Accreditation Report

Health PEI

Charlottetown, PE

On-site survey dates: September 24, 2017 - September 29, 2017

Report issued: October 18, 2017

About the Accreditation Report

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

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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

Health PEI (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

Health PEI'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: September 24, 2017 to September 29, 2017**

- **Locations**

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

1. Addiction Services Provincial Addictions Treatment Facility
2. Beach Grove Home
3. Cancer Treatment Centre
4. Community Hospital O'Leary
5. Garfield Street (Health PEI headquarters)
6. Harbourside Family Health Centre
7. Hillsborough Hospital
8. Home Care Queens County
9. Homecare - Summerside
10. Homecare Montague
11. Kings County Memorial Hospital
12. Margaret Stewart Ellis Home
13. McGill Centre
14. Mental Health & Addictions West-PCH
15. Montague Health Centre
16. Palliative Care Centre
17. Prince County Hospital
18. Prince Edward Home
19. Public Health - Sherwood Business Centre
20. Public Health - Summerside
21. Queen Elizabeth Hospital
22. Queen Elizabeth Hospital - Medicine (Adult)
23. Queen Elizabeth Hospital - Medicine (Pediatrics)
24. Riverview Manor

25. Souris Hospital
26. Stewart Memorial
27. Tyne Valley Health Centre
28. Wedgewood Manor
29. Western Hospital
30. Youth Recovery Centre, Summerside - Strength Program

- **Standards**

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

System-Wide Standards

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

Population-specific Standards

5. Population Health and Wellness

Service Excellence Standards

6. Ambulatory Care Services - Service Excellence Standards
7. Biomedical Laboratory Services - Service Excellence Standards
8. Cancer Care - Service Excellence Standards
9. Community-Based Mental Health Services and Supports - Service Excellence Standards
10. Critical Care - Service Excellence Standards
11. Diagnostic Imaging Services - Service Excellence Standards
12. Emergency Department - Service Excellence Standards
13. Home Care Services - 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. Perioperative Services and Invasive Procedures - Service Excellence Standards
20. Point-of-Care Testing - Service Excellence Standards
21. Primary Care Services - Service Excellence Standards

22. Public Health Services - Service Excellence Standards
23. Rehabilitation Services - Service Excellence Standards
24. Reprocessing of Reusable Medical Devices - Service Excellence Standards
25. Substance Abuse and Problem Gambling - Service Excellence Standards
26. 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)	117	0	0	117
Accessibility (Give me timely and equitable services)	161	3	0	164
Safety (Keep me safe)	808	45	18	871
Worklife (Take care of those who take care of me)	197	5	1	203
Client-centred Services (Partner with me and my family in our care)	658	15	0	673
Continuity (Coordinate my care across the continuum)	141	2	2	145
Appropriateness (Do the right thing to achieve the best results)	1344	84	16	1444
Efficiency (Make the best use of resources)	79	1	0	80
Total	**3505**	**155**	**37**	**3697**

