been modelled to align with the NSHA senior leadership team, with a pharmacy director in each Zone who also has provincial responsibilities. All zonal director positions have been recruited and the team is now focused on building upon the strategic framework developed in 2015 under the previous senior director.

Successes include the establishment of the NSHA antimicrobial stewardship program (ASP) which has built upon the successes of the earlier district health authority antimicrobial stewardship activities. An infectious disease physician and ASP pharmacist are leading the team with medical microbiology, IPAC, decision support, and the ASP pharmacists in the Zones. The initial focus of the NSHA program has been on IV-to-PO step down. This has been well received and rolled out in all of the smaller sites. Education to front-line pharmacists has begun and continues to be offered to the teams.

The NSHA Drugs and Therapeutics Committee has been formed and reports to the NSHA Medical Advisory Committee. Numerous subcommittees support the work of the Drugs and Therapeutics Committee. Some of the early priorities include standardization of the drug formulary and ongoing creation of provincial pre-printed orders.

Throughout the Zones, automated dispensing cabinets (Pyxis/Omnicell) have been implemented at most of the sites. The technology is well received by nursing staff who report reduced turnarounds for medication orders to be processed and available through the cabinets. Significant work has been completed on maximizing the scope of practice with the pharmacy practice assistants and many of these assistants have been deployed onto the units to work alongside the clinical pharmacists. Other novel roles include work in medication reconciliation, clinical trials, computer support, medication safety, and Pyxis support.

Patients participate in quality of care reviews related to medication errors (in some cases consenting to being video-taped) to assist in the quality improvement process. To address an error, bar coding was added on antibiotics to validate that the correct dose was dispensed.

In the central Zone, clinical documentation using key performance indicators has been created to capture pharmacist clinical workload measurement. This allows for review of services by teams and includes admission and discharge medication reconciliation, therapeutic monitoring, warfarin dosing, and discharge counselling which often includes the preparation of medication calendars.

With the exception of sterile products, medications delivered to the Nova Scotia Rehabilitation Centre are sent over from the Halifax Infirmary site. These inpatient units have automated dispensing cabinets. There is a comprehensive self-medication program at the rehabilitation site which consists of three phases; nurse-administered medications; patient-administered monitored and counted daily by the nurse; and patient-administered monitored/counted weekly by the nurse. If needed, dosettes are provided.

The Victoria General provides all the high cost drugs for the Department of Health and Wellness to patients across the province, with the exception of the Dartmouth site which provides Clozaril prescriptions.

The team at the South Shore Regional site has developed computerized medication administration records (cMARs) that were subsequently rolled out to the other Meditech sites. A camera system has recently been installed in the chemotherapy satellite which improves the pharmacy work flow and is used to support the dispensing of the pharmacy practice assistant at Queens General site.

The use of the Omnilink scanning system allows for decentralization of pharmacists onto the clinical units and support between sites.

A number of pharmacists who work in clinics and on the surgical team are certified to administer injections and participate in the influenza campaign for staff and provide injections to splenectomy patients. The safety information management system (SIMS) has recently been introduced and is used to report actual and near miss medication incidents.

Opportunities for improvement include the following:

• There are a number of small sites such as Hants Community Hospital and Northside General Hospital that continue to dispense medication in a traditional system (non-unit dose). They would benefit from the automated dispensing cabinets. As well, some busy areas such as the ED at New Waterford Consolidated Hospital would benefit from these cabinets.

• Lack of space is an issue at a few locations including the QEII Victoria General site which has plans for redevelopment. This site supports the Cancer Centre and it is suggested that it be designed to meet the new National Association of Pharmacy Regulatory Authorities (NAPRA) hazardous sterile compounding standards. Plans have been approved to renovate the Aberdeen Hospital to improve the space.

• Given the significant investment in the sterile compounding areas and the new NAPRA standards, it is suggested that NSHA consider sending a team member to a training course on sterile compounding, such as those offered at CriticalPoint, New Jersey, to obtain hands-on exposure. The team is encouraged to continue to revisit its sterile compounding policies and procedures to align with NAPRA standards.

• NSHA is beginning a needs assessment of infusion devices to support a request for proposals for SMART pump technology. This will provide additional safety features for the administration of high-risk medications.

• The team is encouraged to consider implementing a self-medication program for obstetrical patients.

• In addition, the team is encouraged to consider the implementation of cMARS throughout NSHA to minimize transcription errors.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.7	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
8.13	A comprehensive and individualized care plan is developed and documented in partnership with the client and family.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
15.5	Quality improvement activities are designed and tested to meet objectives.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Comments on Digby General Hospital and Yarmouth Regional Hospital are in the competency section.

Summary comments on the entire medical service are in the episode of care section.

Comments on QEII, Valley Regional Hospital, and South Shore Regional Hospital are in the impact on outcomes section.

Priority Process: Competency

Digby General Hospital

This small facility has established a unique role in relationship to the larger facility in Yarmouth. Some of the medical beds are used for restoration/mobility functions, some for acute medical events, and a larger number for patients designated as alternate level of care. This allows for some longer stay patients to be closer to home and allows Yarmouth to decant some of its patients quickly.

Recognizing this role, a number of initiatives have been established. The collaborative nature of the membership and discussion on the weekly rehabilitation rounds are impressive. All members participated and offered suggestions on how to mobilize and return the patient to the community quicker.

The program also has regular medical rounds attended by the family physician who is covering inpatients for the week.

The roles of the utilization nurse and the clinical nurse educators were reviewed. The organization appears well supported by their skills and unique understanding of the community and the nursing staff.

The organization uses a number of advocacy processes to try to improve venous thromboembolism prevention and uptake of flu shots.

The community recently added two new primary care physicians. Both are involved in supporting the inpatient service and are quickly getting up to speed. There is a need to continue to recruit for new family physicians or nurse practitioners and one of them expressed a desire to add a local flare to the recruitment process. They are also open to exploring using nurse practitioners in primary care.

There is an effective process for laboratory results sign off, use of interdisciplinary progress notes, and inclusion of the patient's photo on the patient profile sheet.

Overall, this service proves that one does not need to be big to be good. They do a very good job supporting the needs of the more rural population.

Yarmouth Regional Hospital

The medical units are housed in a more modern section of the complex. This allows for a very centralized nursing station that has ready access to the patient rooms.

The processes involved with assessment and monitoring were reviewed with a very engaged nursing staff. Their knowledge base is solid and they clearly feel very comfortable playing the role of patient advocate. The medical staff are very engaged and comfortable with advocating, especially if it involves trying to access services and supports from Halifax.

Patients feel well served and appreciate the family environment.

Discussions were held with a large number of allied staff including pharmacy, physiotherapy, and others. The program creatively uses one of the physiotherapists as a falls coordinator. This person documents and monitors, helps educate staff, and reinforces risk mitigating strategies with patients. The team approach is very apparent, especially in focused activities such as utilization rounds, safety huddles, and bed board rounds.

As in other centres, a challenge is difficulty hiring new staff. The process from identifying the vacancy to having the new staff member on site is very long and significantly worse over the last year. This is significantly handicapping staffing patterns and impacts the workload of existing staff. There is concern that with increasing acuity, the organization will be stretched to cope.

Staff are also concerned about the number of new policies and procedures. Although they recognize the value of these new directions, the time allotted to upgrade their skills is very limited. Use of the READ ME binders is helpful.

The physicians are concerned about the significant difficulty in accessing patient records from Halifax. It is extremely difficult to access information via the computer software programs. It seems the regional and central systems do not talk to each other. In simple words, it is not user friendly.

This is a very strong program committed to its local population.

Priority Process: Episode of Care

Fourteen sites across the province were assessed, from tertiary centres in Halifax, community and regional centres, and small rural sites. Some of the latter have a small number of inpatient beds.

Across the province, the compassion and caring of the various staff members is impressive. There is a clear sense that care is patient and family focused and that the needs of the patient come first.

Staff are well trained and generally well supported in care delivery. With few exceptions, the physical plants are well maintained and adapted to the deliver quality care. Despite the size variability, care is significantly standardized and a patient in Halifax and a patient in North Cumberland would have the same general approach taken to their care.

The medical services have embarked on some creative solutions to delivering care. The use of hospitalists has been spreading across the province along with the use of nurse practitioners in general or specialized services. The latter were noted to play creative roles in stroke and chronic kidney disease management. Staff are also used as falls coordinators, palliative care consultation nurses, and other more focused roles.

Allied staff are actively engaged in care and especially the daily rounding process. Pharmacists, dietitians, physiotherapists, occupational therapists, spiritual care, and utilization staff are active members of the care team.

Most sites have access to medical and nursing students and this helps raise the quality of the various programs.

Some facilities, especially the more rural settings, are challenged with increasing acuity and periods of nursing and medical staffing issues. At times, the prolonged process to hire and train new staff makes these situations worse. It was heard almost universally that the time to hire is very long and makes it harder to respond to changing demands for service. The failure to hire quickly is resulting in potential new staff leaving, increasing middle manager angst, and creating challenges with staffing plans.

Some facilities have some specific issues around securing some patient areas, updating care plans, incomplete performance reviews, and the challenges of adapting to multiple new policies and procedures. The latter is a challenge because of the vast number of new policies and limited time for self-education. Consideration needs to be given to providing educational time and alternative pathways other than electronic teaching.

As flu season approaches, the issue of surge capacity becomes more acute. In most settings, it is a direct consequence of too many alternate level of care patients and limited opportunities to place these patients. Solutions take time but significant effort needs to be directed in this area.

A number of creative ideas are spreading across the province. Ideas such as the Ticket to Ride and Choosing Wisely initiatives are noted at a number of sites. Other strong programs are the geriatric rehabilitation programs, the acute care for the elderly program, and the spread of students across the province.

The safety huddle; a focused, nurse-driven activity that quickly assesses risks to patients. A head nurse brings all the nursing staff together and asks a few questions on issues such as fever, diarrhea, and declining patients. Risk mitigation responses can be triggered if needed. This takes 10 minutes and gives each nurse the ability to define risk to their patients. This is a great idea that is well implemented.

Overall, this is a great provincial program that is committed to and focused on the patients. Challenges exist in the areas of hiring, policy overload, information distribution, and the fear that too much is happening too quickly. The leadership, the front-line team, and the team are doing a good job and they are encouraged in their efforts to move this program forward.

Priority Process: Decision Support

See information in the other sections.

Priority Process: Impact on Outcomes

QEII Halifax Infirmary

This is an excellent medical program centred in two wards, one supported by a team of hospitalists and the second, which is the medical teaching unit, supported by a team of residents and staff internists.

The focus on providing strong, patient-focused care is obvious, as reflected in a number of activities such as the goal of care document, transfer of care policies, and use of the Choosing Wisely checklists, and the interdisciplinary referral form.

The daily safety huddle with nursing staff and the daily bullet rounds with the entire staff are excellent examples of effective information sharing. The process is most impressive and fully engages staff in a manner that shows they are all equal partners in the care of the patient.

The time management process is positive. The allocation of time for the registered nurse to update the care plan and screen the chart daily to ensure all orders have been captured is an example of effective time management.

The hospitalist program has developed a number of documents that guide the team in creating effective discharge notes, a very detailed history, and physical and patient-specific handover notes for weekends or vacations.

The transition of care process is supported by the use of the patient PASS form that creates a brief summary that helps the patient and family at the time of discharge

Valley Hospital, Kentville

This is a very strong program centred around two medical units in an active community hospital. The nursing leadership has used a variety of staff members to build some very creative programs.

Interaction during stroke rounds was observed to include internists, nurse practitioners, physiotherapy, occupational therapy, nursing, and community supports. Collectively they deliver an excellent specialized program that supports the immediate response to a stroke and the ongoing support needed to recover from a stroke. The incorporation of a nurse practitioner as a collaborative member of the consultation team is very creative. Not only was the nurse practitioner's role used on the inpatient ward but it is also an integral part of the community assessment for transient ischemic attacks.

The nursing leadership actively supports the team and also monitors its effectiveness, especially in improving door-to-CT and door-to-needle times. This team is about to start bedside rounding to further engage the patient and family.

The inpatient units are supported by family physicians, hospitalists, and internists and a blended model of nursing skills. There are a number of supports including the spiritual service and ready access to community resources.

A challenge is the difficulty hiring new staff. The process from identifying the vacancy to having the new staff member on site is very long and significantly worse over the last year. This is significantly handicapping the staffing patterns and impacting the workload of existing staff. At times, some of the specialty areas such as the intermediate care unit have been stressed by lack of skilled staff. The delay has resulted in new staff going elsewhere because of the long wait. Local staff hope this issue will receive a higher priority at the NSHA head office. On a positive note, they feel that head office is very supportive of the policy and process development and that local ideas or suggestions are received positively.

There were many examples of patient and family engagement on clinical issues but also in response to some process issues such as the management of head injury patients.

The addition of the patient voice is becoming standardized on most quality processes.

The organization has been focusing more attention on the delivery of palliative services and the care of patients living with dimentia. The organization has already taken some creative steps to support these patients, especially to mitigate the risk of wandering.

South Shore Regional Hospital, Bridgewater

This is another strong program based at a smaller regional site. The focus on safety and patient care is illustrated through the daily safety huddle. The team leader and all the nursing staff on one of the units meet and quickly review the patients around issues of fever, diarrhea, deteriorating status, and any worries. It involved eight questions over ten minutes and gave great insight into the existing or potential risks to the patients, and allowed time to trigger mitigating responses.

Another strength is the program's involvement with the acute care for the elderly (ACE) program. This program was jointly developed with a teaching hospital in Toronto and focuses on a number of issues including mobility and catheter issues, patient satisfaction studies, and use of support staff.

The program has developed a strong working relationship with a number of disciplines: the on-site pharmacy, hospitalists, palliative care consultation nurses, physiotherapy assistants.

As noted at many sites, some of the challenges include the difficulty in hiring new staff. The process from identifying the vacancy to having the new staff member on site is very long and significantly worse over the last year. This is significantly handicapping the staffing patterns and impacts the workload of existing staff.

Staff are also concerned by the volume of new policies and procedures. Although they recognize the value of the new directions, time allotted to upgrade their skills is very limited.

Patient and family responses are very positive.

Overall, this is a great service.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.1	Resource requirements and gaps are identified and communicated to the organization's leaders.		
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.		
Priority Process: Competency			
3.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
3.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.		!
Priority Process: Episode of Care			
7.10	The client's informed consent is obtained and documented before providing services.		!
7.11	When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.		!
7.15	Clients and families are provided with information about how to file a complaint or report violations of their rights.		!
8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.6.2	The BPMH is used to generate admission medication orders OR the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.	**MAJOR**
8.7	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	8.7.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	8.7.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**

10.9	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		
11.8	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		

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

With the introduction of NSHA in 2015, mental health and addictions services have evolved into a provincial model and program structure. Clear processes are used extensively to ensure a needs-based and population health planning approach is incorporated. The program is commended on the use of key stakeholder consultation and evidence-based reviews, including provincial and national strategies to incorporate the five-tier framework for mental health and addictions system planning and service delivery. The delivery of addiction and mental health services includes several programs and services throughout NSHA, including inpatient, urgent care and crisis, specialty services, recovery and integration, community services, education, and training.

The program is committed to the integration of mental health and addiction services. Local leadership demonstrates passion and commitment to person- and family-centred, strength-based, recovery-oriented care. The program and services work closely with many partners to inform service delivery, such as the strong collaboration evident between NSHA and the IWK Health Centre for children, youth, and women, as well as the department of psychiatry, Dalhousie, and others.

Client- and family-centred care engagement and approaches are used extensively throughout the mental health and addiction program. For example, several processes are in place with the Quality Improvement and Safety Committees at the program, Zone, and service levels with client and family membership in operation. Other activities include the use of client experience surveys, family meetings, family education and support groups, and focus groups with service design (e.g., Simpson landing).

There is good evidence of programs offering a recovery goal-oriented approach with planning, education, and service delivery. There are significant opportunities to address provincial processes with access and centralized intake, specialized services and primary care linkages, in addition to standardization of processes and mechanisms to ensure evidence-based practice approaches are incorporated. A resource allocation review is suggested, to ensure safe and high-quality services. Opportunities for service resource adjustments are evident to ensure potential risks and gaps are identified in the provision of safe and high-quality care (e.g., forensic services with current gaps in resource requirements, residential services for withdrawal management, and recreational therapy programming on the inpatient units).

Information about the program on the website could be enhanced to provide more clarity to the public on the mental health and addiction program services and supports.

Priority Process: Competency

Team passion and commitment to client- and family-oriented care are evident throughout all service areas. An excellent example reflecting client engagement and role input is the recent establishment and hiring of a peer supporter-peer support coordinator for Valley Regional Hospital.

Staff are supported with professional development opportunities and the use of evidence-based practices through the provincial education and training portfolio. Priorities have been established and several training sessions for a train-the-trainer approach have been initiated, such as cognitive behavioural therapy, cultural safety in working with First Nations, trauma-informed care, and others.

Extensive education is offered to the teams to develop competency and consistent approaches and practices, including suicide risk assessment, medication reconciliation, and other mandatory requirements. All teams express the need for improved access to professional development opportunities at a discipline and program-specific level. Significant opportunity for improvement also exists for the service areas to address competency and skill development for the enhanced assessment and integration of addiction and mental health services.

Completion of performance evaluations across the services varies. The program is encouraged to develop processes and mechanisms to ensure regular performance reviews are completed and documented for all staff.

Priority Process: Episode of Care

Service teams are focused on improving access to services across the program. For example, on the acute care inpatient units, efforts are being made to strengthen partnerships with NSHA community supports in addition to creating positions and new roles focused on housing and financial supports. There is also access to an addictions liaison worker and an early identification group has been started that meets regularly to review clients and facilitate transition to the recovery and integration programs. The withdrawal management support offered by the western Zone Addictions Wellness Community Clinic to the inpatient units, emergency, and other acute and community services is noteworthy.

Client and family feedback specific to the teams and the services offered is very positive. Identified opportunities for improvement are the need to address clients having to repeat admission data to multiple providers, and requests to streamline processes. Suggestions include enhancing communication among team members and using an electronic heath record.

There is minimal evidence of clients' informed consent being documented before providing service. The

There is minimal evidence of clients' informed consent being documented before providing service. The organization is encouraged to re-establish the expectation for obtaining the client's informed consent before providing treatment, and establishing a process to ensure compliance.

Excellent use of standardized assessment tools is incorporated in the health record, such as suicide risk assessment, falls prevention, best possible medication history, and medication reconciliation. Implementation of the tools and comprehensive documentation is inconsistent in several service areas. The Quality Councils and teams are commended on their chart auditing processes and developing action plans to address non-compliance with the new policy specific to the Required Organizational Practices and high priority standards.

The effectiveness of transition planning is not evaluated and the transition of clients between services is not completed in a formalized or consistent manner. The program is encouraged to introduce processes to ensure effective communication and evaluation, with client and family input.

Some service areas are working as a standalone service, such as the Pictou inpatient withdrawal management service, which causes some isolation for the program. It is suggested that this unit be integrated with an acute care setting in the future.

The provincial model for withdrawal services limits access to those who are in active withdrawal only. There are no provincial services for residential programs, which is seen as a gap in the continuum of service and limits access.

Opportunity for improvement for the program and services overall is to introduce mechanisms to evaluate the effectiveness of transition planning and coordination between services, with client and family involvement.

Priority Process: Decision Support

Technology and information gaps have been identified in all services across the program. Teams express frustration in not being able to access data in a timely or organized manner to address trends or provide analysis for service adjustments. Significant gaps are noted specific to client information, trends, and outcomes. Some service areas continue to collect information manually, and the opportunity to capture more extensive client service information for service planning and design is encouraged.

The program has been working extensively on policy development and revisions on a provincial basis, and teams are striving to meet all of the new requirements.

Priority Process: Impact on Outcomes

Service areas receive excellent support from the quality and evaluation department and the staff to address potential safety risks to improve the quality of care. The team has provided education, tools, and active involvement to establish interdisciplinary quality improvement and safety committees and councils, address enhanced client- and family-centred approaches, and action plan to address gaps and key priorities such as performance and accountability.

Client experience surveys, mock surveys, and chart auditing help the service areas identify key priorities, quality initiatives, and quality initiative action plans. Noteworthy examples are the projects on best possible medication record (BPMR) and suicide assessment and management. Pictou County looked at how to improve compliance and is already seeing a percentage decrease in events.

Variability exists across service areas with data collection, identification, monitoring, and reporting on performance indicators. An enhanced focus on evaluation and client outcome performance measurement is strongly encouraged.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.1	Required training and education are defined for all team members with input from clients and families.		!
3.6	Education and training are provided on the organization's ethical decision-making framework.		
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.		
4.4	Standardized communication tools are used to share information about a client's care within and between teams.		!
Priority Process: Episode of Care			
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.5.1	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.	**MAJOR**
	8.5.2	The BPMH is used to generate admission medication orders OR the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.	**MAJOR**
	8.5.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	8.6.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**

8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
8.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
9.16	Information relevant to the care of the client is communicated effectively during care transitions.	ROP
9.16.1	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**
9.16.4	Information shared at care transitions is documented.	**MAJOR**
9.16.5	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**
11.9	Established policies on handling, storing, labelling, and disposing of medications and breast milk safely and securely are followed.	!
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		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
17.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
18.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Over the last 12 months there have been significant changes in the leadership of the maternal and child health services. A new senior director was recruited along with several new managers. To improve communication and the decision-making process, the new structure has eliminated the director positions and the managers report directly to the senior director. This has been favourably received.

Success Factors is a new human resource system designed to facilitate recruitment of staff. Managers state it is very cumbersome and has created long delays in recruiting important vacancies.

The senior director and managers are all very pleased with the partnership with the IWK Health Centre. There is early discussion with NSHA obstetrical program about developing a Memorandum of Understanding with IWK obstetrical service to adapt appropriate policies and procedures. This would prevent duplication of work and improve standardization across the entire province.

Client and family input is an important focus for this program and it is using more traditional methods to obtain feedback. The program is encouraged to focus on implementing a more significant role for clients and families in this program.

Priority Process: Competency

New staff all commented on the effective and supportive orientation process. And, while they do receive regular feedback, many commented that they have not had consistent annual performance reviews.

One recently retired surgeon provides support for his replacement by assisting on gynecological cases. With few family physicians providing obstetrical care it will be important to monitor the need for obstetricians.

Encouraging the medical school and family medicine residency programs to train future primary care physicians outside of Halifax might provide encouragement and confidence for these future family physicians to work in the obstetrical and hospital settings.

To improve team dynamics and standardization of care the organization may wish to facilitate the implementation of the MORE-OB program at all sites.

Priority Process: Episode of Care

The introduction of the translation line provides welcome assistance at almost all of the obstetrical sites.

Providing culturally specific education to all sites would allow staff to proactively offer cultural care rather than patients having to ask specifically for it.

Most of the obstetrical sites frequently have off-service medical patients who are looked after by nurses with obstetrical skills and less familiarity with certain adult medications/doses and medical procedures. This puts the organization at risk and staff are concerned that these patients do not receive the same level of care as on an appropriate medical ward. The Valley Regional site has developed a list of criteria that a patient must not have if they are being transferred to their unit. This has decreased the anxiety and created better partnership with the medical/surgical services.

The bed pressures have resulted in elective gynecological cases being cancelled, which is frustrating for patients and their families.

The yearly morbidity and mortality rounds are opportunities for the entire staff to review issues at their sites in a non-threatening environment. As of March 2017 a new standard operating practice for emergency caesarean sections was developed; not all the team physicians or anesthesiologists are aware of it.