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	35 (97.2%)	1 (2.8%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	93 (96.9%)	3 (3.1%)	0	143 (97.9%)	3 (2.1%)	0
Infection Prevention and Control Standards	37 (92.5%)	3 (7.5%)	0	28 (96.6%)	1 (3.4%)	2	65 (94.2%)	4 (5.8%)	2
Medication Management Standards	61 (82.4%)	13 (17.6%)	4	50 (84.7%)	9 (15.3%)	5	111 (83.5%)	22 (16.5%)	9
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	34 (97.1%)	1 (2.9%)	0	38 (97.4%)	1 (2.6%)	0
Ambulatory Care Services	41 (93.2%)	3 (6.8%)	2	75 (96.2%)	3 (3.8%)	0	116 (95.1%)	6 (4.9%)	2
Biomedical Laboratory Services	67 (95.7%)	3 (4.3%)	1	100 (96.2%)	4 (3.8%)	1	167 (96.0%)	7 (4.0%)	2
Cancer Care	99 (98.0%)	2 (2.0%)	0	125 (97.7%)	3 (2.3%)	0	224 (97.8%)	5 (2.2%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Community-Based Mental Health Services and Supports	40 (90.9%)	4 (9.1%)	0	88 (94.6%)	5 (5.4%)	1	128 (93.4%)	9 (6.6%)	1
Critical Care	49 (98.0%)	1 (2.0%)	0	112 (97.4%)	3 (2.6%)	0	161 (97.6%)	4 (2.4%)	0
Diagnostic Imaging Services	66 (98.5%)	1 (1.5%)	0	67 (98.5%)	1 (1.5%)	1	133 (98.5%)	2 (1.5%)	1
Emergency Department	68 (95.8%)	3 (4.2%)	0	103 (96.3%)	4 (3.7%)	0	171 (96.1%)	7 (3.9%)	0
Home Care Services	47 (95.9%)	2 (4.1%)	0	75 (98.7%)	1 (1.3%)	0	122 (97.6%)	3 (2.4%)	0
Hospice, Palliative, End-of-Life Services	43 (95.6%)	2 (4.4%)	0	107 (99.1%)	1 (0.9%)	0	150 (98.0%)	3 (2.0%)	0
Long-Term Care Services	54 (98.2%)	1 (1.8%)	0	96 (97.0%)	3 (3.0%)	0	150 (97.4%)	4 (2.6%)	0
Medicine Services	45 (100.0%)	0 (0.0%)	0	77 (100.0%)	0 (0.0%)	0	122 (100.0%)	0 (0.0%)	0
Mental Health Services	49 (98.0%)	1 (2.0%)	0	90 (97.8%)	2 (2.2%)	0	139 (97.9%)	3 (2.1%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	87 (100.0%)	0 (0.0%)	1	158 (100.0%)	0 (0.0%)	3
Perioperative Services and Invasive Procedures	109 (94.8%)	6 (5.2%)	0	104 (95.4%)	5 (4.6%)	0	213 (95.1%)	11 (4.9%)	0
Point-of-Care Testing	25 (65.8%)	13 (34.2%)	0	32 (69.6%)	14 (30.4%)	2	57 (67.9%)	27 (32.1%)	2
Primary Care Services	52 (89.7%)	6 (10.3%)	0	85 (93.4%)	6 (6.6%)	0	137 (91.9%)	12 (8.1%)	0
Public Health Services	46 (100.0%)	0 (0.0%)	1	67 (98.5%)	1 (1.5%)	1	113 (99.1%)	1 (0.9%)	2
Rehabilitation Services	44 (97.8%)	1 (2.2%)	0	79 (98.8%)	1 (1.3%)	0	123 (98.4%)	2 (1.6%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Reprocessing of Reusable Medical Devices	82 (96.5%)	3 (3.5%)	3	40 (100.0%)	0 (0.0%)	0	122 (97.6%)	3 (2.4%)	3
Substance Abuse and Problem Gambling	45 (100.0%)	0 (0.0%)	0	82 (100.0%)	0 (0.0%)	0	127 (100.0%)	0 (0.0%)	0
Transfusion Services	67 (97.1%)	2 (2.9%)	6	62 (93.9%)	4 (6.1%)	3	129 (95.6%)	6 (4.4%)	9
Total	**1411 (95.3%)**	70 (4.7%)	19	1993 (96.3%)	76 (3.7%)	17	3404 (95.9%)	146 (4.1%)	36

* 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 (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
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	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)	Met	1 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 (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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 (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	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)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Unmet	11 of 12	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care)	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 (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	5 of 5	0 of 0

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	4 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Unmet	4 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 (Home Care Services)	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 (Medicine Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics 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			
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Unmet	6 of 7	0 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Critical Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Unmet	3 of 3	0 of 2
Falls Prevention Strategy (Emergency Department)	Unmet	2 of 3	0 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Hospice, Palliative, 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)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Unmet	3 of 3	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	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
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0

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

Summary of Surveyor Team Observations

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

Health Prince Edward Island (PEI) continues to make quality improvement a priority by participating in the Accreditation Canada process. The survey visit was comprehensive, and the eleven surveyors were able to meet with a range of staff, physicians, patients and stakeholders. Written, verbal and visual evidence was provided to confirm Health PEI's level of compliance with the standards. And most importantly, the "Islandness" experience of everyone's warmth and honesty in answering questions and demonstrating knowledge, skills and passion for health care was palpable and much appreciated.