A trigger list of 13 key performance indicators (KPIs) has been reviewed, with excellent input from staff. They feel this is a much more manageable number and it provides a clear focus for the program. Although staff are recording more near misses or incidents, several staff are still concerned that this might be used for punitive purposes. Managers will need to reinforce the importance of KPIs.

All sites have agreed to adopt the Fresh Eyes protocol of mandatory review of fetal monitoring tracing every 60 minutes. All staff were aware of this requirement and it is slowly being implemented across the NSHA.

The sites all have learners and feedback from those on the wards was extremely favourable.

Valley Regional Hospital has surgical, pediatric, and maternal/child patients all enter the ward through a common entrance/door. Although a ward clerk is at the desk during daytime hours, the organization is strongly encouraged to look at a security system to ensure the safety and security of newborn babies. The labour and delivery area would also would benefit from an after-hours lock down system to ensure the safety of patients and staff.

Valley Regional Hospital does not have a neonatal respirator. Staff and the respiratory technicians must hand bag the neonates until the provincial transport team arrives. Several staff commented that a transport team can take several hours depending on weather and availability.

Priority Process: Decision Support

Several new standardized forms have been introduced by NSHA, including the breast feeding assessment and discharge form. Staff find it busy and very labour intensive. The form is not being completed appropriately and the Quality Council is encouraged to review and alter it as appropriate.

A variety of forms and documents at individual sites could be shared and standardized across NSHA. The Valley Regional site has developed clear criteria and a process for accepting of- service patients to the ward. This has been received favourably by the staff and potentially could be implemented at all sites.

Priority Process: Impact on Outcomes

The new senior director and the managers are congratulated on the work they have done in a short 12 months.

Standardization of various policies and procedures will take time. However, over the last few months the leadership team in Halifax has rolled out several e-learning and policies in preparation for accreditation. This program will require refreshers on the new policies as the rollout did not allow focused education and adoption.

All sites are at different stages of implementing the Baby Friendly designation. There appears to be support from the staff to work toward this designation and they are encouraged to continue.

Working with clients and families in all aspects of planning and evaluating the obstetrical service is still in the early stages. This will require a significant culture change but with the current leadership of this service it seems very likely to occur.

Standards Set: Organ and Tissue Transplant Standards - 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.	
Priority Process: Organ and Tissue Transplant	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Multi-Organ Transplant Program (MOTP) covers all of Atlantic Canada with a catchment area of 2.5 million. Most of the transplants are kidney and liver. As the program is based in Nova Scotia, there are service-level agreements with each of the Atlantic provinces, as well as with the Department of Health and Wellness, which present challenges for the program. The leadership team works with each provincial team to address issues. The team has recently begun to perform transplants from donation after cardiac death but due to the protocols for these donors, recipients outside of the province are not considered.

Repatriation to home provinces is a slow process and patients often wait for longer periods than a Nova Scotia patient would. Some of the reasons cited are the lack of confidence in physicians in the other provinces to manage medications and potential complications. Nova Scotia used to provide all of the follow-up for patients coming from Prince Edward Island. As of March 2017, PEI has trained staff and now looks after their own patient follow-up. A recent transplant patient hoped she could return to PEI within 10 days of her transplant. Patients waiting to go back to Newfoundland wait the longest. It is difficult to

discharge them into the Nova Scotia community as they are not entitled to home care in the province and subsequently have to wait in the hospital. Funding does not cover all ancillary costs.

Allocation is done regionally with the use of a computer program. The province is looking at national allocation with Canadian Blood Services.

The formation of NSHA has slowed decision making as the team has a matrix and operational reporting structure.

Priority Process: Competency

A large interdisciplinary team provides support for this program. Staff are passionate about their work and have many years of experience.

The team has presented a business case for a nurse practitioner for the unit. A response to the request has not been received.

Priority Process: Episode of Care

Nova Scotia patients have been cared for the in the pre-transplant clinic and are well known to the team. Patients coming from elsewhere have their complete file sent. Kidney transplant patients come directly to the unit's intermediate care unit from the OR, while those who have had a liver transplant go to the ICU first. Private rooms on the inpatient unit are not always available post-operatively.

Patients and family in the post-transplant clinic spoke positively about the care and long-term relationship they have with the clinic staff.

The unit Practice Council is active and implementing quality improvement initiatives. Modified early warning scoring (MEWS) is being implemented site wide while care maps and PPO have been developed for the unit. Patients on the Quality Council subcommittee have had input into the revised patient education material.

Priority Process: Decision Support

Client records are up to date and complete. Standardized tools are used. Information is readily shared between the individual provinces and Nova Scotia. A satellite office spoke of the good communication from Nova Scotia and how readily they get up-to-date information. New standard operating procedures are sent in a timely manner.

The MOTP website is a useful resource. They are able to dial in to the weekly transplant rounds.

Priority Process: Impact on Outcomes

The team has a strong focus on quality improvement. There is a program Quality Council and patients have been on the council for 18 months. They now sit on a subcommittee of the council as they determined they would be able to contribute and be more valuable at that level. They review guidelines and policies as well as provide input in other areas.

The team is working on initiatives that came out of the Practice Council. Labelling of specimens and identification of vancomycin-resistant enterococci and methicillin-resistant Staphylococcus aureus patients are two areas where improvements have been made. A scorecard has been developed and posted. Hand hygiene is one of the indicators been worked on. A poster identifying areas of risk, called Risky Business, is posted publicly. There are many educational forums including an annual Transplant Atlantic conference and public forum.

Research is an integral part of the program. Activities include the development of an app to manage neutropenia, a retrospective study to understand why kidney transplant may fail, and a study with the University of Saskatchewan to look at how education can support patient adherence.

Priority Process: Organ and Tissue Transplant

A comprehensive assessment is completed on all transplant patients. Transplant patients spoke of the support, education, and information they received throughout the assessment process; this continued post-operatively.

Patients feel they have lots to offer new transplant patients and hope the organization will provide opportunities to connect people.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.3	Service-specific goals and objectives are developed, with input from clients and families.		
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			
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
11.6	FOR INPATIENTS ONLY: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	11.6.2	The BPMH is used to generate admission medication orders OR the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.	**MAJOR**
11.11	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	11.11.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
12.11	Information relevant to the care of the client is communicated effectively during care transitions.		ROP

12.11.5	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**
13.1	Availability of all necessary supplies and functionality of equipment is confirmed before the client enters the operating/procedure room.	!
14.4	Procedure-specific care maps or guidelines are used to guide the client through preparation for and recovery from the procedure.	
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.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
Priority Process: Medication Management		
16.3	Medications and related supplies stored on anesthesia carts are standardized.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a co-leadership model for the program. The organizational structure has been developed and recruitment for leadership positions is underway. Goals have been identified that align with the organizational goals.

The move to NSHA has improved the ability to share and connect to all the surgical programs. The focus has been on planning and integration with standardization and consolidation of services as next steps. The leadership team spoke of the strong co-leadership model and interdisciplinary collaboration that has offered more opportunities and of the cultural change that has helped influence positive change.

While legacy policies are still in place, the leadership is encouraged to develop and implement key policies that impact safety. For example, there is significant variation in the dress code in the different OR sites, in particular the wearing of rings and jewellery. Not all preferred provider organizations have included the need for venous thromboembolism assessment. The organization is encouraged to move forward on the development and implementation of the high-priority surgical policies.

Preventive maintenance for the program could be more robust as there is no formal plan to replace aging out-of-date equipment.

Performance measure data are being collected and the program is planning on implementing a scorecard. A formal wait time management strategy would be a benefit to the program and organization as there are procedures that have long wait lists. While additional funds have been received to address the long wait list for orthopedic surgery, the challenge will be to find additional OR time and physician and staff resources. This increase has the potential to impact the inpatient surgical units that have surgical cancellations due to beds not being available. The organization is looking at the possibility of introducing RN First Assist to address lack of physician assistants.

Priority Process: Competency

Managers have identified that challenges in the implementation of the new hiring program have led to delays in recruitment and onboarding at many of the sites.

Educators are involved in the policy review process, which takes them away from the bedside. Meeting together as a provincial group is considered as an opportunity for integration at NSHA. Staff spoke highly of the support they receive from their manager and the opportunities for ongoing education and professional development.

Priority Process: Episode of Care

Pre-op assessment, the post-anesthesia care unit, OR booking, the ORs, the inpatient units, the heart cath laboratory, and endoscopy were assessed during the on-site survey.

All ORs have a focus on safety and quality. Documentation is complete and the surgical safety checklist is performed in all ORs with varying degrees of thoroughness and completeness. Handoffs among the different areas are completed with a transfer of accountability. The liaison nurse position in Halifax provides families with an up-to-date status on their family member. The leadership is encouraged to evaluate the process and help those sites where there are opportunities to improve.

Thoracic surgery wait lists are monitored closely as they serve the entire province as well as Prince Edward Island. Three additional beds were recently added to improve access. A new ambulatory clinic is planned where a Tenckhoff catheter will be inserted rather than using an inpatient bed. The initiative begins at the end of October and there are plans to evaluate the clinic.

Patients spoke of the excellent care they receive. They feel well informed and one family member described the care as though it was “one of their own.”

The OR at Dartmouth General is being rebuilt. There are two doors to the OR that do not have restricted access and the public can easily wander into the area. This would be a concern when there is minimal staff in the OR when on-call. The manager is encouraged to look at what secure systems could be in place to ensure that only hospital staff enter either door. On-call at Dartmouth OR is staffed with two nurses. As there are no resources the nurses are required to come in and pick the sets and attend to other clerical responsibilities. The manager is encouraged to gather data to prepare a business care to determine if more staff are required. Other ORs have commented on the type of surgeries that occur after hours. The program is encouraged to work with all the ORs to ensure that the appropriate type of procedures are performed after hours. Several unit managers and team members identified the need for a booking clerk as critical to better assess and coordination.

At the Halifax Infirmary a regional block program has been introduced and this has resulted in more efficient OR time. They use an OR safety checklist and conduct a follow-up phone call to the patient the next day to support pain management.

Flash sterilization occurs at the Halifax Infirmary site. While its use is being trended and it has been reduced, the organization needs to take steps to purchase the equipment so it does not occur.

The endoscopy program in Halifax introduced an endoscopy safety checklist in August 2017. The checklist will be rolled out to the rest of the province’s units. Documentation is standardized across the central Zone. A reprocessing audit has been completed. Physicians from other regions will travel to help address the volume. All sites now use the global rating scale. Colon screening has added a significant number of people to the wait list, resulting in completion of 85 percent of the volume of 2016. Additional resources have not been added to address wait times. Approval has been received for a wait list coordinator to help implement the CAC guidelines for booking.

In April the cath lab day unit moved to same day admission, based on patient feedback. The patient prep checklist is being revised, also based on feedback from patients. The unit could also work with patients to develop a communication package to better inform patients about expectation of the time of their procedure.

Air exchanges in the OR in Cape Breton are at 1995 standards. Temperature and humidity are also monitored and joint surgeries have been cancelled when the humidity is too high in the theatres.

The MDRD at Aberdeen has been closed due to mould and moisture. OR equipment (surgical set ups etc.) are now sent to Truro for cleaning and processing. Since August a significant number of trays have been returned with particulate matter and cement particles. This delayed OR starts.

OR booking for the Zone is electronic. The expectation that all physical offices use the Novara booking system that links to the organization.

There is a strong focus on research through the department of surgery, including partnering with the university.

Priority Process: Decision Support

There is a complete record for all patients, with comprehensive assessments.

Priority Process: Impact on Outcomes

The NSHA Peri Operative Quality Improvement and Safety Concil meet on a regular basis and is recruiting for patient advisors. Each site has a similar committee with the goal of having patient advisors.

The program is committed to including patients and families and is actively recruiting for patient advisors at the unit level. They are many opportunities to include patients in a more formal way. The programs receive feedback from patients through surveys and other informal mechanisms.

Data are being collected and used by the individual units. Quality improvement projects have been developed based on improvement opportunities. The program has received approval for the National Surgical Quality Improvement Program and is in the planning stages.

Failures modes and effects analyses to review wrong-side surgery and retention of foreign objects have been completed. Patient advisors were on the team. The cardiac program includes patients on a working group looking at disclosure of risks. Design teams in endoscopy also include patient advisors.

Priority Process: Medication Management

Medication management is well done. No issues were noted.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
2.1	The organization has the appropriate mix and number of staff to carry out POCT. CSA Reference: Z22870:07, 5.1.1.	
3.1	The organization orients and trains all health care professionals delivering POCT on the standard operating procedures (SOPs) for POCT.	
3.2	Health care professionals delivering POCT receive ongoing training and development. CSA Reference: Z22870:07, 5.15.	
3.3	The organization evaluates the performance of health care professionals delivering POCT annually. CSA Reference: Z22870:07, 5.1.5.	
3.4	As part of their performance evaluation, health care professionals delivering POCT must routinely demonstrate their competence. CSA Reference: Z22870:07, 5.1.5.	
4.5	The lab director or suitably qualified health care professional verifies that health care professionals performing POCT are trained prior to implementing a new or revised SOP.	
4.6	The lab director or suitably qualified health care professional annually reviews and evaluates the effectiveness of the SOPs and adjusts the SOPs, training activities, or monitoring processes as necessary.	
4.8	The organization has a policy on POCT client self-testing.	
6.1	The organization maintains an accurate and up-to-date inventory for all POCT supplies, reagents, and media.	!
6.6	The organization uses a standardized and consistent format to label POCT supplies, reagents, and media.	!
7.5	Immediately prior to performing the point-of-care test, the health care professional verifies that the POCT equipment is in proper working order by means of a quality control check.	
8.2	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

8.2.1	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**
8.10	The health care professional delivering POCT documents the date and time of the test, the individual carrying out the test and the results of the test on the result form.	!
10.4	The organization regularly monitors a set of POCT quality indicators.	
10.6	Health professionals delivering POCT gather and record quality control data for each point-of-care test.	!
10.7	Health professionals delivering POCT record quality control data in a daily a log.	!
10.8	Health professionals delivering POCT regularly compare and correlate their quality control results with a central lab.	!
10.13	The organization retains records of quality control results and nonconformities for POCT for at least two years.	

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

NSHA's point-of-care testing (POCT) program is well established. The program is supported by medical, management, and technical leadership in formal reporting relationships across all Zones. Provincially, there is a collaborative process underway to standardize POCT and other laboratory quality documentation and, in time, implement an electronic document management system. The POCT coordinators are well informed and committed to quality improvement.

Resource constraints limit the time the coordinators can commit to sustaining and improving POCT. One of the challenges is providing necessary oversight and guidance to POCT users. It was observed in most POCT locations that the POCT users are not diligent in documenting the performance of necessary maintenance and quality control, and are not in compliance with reagent and supplies labelling requirements. POCT coordinators may find it of value to schedule, perhaps biweekly or monthly, a surveillance visit to each POCT area under their jurisdiction to provide support and to assess the need for further education or competence assessment. As an example, the POCT coordinator in Antigonish area holds a 0.5 FTE position with oversight for five sites; this impedes her ability to visit all sites regularly. It is suggested that the need for additional resources be assessed on a site-by-site basis.

It is suggested that an audit be performed at each POCT-performing site to determine whether unknown or unauthorized POCT is being performed. During the on-site survey, POCT was observed to be performed outside of laboratory oversight and was therefore unauthorized. During the visit to Cumberland and Aberdeen facilities, staff in ambulatory care (Cumberland) and in the ED (Aberdeen) revealed that POCT was in use. This resulted in a number of non-compliant ratings for POCT.

A glucose POCT performed by a nurse was observed at Victoria General. The nurse did not use the two patient identifiers as required for the POCT Required Organizational Practice. It can be a challenge to ensure the two-identifier process is used when the patient is well known to the nurse, as in this case.

In the eastern Zone, some POCT is performed by medical laboratory technologists or medical laboratory assistants. The plan to move responsibility for testing from the laboratory staff to nursing staff has met with some resistance from the nursing staff. The organization is encouraged to schedule staff so that the POCT coordinators have sufficient time to manage the implementation of this project. There is a great deal of expertise at Cape Breton Regional that will be an asset to the team.

At All Saints Springhill Hospital, there are several devices that perform an extended POCT menu. Nursing demonstrated a solid understanding of quality assurance and control practices. Daily checks and quality procedures are well documented. The laboratory/nursing team is encouraged to continue to work together to maintain the quality of the testing. Interfacing the POCT instruments will enhance remote support and reduce manual intervention which introduces risk.

The POCT documentation process is progressing well and the POCT coordinators are proud of what they have achieved. They are commended for the work they have done. There is a commitment to continue to move forward and the organization is encouraged to keep up the momentum.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
4.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
10.6	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
8.16	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
9.2	The assessment process is designed with input from clients and families.	
11.13	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		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	

14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.4	Safety improvement strategies are evaluated with input from clients and families.	!
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is strong and experienced leadership at all levels of NSHA for primary health care. There is a healthy mix of new leaders and seasoned leaders both administratively and for physician leadership. The clinical teams on the ground are caring to the best care they can provide and practice from a patient/client-centred (and directed) stance.

Of particular note is the organization's approach to collaborative family practice teams whose focus in on comprehensive, accessible, and coordinated care to foster continuity of care and a community-oriented system. NSHA has taken a bold step to integrate with fee-for-service and alternate payment family practices and academic family medicine practices to serve the population better.

It is a NSHA first to sign MOA's along with co leadership and the Team agreements with family physicians. The future vision includes evolving both co leadership and contracted services models and have them be available along with turn key governance options.

Provincial and national strategies are needed for family physician and nurse practitioner recruitment as some provinces gear up to recruit high numbers of nurse practitioner. There may also need to be legislative changes to the professions to support service delivery changes, and an exploration of the role of physician assistants for Nova Scotia.

The development of Zones, networks, and local clusters geographically based on population health data and asset mapping is recognized as a strength. This is a further opportunity to continue to allocate resources based on need and to leverage the local community assets to improve the health and well-being of Nova Scotians. There will need to be a carefully developed plan for integration of existing community services to the primary health model as it is not clear how some teams will be re-aligned with the new way of doing business.

There is considerable strength in applied research to support evaluation, monitoring, and innovation. The teams have been recognized with a number of awards for their approaches to primary health care and their ability to engage patients and their families.

Priority Process: Competency

A comprehensive onboarding system cascades from the provincial level to Zones, networks, and the day-to-day role. A buddy system is evident in many locations. Staff feel well supported for success.

The well-crafted guide entitled Engaging with Patient and Family Advisors in Decision Making: Quality in Action, A Resource Guide is a good foundation to involve patients and families for input, co-design, and beyond. The next step is implementation.

All team members encountered were appropriately confident, competent, and respectful communicators whose sole goal is to support patients to co-create health and well-being. Patient-centred approaches are evident and there is pride among the leaders and staff alike; they are serving their neighbours and friends.

Priority Process: Episode of Care

High-quality and excellent program delivery is evident. Patients are well satisfied with their care and report this readily.

Patients are provided with the necessary information to support self-managed care, and appropriate use of the health care system (i.e., when to use the ED, the family physician, or a collaborative emergency centre). There is excellent documentation of patient information to primary care physicians and good

integration. For example, a group medical visit program was implemented for diabetes and hypertension patients in Middleton, where about 25 patients attend a group clinic attended by the primary care doctor, nurses, and diabetes clinic staff. Patients sign confidentiality agreements.

Staff can readily identify ethical dilemmas and know how to seek assistance and that speaking with their manager is the first step.

Overall, the main barrier to access is the shortage of family physicians in many rural communities. Nurse practitioners are becoming well integrated; however, as positions open in the larger cities, they are moving into these roles. In most rural areas, there is an inability to get timely referrals to specialists, especially psychiatrists and geriatricians.

Patient advisors participate on the western Zone Quality Team. However, to support the primary care program in this Zone, it is suggested that a patient and family network be established whereby patients with a variety of chronic disease conditions could be called on to provide feedback and to work with the program to develop Zone primary care strategies and processes. This was a request of the patient advisors to improve engagement.

For the future, NSHA needs to communicate its primary care vision and goals so the Zones can move forward with their primary care plans in support of the overall strategic direction. There is limited evidence of specific ways NSHA is addressing the truth and reconciliation calls to actions.

Priority Process: Decision Support

Decision support services are available and data are collected by various means manually and electronically. There is a robust set of metrics for primary health care overall. The leaders are encouraged to develop cascading metrics so they are not too time consuming to collect and there is time to analyze, explore limitations and assumptions, and use the data to drive quality improvement.

Managers and teams are looking forward to learning from the data.

The addition of a metric that measures the interface between acute and community care is suggested. For example, there have been examples of patients discharged with G-tubes and other complex needs that are outside the present scope and competency of community services. This is a risk for the organization and needs further study to determine the nature and extent of the problem.

The transition to the new electronic medical record will support continuity and the continuum of care; being mindful that there are legacy systems that are functioning well in some settings (i.e., Nightingale). Doc in the Box may be an option to explore for remote clinics where there is no telehealth capacity or the investment is too high. Through Doc in a Box, with a cell phone connection the physician or specialist can establish a high resolution two-way video link with patients and nurses or paramedics hundreds or even thousands of kilometres away.

Priority Process: Impact on Outcomes

The organization is early on its journey to measure impact on outcomes, which is understandable in an organization in transition. The macro key performance indicators relevant to primary health care set a strong foundation and need to be implemented.

Routine and traditional outcome measures (the easy-to-collect and measure ones) are in place. There are sound plans to improve the types of outcome measures and standardize collection, with definitions. For example, the team at Colchester plans to start collecting data effective October 31. They know it will be challenging at first and that, for comparability, team members will need to agree on definitions. Also, benchmarks are underdeveloped in community settings (i.e., how many clients can provider X see in a day?).

Patient safety is a key focus and the "five simple questions" for medication safety is a good example of a straightforward approach. The poster to support this strategy is evident everywhere.

Staff health, safety, and well-being are also an important focus and staff feel safe and supported at the workplace. Team members support colleagues to work safely, and good hand hygiene is evident at each site.

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		
4.3	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Public Health		
10.8	Equitable, evidence-based screening programs are provided or promoted.	!
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		

Public health uses a variety of approaches to obtain input from clients, families, staff, and community partners on work, job design, roles, and responsibilities. This reflects the belief and practice that the perspective of clients and partners is a critical component of a collaborative approach and underlying value.

The client perspective is incorporated into program and service planning.

The process to establish public health goals and priorities is under development. Changes in responsibilities with roles and capacity at the Department of Health and Wellness and the changes with the establishment of NSHA have created confusion and potential gaps.

For example, Dr. Strang had developed a public health emergency preparedness plan that was released around the time that NSHA was developed. The plan was not socialized so many staff are not aware of it or what their responsibilities under the plan would be.

Work is occurring to integrate the plan with the NSHA all-hazards plan as a way to re-engage with local municipalities who historically have had strong relationships with public health, in particular medical officers of health and environmental health officers for emergency preparedness. This is a significant risk for the organization and the province and, while staff have come together to respond to infectious disease outbreaks, clarification on roles, responsibilities, and activation of the plan is needed.

Other potential gaps in program goals identified in discussion with staff and providers were the NSHA harm reduction program and policy, given the stigma that some community partners say their clients have experienced when they try to access services. This is urgent because of concerns over the high rates of opioid use, overdoses, and uncertainty in funding of needle exchange and other harm reduction services. Updating the provincial blood borne pathogen and sexually transmitted infections is also identified as another area where roles need to be clarified between NSHA and Health and Wellness.

For example, although NSHA has adopted a co-leadership model with physician and administrative leaders working together collaboratively, the role of the medical officers of health is not formally represented in organizational charts. In some Zones, the terms of reference for the quality and safety and public health leadership identifies the medical officers of health as co-lead but not in other Zones, and this role is not identified as a formal member of the Zone administrative structure but as an invited guest. The organization is encouraged to consider formally acknowledging the leadership role of the medical officer of health in the organization structure.