The population of PEI continues to grow, surpassing 150,000 residents, as a result of the government's action plan. This has implications for Health PEI to be responsive to changing needs of immigration, birth rates and a large retiree population.

The Board of Directors of Health PEI is comprised of eleven highly engaged and motivated community leaders. The members come from across the Island, representing various community perspectives. The Board helps set the tone for the organization's commitment to quality and safety through walking tours and learning first-hand from frontline staff and patients and families about quality and safety of care provided. The Board closely monitors strategic performance indicators to assess progress towards goals.

Community-based health services across the continuum are in place to provide access to care. Health PEI partners with numerous government and non-government organizations throughout the province. Community partners affirm the importance of collaborative efforts achieved with Health PEI. The toll-free language translation service, coordination of care with EMS (Emergency Medical Services) for paramedic palliative support at home, and provincial stroke care coordination are just a few examples of successful partnerships.

Community members provide input into the Quality & Safety Sub-Committee of the board. Community outreach helps to provide satellite services in rural areas. Examples of bridging hospital to home were shared, for example the success of the Stroke Care Program and many successes with mental health programs and services. COACH – Caring for Older Adults in the Community and at Home, is an excellent example of connecting seniors to services to keep them in their homes. Health PEI heard through consultations with the public that increased communication and meaningful input is desired. It is hoped that the Community Health Engagement Committees will continue to support increased connections and input.

Health PEI has integrated the LEADS (Leading Self, Engaging Others, Achieving Results, Developing Coalitions and Systems Transformation) framework into leadership performance and development plans. As well, a Leadership Development Workshop Series has supported increased knowledge and awareness of quality, risk management and other operational information. The leadership of Health PEI is encouraged to continue their efforts on reducing wait times and improving patient flow, improving access to primary care, and strengthening medical leadership and Bylaws.

With over 4600 staff, physicians, and volunteers, Health PEI has worked hard to create a welcoming culture, atmosphere and workplace across the province. Staff report a workplace that is “welcoming, professional, trusting and safe.” Despite that, recruiting and retaining physicians and staff continues to be a challenge faced by Health PEI. Some clinical services such as mental health are facing significant access and treatment issues as a result of lack of specialized professionals.

Access has been an area of focus for Health PEI. Leadership is aware of the challenges and has established goals to reduce wait times in priority areas. Technological improvements such as the introduction of the electronic health record (in acute inpatient services primarily), and remote patient monitoring are helping to improve care. It will be important to continue to roll out an electronic health records solution in all sectors across the province.

The implementation of a Provincial Patient and Family-Centred Care Steering Committee has helped to increase everyone’s (staff, patients, families) involvement with planning, quality improvement projects and evaluation of services. Patient and family advisors are members of several committees, offering valuable and timely ideas and feedback. Additionally, patient experience survey data demonstrates a high level of satisfaction among people receiving Health PEI services. Changes such as the Family Presence Initiative, make it possible for family members to be with their loved ones while in care at any time, have been very well received and welcomed.

Health PEI has much to be proud of in terms of accomplishments to date and should work to maintain the gains achieved, while continuing to address challenges and opportunities ahead. The commitment, teamwork and dedication of your staff and community will help you as you continue in your journey of being the “one island health system.”

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 resident is communicated effectively during care transitions.	· Long-Term Care Services 9.19
Medication reconciliation at care transitions Outpatient services only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications at ambulatory care visits where the client is at risk of potential adverse drug events. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and how often medication reconciliation is repeated.	· Cancer Care 15.6
Patient Safety Goal Area: Medication Use	
Antimicrobial Stewardship There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	· Medication Management Standards 2.3
High-Alert Medications A documented and coordinated approach to safely manage high-alert medications is implemented.	· Medication Management Standards 2.5

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 · Diagnostic Imaging Services 15.6 · Obstetrics Services 8.6

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

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.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
2.3 The governing body includes clients as members, where possible.	