Priority Process: Competency

Public health services are delivered by a skilled interdisciplinary team. One of the standardization initiatives has been to look at roles and responsibilities from the former health authority to develop a common role description.

There are various mechanisms of communicating within teams and across and between Zones.

There are processes to ensure staff maintain appropriate licences.

The staff orientation process includes orientation to relevant public health legislation related to their roles and other relevant legislation such as protection of privacy and information and reporting of suspect child abuse. The orientation also includes cross cultural and Indigenous awareness.

There is support for continuing education and professional development. All staff interviewed indicated they have opportunities to identify and participate in professional development.

There are team-based learning activities.

Priority Process: Impact on Outcomes

Team members presented a number of examples of how they use data in planning, service delivery, evaluation, and individual quality improvement activities.

Work is occurring on the processes to identify process and outcome measures. There was variation in the previous organization of the indicators that were collected. As an example, for one service data for over 300 indicators were being collected. The quality team is looking at reducing this to 30 indicators.

The team is encouraged to continue its work on the development of performance indicators and in particular to look for potential outcome measures.

The team is also encouraged to look at measures to evaluate the impact of risk factors that cross between programs and services. As an example, many public health services identify tobacco use and current practice is to provide clients with information about how to access cessation services instead of making a direct client referral to the service. Provision of information is a less effective strategy than a direct connection as it creates another task for the client to undertake when they may already be overwhelmed. This concern exists for other screening and chronic disease management programs.

The team identified that is has used Public Health Ontario evaluations and reviews in its planning activities. Current benchmarking activities focus on internal benchmarking between Zones.

The team is encouraged to look at benchmarking against high-performing public health programs and services. Performance monitoring needs to also include an equity lens to ensure programs are decreasing and not increasing health inequities.

Priority Process: Public Health

As per Department of Health and Wellness public health standards and protocols, NSHA public health identifies its purpose as “public health works with others to understand the health of our communities and acts together to improve health.” Staff understanding of and commitment to this statement is strongly evident in all five Zones and in discussion with leadership teams. Numerous examples, including a number of innovative approaches, were shared or observed. Clients and partners also spoke highly of NSHA as a partner or collaborator.

Population assessment data are used to inform public health services at a provincial and Zone level. The data are used to identify populations who are vulnerable as a result of social or environmental factors. There are both primary data that public health collects, often in partnership with others, and secondary data sources. There is a need to enhance primary data collection and strengthen systems to enhance surveillance data.

The importance of using the population health assessment to direct not only public health services but all activities of NSHA is illustrated in the most recent Nova Scotia population health assessment that finds that male and female Nova Scotians live two years less in full health than other Canadians and these differences are further magnified within Nova Scotia. The majority of factors responsible for these differences are social and environmental factors other than health services that need to be considered in the health improvement plan.

NSHA is encouraged to use population health status information in the development of Nova Scotia's population health improvement plan. Various activities are occurring to improve population health outcomes but often these are pilot projects rather than sustained province-wide initiatives with meaningful investment. For a meaningful impact on population health status and improvement in health equity there is a need to invest to scale and spread initiatives that have been proven to be effective.

Public health has identified the following priority areas to focus activities for 2016 to 2018: implement the new structure, clarify roles and expectations related to community health boards, connect with the medical officers of health, oral health, health-promoting school model, review the enhanced home visiting program, health protection quality improvements, public health role in early years centres, needle exchange, public health emergency management, increase investment in public health, public health research, and implement Panorama (new public health information system).

There are three main public health service areas: Early Years; Health Protection, Healthy Communities; and Science And System Performance.

The implementation of NSHA's co-leadership model of program and medical leadership varies across public health. Factors contributing to this are vacancies in medical officer of health positions and lack of understanding of how medical officers of health (even though they are Department of Health and Wellness staff) can be involved directly in public health clinical leadership as well as medical leadership in NSHA's medical staff structure. Managers and staff identified how the vacancies in Ministry of Health positions were directly affecting relationships with community partners and the response to Zone public health issues, such as effectively responding to the high rates of hepatitis C in Cape Breton (east Zone).

Major focuses in health protection have included standardization of practices across the five Zones. Of concern is the variation in vaccination coverage rates between the Zones for the grade 7 program. (Information on vaccination coverage rates for infants and pre-school children was not seen or reviewed during the on-site survey.) There is considerable hope that with the implementation of Panorama that there will be significant improvements in the information available to inform the NSHA vaccination plan.

While there was demonstration of compliance with the Public Health Agency of Canada (PHAC), guidelines for cold chain protection for vaccine when it is under the control of NSHA. Very little if any information is available on whether the protection of the cold chain and vaccine effectiveness occurs in physician and pharmacies before being administered to clients. NSHA is encouraged to work with the Department of Health and Wellness and all providers to ensure compliance with PHAC guidelines.

Zones that do not have any or very limited infrastructure support speak highly of the support provided through Science and System Performance. Communication, evaluation, and epidemiological support were identified during conversations. Concern was expressed about the capacity of Science and System Performance to provide particularly epidemiological support to fully meet the needs at the Zone levels.

Clients and partners spoke highly of their experiences in working with and receiving services from public health. Public health staff play a key role in delivering services and building relationships. These relationships are particularly important in healthy public policy and health equity work. Examples of work on alcohol and tobacco policy and healthy built environment were shared. The work of a housing coalition in the west Zone to improve the quality and affordability of housing options should be considered for submission as a Leading or Innovative Practice if the evaluation demonstrates its effectiveness. There has been success in identifying system issues to address.

In the development of public health's health improvement plan, the identification and use of indicator and outcome information will be important. While examples were provided of how data are being used to assess and improve programs as part of the standardization, the use of quality and relevant performance information needs an ongoing focus.

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		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
7.7	Translation and interpretation services are available for clients and families as needed.	
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.5.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
10.8	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		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Leadership teams from the Nova Scotia Rehabilitation Centre (NSRC) in Halifax and the Harbourview Hospital in Sydney Mines participated in a joint leadership discussion group and provided the following insights.

NSRC and Harbourview Hospital provide provincial and regional, respectively, rehabilitation services in Nova Scotia. Although NSHA has not defined rehabilitation services provided in Nova Scotia in the context of a program or a network, both leaders expressed interest in collaborating and sharing best practices between the two organizations/locations. There appears to be a willingness among the leadership to develop a provincial rehabilitation strategic plan for Nova Scotia. This is encouraged, as it aligns with NSHA's articulated provincial focus on the aging population with complex conditions and on the desire to maintain frail seniors in their homes.

Reporting through the eastern Zone, the leadership of the Harbourview Hospital developed a strategic plan for overall rehabilitation services in the 15 sites in the Zone that offer rehabilitation. The plan aligns with provincial directions and goals and includes a broad range of action plans, performance indicators, and targets.

Opportunity exists for the development of a rehabilitation strategic plan in conjunction with a provincial physician resource plan for rehabilitation services, with an emphasis on physiatrist resources. Consideration could be given to innovative models for resourcing rehabilitation services to meet patient needs across the province, such as is already being done via telehealth and which could be further expanded or via development of community-based specialist practices. NSRC already provides telehealth across the province for inpatients and outpatients. Opportunities presented by this and other technologies may permit an expansion of rehabilitation supports, such as providing remote consultations and assessments where physician, and especially physiatrist, resources are lacking.

Priority Process: Competency

Harbourview Hospital is a long-term care and rehabilitation care facility that serves the Cape Breton region. There are 15 designated inpatient rehabilitation beds, six inpatient restorative care beds, and a large volume of outpatients. The client population is primarily older patients who have experienced a stroke, amputation, or musculoskeletal (MSK) issues. The care team includes a shared family practice physician/medical director with the hospital's long-term care facility, part-time physiatrist (two days per week), dietitians, nurses, occupational therapists, physiotherapists, recreation therapists, orthotics, social workers, pastoral care, and environmental services. The Harbourview Hospital rehabilitation team held a four-hour interdisciplinary collaboration session in 2016 to evaluate team functioning; perhaps an outcome of the session... Staff who were interviewed report having a very collaborative team culture and that they "love working at Harbourview Hospital."

Harbourview's inpatient rehabilitation unit accepts all adult tertiary rehabilitation clients in the catchment area except those with brain injuries and those who require IV therapy. While there are no barriers to access (very short waiting list), there are barriers to discharge, including a lack of allied health in many communities especially neurorehabilitation, funding for home modifications, and transportation, among others.

NSRC is a tertiary rehabilitation centre serving the people of Nova Scotia and the Atlantic provinces. The centre offers an interdisciplinary team approach in four key clinical subprograms. It has 66 inpatient beds, a range of outpatient clinics (such as multiple sclerosis, amyotrophic lateral sclerosis, neurology, acquired brain injury, musculoskeletal, amputee, spina bifida, orthotics, spasticity, stroke, and transition clinics), telehealth services, a day program, and an outreach service for acquired brain injury patients. The team comprises physiatrists, hospitalists, nurse practitioners, nurses, occupational therapists, physical therapists, dietitians, psychologists, recreation therapists, and social workers as well as orthotics/prosthetics, spiritual care, and vocational counselling services.

The centre's leadership has worked hard to develop academic training opportunities across disciplines that serve the centre well in terms of career laddering. This, in turn, supports recruitment and retention of clinicians. The centre is commended for its academic partnerships, which have virtually eliminated the need in the last two years to close beds to address vacancies in hard-to-fill positions.

Research is also an important component of the centre's mandate. There are many examples of interdisciplinary research; a project exploring pain self-medication was highlighted during the on-site survey. And the 2017 Shears Lecture in Physical Medicine and Rehabilitation, held at NSRC, brought in an internationally recognized expert in concussions and headache to provide the keynote address, in addition to related presentations by local researchers.

Opportunities presented by expanding the existing telehealth consult service offered by NSRC, along with other technologies, may permit virtual consultations and assessments where physician, especially physiatrist, resources are lacking in the province (physiatrist vacancies exist at both Harbourview Hospital and NSRC).

Staff evaluations at Harbourview Hospital are up to date. Although team members on the MSK unit at NSRC have opportunities for informal feedback on their performance and are recognized for their accomplishments, formal documented evaluations that could inform performance plans and personal and professional development are not regularly conducted for all staff on the MSK unit. The MSK unit manager is encouraged to explore with NSHA's human resources leaders whether documented performance conversations adhere to NSHA's policies related to performance appraisal; this approach has been successfully adopted in many organizations where, like the MSK unit, span of control is large.

Priority Process: Episode of Care

Harbourview Hospital is commended for its leadership in being an early adopter of the Canadian Foundation for Health Improvement's Better Together pledge to adopt family presence policies that welcome families and loved ones as partners in care and to engage them in planning and decision-making based on patient needs and preferences. The Harbourview Hospital rehabilitation team collaborated with their long-term care colleagues at Harbourview to develop family presence guidelines based on patient and family feedback and guidance. These are being rolled out to the rest of the Zone and to NSHA. Harbourview was one of a coalition of 13 health care organizations across Canada that worked together

to integrate patient- and family-centred care into all aspects of care, working in partnership with patients, families, and health care professionals to increase the family presence in care processes and decision making.

NSRC is congratulated on the renovations that were funded by the Revitalizing Rehabilitation Campaign. These include a fabulous new therapeutic pool; the upgrade of four elevators that, based on feedback from patients, families, and staff now include an oversized open/close button located at the rear of the cab to assist patients in wheelchairs; changes to the main entrance; and paving of the parking lot. In addition, two new activities of daily living suites are under construction with targeted completion in the new year. One suite will be high tech, the second will be similar to a typical home or apartment. These capital plant changes reflect significant improvements to the aging physical infrastructure of the centre and permit opportunities for increased engagement and collaborative programming with the Halifax community. The NSRC pool, for example, is used by the centre's inpatients and outpatients as well as by the YMCA for a community program four evenings each week. The centre has developed the community YMCA partnership with consideration of maximizing use of the space while ensuring safety is paramount in the contracted relationship.

In light of these positive changes to NSRC infrastructure is concern about the implications for NSRC about the development of a single campus of acute care in Halifax that will see the closure of the Victoria General Hospital in approximately seven years. The underground/basement tunnel between NSRC and Victoria General supports essential services for NSRC, including patient meals, diagnostics (imaging, including barium swallows), respiratory therapy and code teams, IT services, and evening pharmacy services

NSRC staff led the work to partner with patients to develop a checklist guide for patients that follows the episode of care (upon admission, during your stay, as you near discharge, the day of discharge, after discharge). The guide meets the program goal of providing consistent care and messaging at key transitions. The Your Journey through Rehabilitation documents (one version for patients/families; a second for care staff) are the result of a staff and patient engagement project that identified the need for a checklist to prepare patients for discharge from NSRC. The patient version provides space to add notes and the care staff version prompts key discipline staff to provide consistent (where appropriate) and customized information for each item on the checklist.

Compliance rates with medication reconciliation being completed within 24 hours of admission is monitored at NSRC via inpatient chart audits. Evidence of medication reconciliation on admission and discharge was noted. Medication reconciliation on transfer has not yet been consistently implemented in the MSK program. The percentage of falls assessments completed within 24 hours and Braden scale completion rates on admission are also monitored. The centre's CNE produces a monthly newsletter, provides comprehensive orientation for new nursing staff, and offers topical lunch-and-learn sessions.

When asked to rate the quality of care received on the unit, using a scale where 1 is poor and 5 is excellent, all patients interviewed provided a perfect 5 score. Narrative comments from patients and families illustrated the positive ratings. Examples include, "They focused on my mother as a person, as an

individual, not as an organ that needed treatment," and "Getting a high school-aged patient to her prom was as much a goal for the patient as it was a goal for the team."

Priority Process: Decision Support

Acentralized intake and prioritization system is in place across NSHA. This is the first line of triage for patients referred to NSRC and Harbourview Hospital. Clinical assessment data and information from standardized assessment instruments are submitted to the Canadian Institute for Health Information (CIHI) and information is used to compare performance with other tertiary rehabilitation facilities (based on peer groups) across Canada on metrics such as average wait times for programs, number of admissions/discharges, average length of stay, and change in function based on functional independence measure scores.

The MSK education series has been evaluated and changes made based on patient and family feedback, including changes to the day and time the sessions are offered, format and topic changes, as well as additional presentations from the physiatrist.

NSRC worked with patients and families to develop an inpatient survey instrument. This short tool has 14 items that yield quantitative results, with the opportunity to collect narrative/qualitative comments. While response rates have been high, a limitation of the tool is that the items have not been validated and as such may not measure what is intended. For example, several of the items are double barrelled. NSRC and Harbourview Hospital are encouraged to consider fielding instruments with demonstrated validity and reliability that offer opportunities for benchmarking with centres that provide similar case mix and/or services. No benchmarking is currently possible; as such, sharing or learning from the best practices of others is not possible, and it is unclear how to interpret scores. Finally, it is important for the quality team that reviews the results of the survey to recognize that respondent n sizes are low, making margins of error high. A more targeted open-ended question that asks respondents to name one thing that would improve the service/program may yield more actionable feedback.

Reporting through the eastern Zone, leadership at Harbourview Hospital developed a strategic plan for overall rehabilitation services in the 15 sites in the Zone that offer designated rehabilitation services across the Zone. The plan aligns with provincial directions and goals and includes a broad range of action plans, performance indicators, and targets.

Harbourview's inpatient rehabilitation unit accepts all adult tertiary rehabilitation clients in the catchment area except those with brain injuries and those who require IV therapy. While there are no barriers to access (very short waiting list), there are barriers to discharge, including lack of allied health in many communities especially neurorehabilitation, funding for home modifications, and transportation, among others.

Priority Process: Impact on Outcomes

Patient safety reporting and monitoring is evident in rates of hand-hygiene compliance and falls posted on the MSK quality boards, SIMS reporting of incidents (near misses, harm, no harm incidents), as well as complaints and compliments. Clinical assessment data and information from standardized assessment instruments are submitted to CIHI and information is used to compare performance with other tertiary rehabilitation facilities (based on peer groups) across Canada on metrics such as average wait times for programs, number of admissions/discharges, average length of stay, and change in function based on functional independence measure scores. Standardized tools and care plans are used to manage falls and pressure ulcers.

Goal attainment scaling is used by therapists to measure outcomes at the patient level and to inform clinical practice decisions in partnership with patients and families. Although best practice guidelines are reviewed in collaboration between clinicians and practice leaders and discussed at team meetings, there is no formal mechanism on the MSK unit to engage patients and families in this process.

Standards Set: Spinal Cord Injury Acute 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

There is a strong interdisciplinary team. The unit has recently expanded by four beds to accommodate demand, and the intermediate care unit moved to a renovated space.

The care model using care team assistants did not meet the needs of the patients. A review resulted in a recent change to all registered nurse staffing. Staff indicate that the new model is working well. The team has also added additional therapy staff.

Many of the patient rooms are small which can be challenging with the amount of equipment that is required.

Priority Process: Competency

Patients and families have access to an interdisciplinary team and staff are supported through education and training. Staff spoke of the support they receive for ongoing professional development.

There is a plan to provide training to all staff on the use of the ASIA impairment scale.

Care pathways are being developed which are supported by care plans.

Students are encouraged to select placements on the spinal cord unit.

Priority Process: Episode of Care

There is a strong interdisciplinary team on the unit. Staff spoke of the supportive environment and the opportunities for professional development.

There is a defined pathway and criteria for admission to the unit for traumatic spinal cord injury patients. Once they arrive, they are thoroughly assessed by the team members. The team works with the patient and family to help and support their involvement in care. Private rooms are available when required.

The team strives to understand who patients were before the accident and works with them and their families to establish goals of care. When rehabilitation is possible goals for transfer are established. There are processes in place to safely care for patients who may be aggressive.

The team is encouraged to continue the development of a care pathway and preferred provider organization to include venous thromboembolism.

Priority Process: Decision Support

Patient records are complete and accessible. Patient information is shared readily to ensure continuity of care.

The unit is supported by nurse practitioners.

Priority Process: Impact on Outcomes

There is a strong focus on quality improvement. The team is engaged in looking at policies and processes that would benefit patients and staff.

Evidence and best practices are used to guide care and make improvements.

Patient safety is key and the team has a proactive approach to ensuring patients and staff are safe.

Standards Set: Spinal Cord Injury 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		
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Leadership teams from the Nova Scotia Rehabilitation Centre (NSRC) in Halifax and the Harbourview Hospital in Sydney Mines participated in a joint leadership discussion group and provided the following insights.

NSRC and Harbourview Hospital provide provincial and regional, respectively, rehabilitation services in Nova Scotia. Although NSHA has not defined rehabilitation services provided in Nova Scotia in the context of a program or a network, both leaders expressed interest in collaborating and sharing best practices between the two organizations/locations. There appears to be a willingness among the leadership to develop a provincial rehabilitation strategic plan for Nova Scotia. This is encouraged, as it aligns with NSHA's articulated provincial focus on the aging population with complex conditions and on the desire to maintain frail seniors in their homes.

The opportunity exists for the development of a rehabilitation strategic plan in conjunction with a provincial physician resource plan for rehabilitation services, with an emphasis on physiatrist resources. Consideration could be given to innovative models for resourcing rehabilitation services to meet patient needs across the province, such as is already being done via telehealth and which could be further expanded or via development of community-based specialist practices. NSRC already provides telehealth across the province for inpatients and outpatients. The opportunities presented by this and other technologies may permit an expansion of rehabilitation supports, such as providing remote consultations and assessments where physician, and especially physiatrist, resources are lacking.

With respect to the programs and services offered by the spinal cord injury (SCI) unit at NSRC, demographic data and information about community needs is collected and used by the leadership of the unit to identify and develop services for target populations in NS and to understand needed service and staffing levels. The close working relationship with the neurology and SCI acute units at the QEII ensures continuity across transitions in care for their shared clientele. The program is congratulated for being a "poster child" for provision of the hallmarks of continuity across transitions in care (i.e., relational, informational, and managerial continuity).

The strong interdisciplinary, collaborative and patient-centred focus of every SCI team member met at NSRC indicates that this team has and will continue to be poised to provide expertise in building capacity beyond the walls of NSRC and across the full continuum of prevention, education, rehabilitation, and post-injury service delivery and research. The team is encouraged to move to the next stage by articulating its goals through the lens of "with input from" and "in partnership with" patients and families. The team is encouraged to publish its findings and lessons learned from when a patient partner was included on a quality team, including why it didn't work and what other opportunities for patient engagement and co-design have worked or could work better.

Priority Process: Competency

NSRC is a tertiary rehabilitation centre serving the people of Nova Scotia and the Atlantic provinces. The centre offers an interdisciplinary team approach in four key clinical subprograms. It has 66 inpatient beds, a range of outpatient clinics (such as multiple sclerosis, amyotrophic lateral sclerosis, neurology, acquired brain injury, musculoskeletal, amputee, spina bifida, orthotics, spasticity, stroke, and transition clinics), telehealth services, a day program, and an outreach service for acquired brain injury patients. The team comprises physiatrists, hospitalists, nurse practitioners, nurses, occupational therapists, physical therapists, dietitians, psychologists, recreation therapists, and social workers as well as orthotics/prosthetics, spiritual care, and vocational counselling services.

The centre’s leadership has worked hard to develop academic training opportunities across disciplines that serve the centre well in terms of career laddering. This, in turn, supports recruitment and retention of clinicians. The centre is commended for its academic partnerships, which have virtually eliminated the need in the last two years to close beds to address vacancies in hard-to-fill positions.

Research is also an important component of the centre's mandate. There are many examples of interdisciplinary research; a project exploring pain self-medication was highlighted during the on-site survey. And the 2017 Shears Lecture in Physical Medicine and Rehabilitation, held at the NSRC, brought in an internationally recognized expert in concussions and headache to provide the keynote address, in addition to related presentations by local researchers.

The clinicians working on the SCI Unit offer a unique skill set to meet the needs of the patient population. An environment of mutual respect among disciplines is apparent. Staff who were interviewed report feeling involved in decision making regarding their work with the patients and report feeling listened to when they have suggestions for improvement.

Although team members on the SCI unit at NSRC have opportunities for informal feedback on their performance and are recognized for their accomplishments, formal documented evaluations that could inform performance plans and personal and professional development are not regularly conducted for all staff on the unit. The unit manager is encouraged to explore with NSHA's human resources leaders whether documented performance conversations adhere to NSHA's policies related to performance appraisal; this approach has been successfully adopted in many organizations where span of control is large.

A strong commitment to excellence in care provided to the patient population is evident, and patient feedback supports this. Staff report being well supported by the leadership team, as well as having timely information and mentorship to do their job.

Staff are committed to keeping competencies current and report that they are supported by the management team for ongoing professional development. Specialized training is supported and off- and on-site learning is provided.

Priority Process: Episode of Care

It is evident that staff at the SCI unit are committed to meeting the needs of patients and families. All staff interviewed expressed a passion for their work and for being a part of NSRC and the SCI unit. There is clear evidence of a desire to evaluate and continually improve the effectiveness of interventions for each patient and to improve the effectiveness of the unit overall. Clinicians work closely with patients and families to define their goals of care, as well as monitoring progress and re-evaluating goals over time. There is a streamlined intake process, attention to wait times for admission, and excellent relationship with the acute SCI unit. The patient/clinician relationships that were observed showed patients being involved as active participants in decision making regarding their care, demonstrating a clear focus by staff on patient-centred care.