Surveyor comments on the priority process(es)

The Board of Health PEI is comprised of eleven dedicated, experienced professional community leaders who are passionate about their role in serving PEI's One Island Health System in providing the best and safest care. In addition to having responsibility HPEI's financial viability and stakeholder accountabilities, the board has worked on improving quality of care by visiting clinical areas and continually strives to improve their own governance functioning through board retreats and learning and applying best practices. An example is the board's use of the LEADS framework in enhancing their board development. The LEADS framework includes: Leading Self, Engaging Others, Achieving Results, Developing Coalitions and Systems Transformation.

The board has established the following committees and sub-committees: Compliance and Monitoring, Quality and Safety, and Public Engagement Committee. The Board members report undergoing a fulsome orientation to prepare them for their role and feel that they generally receive information at least a few days prior to a meeting. While this may provide adequate time to prepare for board meetings and decision making, a minimum of one week is suggested. The board receives information via e-mail and Health PEI makes a laptop available should one be required.

The board sets the tone for its commitment to the Health PEI values. The strategic plan and corporate goals and objectives have been streamlined and the board receives dashboard reporting to provide oversight for performance and accountability. Strategic Performance Indicators (SPIs) are monitored.

With oversight for physician credentialing and re-appointments, the board receives recommendations from the Provincial Medical Advisory Committee (PMAC), after the local Medical Advisory Committee

(MAC) has signed off. The board described adding new rigour in ensuring the medical bylaws are reviewed and updated.

The board is committed to quality patient care and has embraced patient-centred care. Patient stories are included in board meetings and a patient representative sits on the Quality & Safety sub-committee. The board is able to make recommendations for government appointments to the board. Currently a client is not included as a board member, although the board has indicated that they are considering this.

The board has participated in evaluating itself using the Accreditation Canada Governance Functioning Tool, along with other surveys evaluating individual board member performance.
In describing things that make the Health PEI board proud, examples such as: working hard on tough decisions, tackling challenges, monitoring goals, appreciating the depth and wealth of talent and “gelling” were shared.

Priority Process: Planning and Service Design

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

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

Surveyor comments on the priority process(es)

Health PEI is committed to meeting the needs of those they serve and work hard with their community and stakeholders to understand and identify health needs and achieve the vision of “one island health system supporting improved health for Islanders.” Community partners describe their relationship as strong, with key contacts and linkages particularly at the facility level. With many changes in senior leadership over the past several years, corporate level collaboration has at times been more challenging. There is hope that there will be some stability for the organization going forward.

Clinical priorities are established appreciating resource availability, and the ethical decision making framework is used to reflect the organization values and impact of decisions. Planning is aligned with fiscal forecasts and environmental scans to make informed choices. There is a cascade from strategic plans to operational activities through priorities established. Business plan indicators and quarterly reports are being revised based on the new strategic plan. The health information unit reviews CIHI reports, trends and identifies potential needs and Health PEI works with patient and family advisors to create proposed options. One example is the work on standardizing ambulatory clinic services currently.

A dashboard analytics tool along with enterprise business intelligence with the government of PEI is planned in the future, and the organization is encouraged to roll out and educate managers in the use of these tools. Patient stories have been a positive addition to the annual report and a shorter 2-page version of the annual report provided to primary care sites throughout PEI.

The values of Caring, Integrity and Excellence were reviewed and continued to resonate with the extensive consultation groups feedback was obtained from. In order to manage and communicate change the staff resource centre is available on the external website. Links to toolkits for change and how to incorporate change management principles into projects are defined.

Community partners look forward to the opportunities to expand some of the successes with Health PEI to date, with more opportunities to collaborate with fewer silos, a system more focussed on prevention as opposed to a medical model, and ensuring recruitment and succession for personnel.

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 annual budgeting process is included in the regular planning cycle for the organization. Planning for the next two fiscal years begins each September based on the second quarter forecast. Financial analysts work with the managers and medical leads to review the financial results and determine causes for over expenditures.

A financial management education series is provided to managers to support their understanding of their budgeting and financial management responsibilities. In planning the budget, historical trends are reviewed and internal and external influencing factors are considered.

A resource allocation template is utilized for decision making. In addition, a mitigation template is developed. Once approved by the senior executive, the proposed budget is reviewed by the Audit Committee of the Board and tabled for Board endorsement. Capital budget planning is initiated each September with a five-year planning cycle. Each submission is fully scoped with an expert opinion on costing. Once approved by senior executive, the capital plan is moved forward for Board endorsement.

The senior executive team reviews detailed budget and forecasting reports quarterly. The team scrutinizes a detailed analysis of resource utilization in order to improve the effective and efficient use of resources.

Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.4	Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.	

Surveyor comments on the priority process(es)

The Human Resources Department has made significant strides toward supporting a culture that encourages quality work life and healthy and safe work environments. Making communication a priority, the CEO initiated 'Soapbox' an open invitation to staff to write with questions or concerns with replies posted for all staff to view. An electronic Staff Resource Center has been implemented to provide current information on topics such as training and development programs and workplace wellness and safety activities.

A Declaration of Commitment to Psychological Health and Safety was made with the Mental Health Association of Canada and HealthCare CAN to endorse psychological health and safety in the workplace. Staff that are fatigued or stressed are identified earlier and provided support through programs such as Employee Assistance Programs and workplace accommodation. The Harassment in the Workplace policy is in place with a planned review in collaboration with the Unions.

A multi-year nursing recruitment strategy has been developed. Robust education and training programs are in place for new and experienced managers including topics such as LEADS 101, coaching skills, effective communication and budget forecasting. The on boarding program and peer-to-peer support program for new managers is commendable. A policy and procedure for performance reviews is in place and there has been a significant improvement in the number of performance reviews that have been conducted.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Quality is embedded in the Strategic Plan of Health PEI. From the board to the bedside, quality and safety is embraced by all levels of staff at Health PEI. The board's Quality and Safety Sub-committee is made aware of issues and outcomes, and receives regular reports and data. The Senior Management Group plays a key role in participating in quality walks and huddles every two weeks, and feels much progress is made in the face to face interactions with staff. Staff are proud to share their efforts with the Family Presence – Better Together initiative they have implemented this year. The Integrated Quality and Patient Safety Framework has been approved by the board and actions have been rolling out in response to the Patient Safety Culture Survey. Patient and staff safety have been a focus as the organization has undergone a review of mental health services and is working towards addressing the 88 recommendations made for the Hillsborough Hospital site.

The structure of Quality, Safety and Risk at Health PEI includes a leadership team, 19 quality improvement teams, a clinical and organixational ethics team, 6 quality/risk coordinators, a patient safety coordinator, a risk advisor, and health information support. Due to scheduling challenges and locum appointments, sometimes it is difficult for physicians to fully embrace their opportunity and role in the quality agenda. There has been some preliminary work initiated on enterprise risk management, and the organization is encouraged to continue this effort. In an effort to be more transparent, Health PEI has begun to post level 4 and 5 incident data on their external website. As well thorough quality reviews and disclosure to patients and families is evident and commendable.

Quality Initiatives such as the Seniors Friendly Policy, tele-health education for stroke education, meeting bariatric patient needs, bedside report/handoff are just a few of the many efforts of the various Health PEI sites and services. The organization is encouraged to leverage the learnings across sites to achieve more standardized practices. Staff are recognized for quality efforts through the "Leadership Excellence in Quality and Safety Award" annual recognition.

Client experience results are generally positive and patient advisors are included in all quality committees, including at the board level. The patient navigator office has played a key role in helping the public understand trends, access and wait times. Patients report challenges with not having one complete electronic health record, particularly for cancer care, ambulatory care and primary care. As a result, access to accurate information is not timely. Patients are concerned about staffing issues and feel more physicians or nurse practitioners are required. As more