Patients describe staff as caring and express satisfaction with the services they receive. When asked to provide a rating of the quality of care provided on the SCI unit, using a scale where 1 is poor and 5 is excellent, the average rating provided was a perfect 5. A testimonial by a patient summarizes the overall feelings expressed as "The care providers make you feel like you are the only one ... they are very special people who are here only to encourage me."

Many examples were presented of quality improvement initiatives that have included patient and family and staff input. Staff feedback resulted in a 15-minute change in the start time of morning report to allow nursing staff to get to patients on the floor earlier. A safety binder was developed to increase communication between nursing shifts about patients at risk, highlighting patients with the same name; patients with no code status; patients at risk of autonomic dysreflexia, skin breakdown, and falls; and patients on infection prevention and control precautions.

In addition to the refurbishing of the pool, elevators, signs, and entrances to NSRC that included input from patients and families, the SCI unit has had ceiling lifts installed in many patient rooms to reduce the risk of injury to staff and to make patient transfers more comfortable and safer for patients.

It is noteworthy that an in-house engineer is available to support the patients on the SCI unit to adapt patient rooms with assistive technologies that give them better control of their call bells, phones, televisions, and personal computers.

Each patient has a whiteboard at the bedside for posting of relevant information, including type of transfers, staff names, estimated discharge date, etc. The team may wish to encourage patients and families to use the board to record questions for doctors and nurses during daily rounds. Using whiteboards in this way has been found to increase patient and family satisfaction with getting information that is important to them, and makes interactions with patients more efficient.

Pamphlets about venous thromboembolism prevention and pressure sore prevention have been added to the Welcome to Rehab binder given to and reviewed with patients on admission. Physicians indicate that venous thromboembolism protocols have been discussed and are under review in the context of the specific patient populations of the NSRC.

Two client identifiers were observed to be used to confirm the identity of patients during medication passes. All providers who were observed adhered to hand-hygiene protocols and were aware of the unit metrics posted on the quality boards regarding this indicator.

Priority Process: Decision Support

The SCI unit's services are highly specialized. Sharing of evidence-based guidelines occurs, and staff are aware of the value this brings to their work. Meetings take place with patients and families soon after the patient's admission, to discuss the patient and family's goals and to establish estimated discharge dates. This process provides a two-fold focus, one on the patient on the unit and two on those waiting for admission. These two foci present a delicate balance that creates a tension for staff and patients and families. During a patient and family interview, it was clear that it is important to reinforce the goals of discharge while also reinforcing that the discharge date is an estimate. While the target date establishes a goal and a target, it can also create anxiety for patients and families, who have questions such as “Will I be ready? What happens if I am not?”

A centralized intake and prioritization system is in place across NSHA. This is the first line of triage for patients referred to NSRC. Clinical assessment data and information from standardized assessment instruments are submitted to the Canadian Institute for Health Information and information is used to compare performance with other tertiary rehabilitation facilities (based on peer groups) across Canada on metrics such as average wait times for programs, number of admissions/discharges, average length of stay, and change in function based on functional independence measure scores. Robust indicators tracked by the team are presented in the form of a scoreboard for review by the NSRC quality and SCI quality teams.

NSRC worked with patients and families to develop an inpatient survey instrument. This short tool has 14 items that yield quantitative results, with the opportunity to collect narrative/qualitative comments. While response rates have been high, a limitation of the tool is that the items have not been validated and as such may not measure what is intended. For example, several of the items are double-barrelled. The SCI unit team is encouraged to consider fielding instruments with demonstrated validity and reliability that offer opportunities for benchmarking with centres that provide similar case mix and/or services. No benchmarking is currently possible; as such, sharing or learning from the best practices of others is not possible, and it is unclear how to interpret scores. It is important for the rehabilitation and SCI quality teams that review the results of the survey to recognize that respondent n sizes are low, making margins of error high. A more targeted open-ended question that asks respondents to name one thing that would improve the service/program may yield more actionable feedback.

Priority Process: Impact on Outcomes

The SCI team engages with patients and families oon after admission to discuss goals and set estimated discharge dates, as well as to begin transition planning. Patient's individualized goals for return to work or development of new and meaningful pursuits are respected and genuine efforts are made to develop patient-centred goals and targets to measure progress. Funding that is available via NSRC to provide enhanced access to technology is viewed with great appreciation by SCI patients and their families.

The clinicians on the SCI unit collect, report on, and receive a lot of helpful data from various sources about patient safety risks and other indicators. Clinicians sometimes need help to interpret the right data, in the right place, at the right time, in order to translate the data into information and to use the information to take action for improvement. The SCI team is encouraged to look at examples of programs that have found new ways to collect and visualize unit-level quality improvement data for point-of-care staff, using evidence-based clinical guidelines and creating templates (posters and storyboards) and data displays (graphics) for clinicians and staff in a way that celebrates success and clearly illustrates opportunities for improvement. This is a team ready to move to this next step of presenting and actioning data for improvement.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Transfusion Services		
4.3	The team has a formal program to maintain team members' competence that includes evaluating their theoretical and practical knowledge on transfusion services using a variety of techniques.	
4.4	Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
4.5	Team managers document the results of competency assessments and reassessments.	
4.8	The organization maintains and retains complete and up-to-date records on qualifications, training, and competence, including competency assessments and reassessments, and remedial actions for each team member.	
5.3	The team reviews and updates the SOPs every two years or more often if required.	
22.3	Immediately prior to transfusion, and in the presence of the recipient, the team verifies and documents that the blood components or blood products matches the compatibility label/tag and that all identifying information linking the recipient and the blood component or blood product matches.	!
22.8	Throughout the transfusion, the team member providing the transfusion verifies that all clinical and identifying information attached to the blood bag remains intact.	
25.7	The team collects new or uses existing data to establish a baseline for each indicator.	
25.9	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
Surveyor comments on the priority process(es)		
Priority Process: Transfusion Services		

Transfusion services were surveyed at South Shore Regional Hospital (Western Zone), Cape Breton Regional Hospital and St. Martha's Regional Hospital (Eastern Zone), and Colchester East Hants Health Centre (Northern Zone).

The technologists working in these laboratory sites are dedicated to providing a safe and effective transfusion service to their patients. There is an emphasis on patient safety and rigorous attention to proper patient identification when procuring and processing specimens for testing. Many processes are already standard (i.e., adverse event reporting) due to the work performed by the Nova Scotia Provincial Blood Coordinating Program (NSPBCP) in the past. This program will be a great asset in standardizing processes. The QEII transfusion service is accredited by the AABB and provides support for investigation of complex antibody identification as well as acting as a resource for information on appropriate use of blood products.

At Cape Breton Regional, there is a senior technologist with responsibility for transfusion. At the other sites the senior technologists also work in the core laboratory and/or perform bench duties. At St. Martha's in particular, the staffing shortage has allowed little time to perform audits and participate in quality improvement projects.

The transfusion laboratories are separated from the rest of the core laboratory at St. Martha's and Colchester East Hantz., in Cape Breton Regional it is at the end of the room but it can become very noisy. This can make it difficult to concentrate when working on complex antibody identification.

The laboratory equipment is well maintained according to standards. The team is commended for its dedication to following a rigorous protocol to ensure blood products are stored under optimal conditions.

At Cape Breton Regional, there is limited storage for plasma protein products. The purchase of a proper blood bank refrigerator to replace the household refrigerator currently used to store reagents would provide extra capacity to store plasma protein products and would provide back-up storage space should the double refrigerator malfunction.

A commitment to continuous quality improvement is evident at all sites. The team is commended for its efforts around blood products use (e.g., reduction of IVIG use and issue/transfuse one unit at a time). The organization recently received a quality award for its significant improvement in red blood cell use. The use of the Choosing Wisely–Transfusion Medicine toolkit is highly recommended.

The lack of a manager and a shortage of technologists at St. Martha's has resulted in less time to focus on local quality indicators. The senior technologist is part of the eastern Zone quality team and performs quality functions as required by the NSPBCP. Ongoing competency assessment is performed at Cape Breton Regional but not at St. Martha's. It is especially important that this is provided for staff who rotate through the department. Once the new manager is in place, consideration could be given to having an on-site technologist responsible for quality.

Transfusion committees are established and meet regularly. It was reported that NSHA is developing a new provincial template for terms of reference. For the Northern Zone, the committee would benefit from the addition of a representative from surgery services to its membership.

Procedures are available for all aspects of pre-transfusion testing and dispensing of product. Rigorous attention is paid to completing request forms and labelling specimens and blood products for transfusion. Products are dispensed and transported to the nursing units in a safe and secure manner. Record of final disposition of all products is maintained in the laboratory information system.

There are policies and procedures in place for the administration of blood products, which includes a separate signed consent. At Cape Breton Regional, the information check at the bedside was performed by only one nurse and not two as per the policy. At St. Martha's the transfusion tag was removed from the product immediately after the transfusion was started and not left on as required in the standards. It is suggested that implementation of the provincial policy and procedure for blood administration be accompanied by education for nursing to ensure all are following the required steps. Excellent tools are available in all nursing units regarding blood products and monitoring for transfusion reactions.

A provincial massive transfusion protocol is under development. This will help clinicians provide blood products to massively bleeding patients in a rapid and timely manner. In some Canadian provinces a new code, code omega, has been developed to respond to and manage patients with massive bleeds with a coordinated, interdisciplinary approach.

Blood products that are transported outside the facilities are packed according to an established packing scheme using validated containers. There is a provincial policy and procedure for home transfusion. This program is available only at Cape Breton Regional.

Document control is moving along well but has not yet been fully implemented. At St. Martha's there is no evidence of recent review. Several unabridged documents can be found in all laboratories. The work towards standardization of documents continues across the province.

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: March 6, 2017 to March 24, 2017**
- **Number of responses: 12**

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	94
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	95
3. Subcommittees need better defined roles and responsibilities.	100	0	0	72
4. As a governing body, we do not become directly involved in management issues.	0	0	100	81
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	8	0	92	94

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	96
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	96
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	100	0	0	64
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	91
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	95
12. Our ongoing education and professional development is encouraged.	0	0	100	92
13. Working relationships among individual members are positive.	0	0	100	97
14. We have a process to set bylaws and corporate policies.	0	0	100	95
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	99
16. We benchmark our performance against other similar organizations and/or national standards.	0	8	92	76
17. Contributions of individual members are reviewed regularly.	0	0	100	69
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	80
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	62
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	85

	% 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.	92	8	0	50
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	84
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
24. As a governing body, we hear stories about clients who experienced harm during care.	0	8	92	78
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	8	92	90
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	88
27. We lack explicit criteria to recruit and select new members.	92	8	0	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	88
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	93
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	93
31. We review our own structure, including size and subcommittee structure.	0	0	100	88
32. We have a process to elect or appoint our chair.	0	0	100	89

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

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	8	17	75	81

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	
34. Quality of care	8	17	75	82

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2016 and agreed with the instrument items.

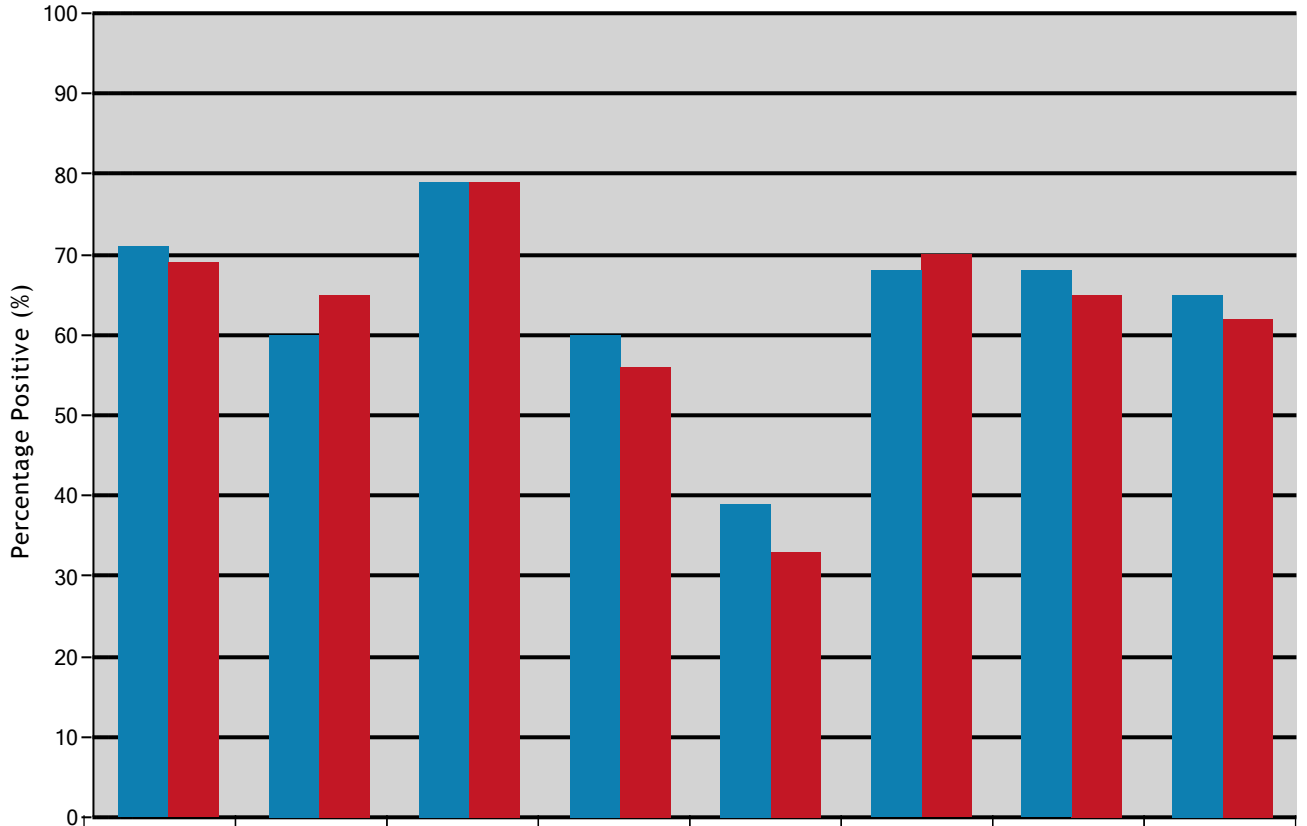
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: May 8, 2016 to May 30, 2016**
- **Minimum responses rate (based on the number of eligible employees): 368**
- **Number of responses: 4620**

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
	71%	60%	79%	60%	39%	68%	68%	65%
	69%	65%	79%	56%	33%	70%	65%	62%

Legend

Nova Scotia Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2017 and agreed with the instrument items.

Worklife Pulse

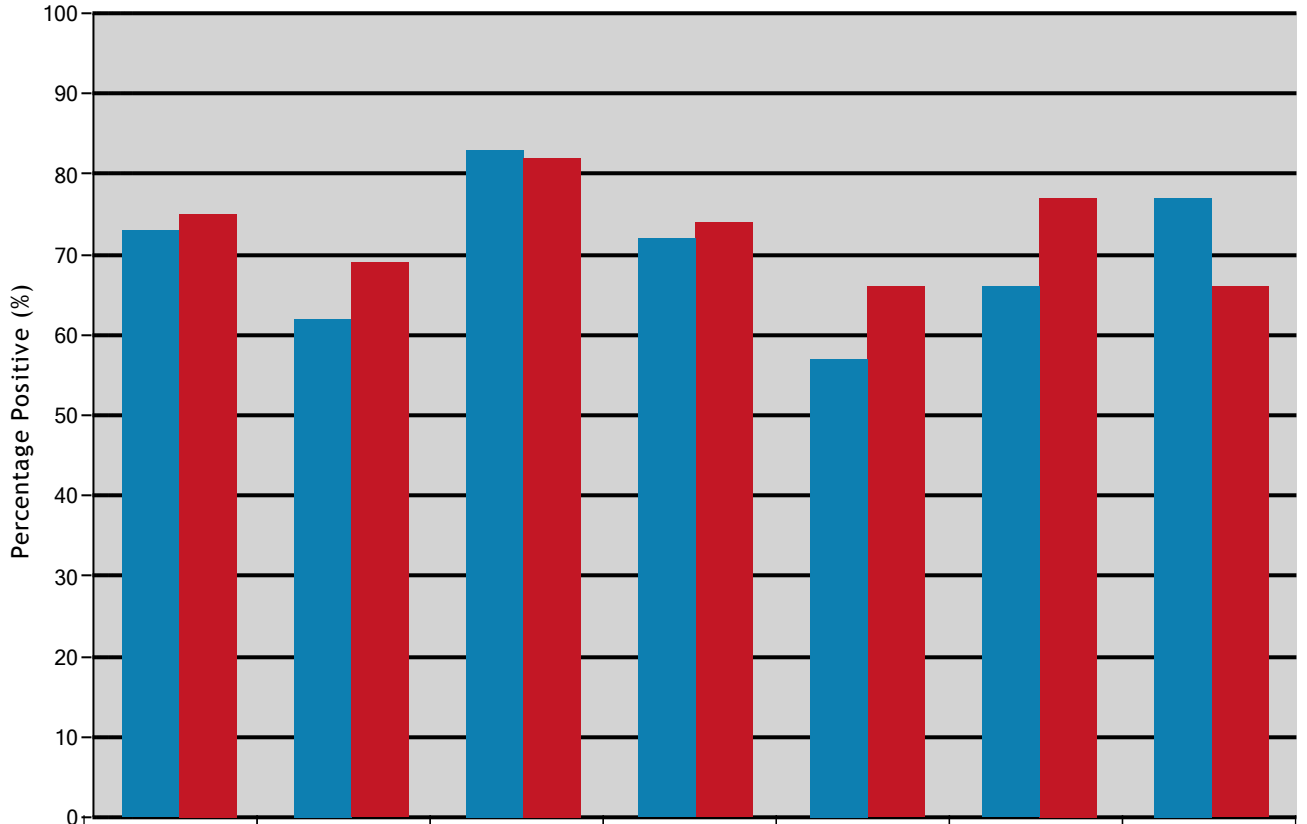
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: May 8, 2016 to May 30, 2016**
- **Minimum responses rate (based on the number of eligible employees): 376**
- **Number of responses: 5382**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	73%	62%	83%	72%	57%	66%	77%
	75%	69%	82%	74%	66%	77%	66%

Legend

Nova Scotia Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2017 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

Organization's Commentary

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

Nova Scotia Health Authority (NSHA) welcomed 30 Accreditation Canada surveyors and one patient surveyor from October 15 - 20, 2017. This was the first province wide survey since an April 1, 2015 amalgamation of nine (9) former District Health Authorities (DHAs) into a single Health Authority.

Our former DHAs held various accreditation ratings ranging from accredited, to accredited with exemplary status and it is important to understand the accreditation decision guidelines have changed since the former DHA's last survey visit. NSHA is still a relatively new organization focused on consolidation and standardization of our practices & processes. We appreciate there is much work to do, and much to learn from the accreditation team and each other.

NSHA's goals for this accreditation cycle were therefore focused around opportunity for standardization, and objectives for improving the quality of care:
1. Enhance quality improvement efforts and outcomes across the continuum of care and health service
2. Identify variability and areas needing improvement
3. Spread excellent & effective practices that occur within the NSHA
4. Stimulate positive and meaningful relationships both amongst teams, and across the continuum
5. Provide the foundation to align policies, practices and approaches
6. Obtain a common baseline of quality & safety measures

Early completion of Standards' questionnaires and relevant surveys strengthened our employees, physicians, leaders and governing board's commitment to a culture of quality and safety. The positive interaction with surveyors in 53 of our sites was a clear reflection of this commitment. We embraced the opportunity for the care and services we provide to be comprehensively evaluated and validated against 4,014 criteria, 26 priority processes within 28 standard sets.

Valuing and promoting a client and family centered care (CFCC) approach; NSHA was pleased to pilot Accreditation Canada's new assessment model - Co-creating the role of patients on the survey team. The experience was extremely positive and enhanced organizational perception of the focus on client centered care. Qualitative feedback received will help to inform NSHA's CFCC objectives of improving the care experience; enhancing engagement and partnerships; and improving staff knowledge and skill base in CFCC.

Overall, the strengths and challenges noted in the report align with those the organization are cognizant of, and are those which our strategic planning has been focused around to address areas for improvement.

Accreditation Canada notation of high level strengths included the achievement of our organizational survey goals; commitment to client & family centred care; courageous and resilient leadership; significant progress in a short timeframe and a solid vision for the future of health and

wellness in Nova Scotia. A few examples of further achievements to date NSHA would like to highlight include: an increased rate of positive overall experience of care reported in our patient experience survey; positive public response to our public engagement campaign 'Talk About Health'; reductions in wait times for home support, initial placement in long term care and MRIs; improved turnaround times for pathology and laboratory histology and cytology tests; the development of several provincial programs of care structures; and recipients of a number of recognition awards from bodies such as the Institute of Public Administration of Canada (IPAC), 3M, and the International Association for Public Participation (IAP2).

Accreditation Canada noted high level areas for improvement, and these included the need to strengthen Client and Family Centred engagement; build on Public and Community engagement / partnerships; rectify issues related to infrastructure and resource challenges; advance the integration and standardization of policies and procedures; and heighten the focus on our people, pace of change and resiliency. To provide further context, NSHA would like to highlight a few examples of the challenges the organization manages while continuously working to improve care. These include but are not limited to overall poor health status of Nova Scotians; high cost per capita of health care spending; significant number of facilities with aging infrastructure; wait times; physician recruitment; patient flow; and complexity of system change.

NSHA is committed to improving its quality of care and diminishing risks to clients, families and our workforce. Our strategic agenda positions our work to support short-term and long-term needs while managing our fiscal responsibility to Nova Scotians. Through the 2017-18 business plan, we are making decisions and taking actions that make a significant difference to the health of Nova Scotians. Many of these activities are currently underway and are aimed at creating a safer, more accessible environment within an organization that successfully engages the clients and families it serves and the workforce which supports the system. Examples include improvements/progress around:

- Infrastructure repair and renewal
- Investment in medical equipment
- One Person, One Record
- Primary Health Care family practices
- Mental Health and Addictions access
- Wait times in surgical sub-specialties
- Responding to capacity issues
- Appropriateness of care (Choosing Wisely activities)
- Recruitment strategies
- Leadership development, engagement and role clarity
- Building capacity in patient and family advisors
- Talk About Health public engagement

In addition, prior to the survey visit, teams developed detailed action plans to address potential gaps / pre-identified areas for improvement related to required organizational practices (ROPs). Many of these actions have already begun, and with the results of the accreditation survey now

known, all ROP action plans will be implemented, expediting improvements related to unmet tests for compliance.

Participating in the Accreditation survey process provided an opportunity for NSHA to learn what we are doing well and where we can improve. It enabled our staff, physicians, learners and volunteers to demonstrate the high-quality care and service they deliver, to share their successes and to learn together where we can do better.

We embrace the challenges ahead and continue to strengthen our commitment to patient safety in all areas. We have a great opportunity to change the narrative around health – planning and acting as one system, and rethinking / redesigning health services for access, sustainability, quality and safety.

We wish to extend a sincere thank you to the dedicated team of surveyors who were with us; their insight is most appreciated as we strive to achieve our mission of achieving excellence in health, healing and learning. Most importantly, we want to thank all staff and physicians, learners and volunteers who participated; including clients, family members and community partners who offered valuable perspectives to a process that directly supports our ability to improve care and service delivery. So much has been accomplished since we became one organization, and while we know more work lies ahead, this was an excellent opportunity to highlight our progress and gain important insight as we move forward. We have much to be proud of.

Appendix A - Qmentum

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

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

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

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

Priority Process	Description
Organ and Tissue Donation	Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.
Organ and Tissue Transplant	Providing organ and/or tissue transplant service from initial assessment to follow-up.
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge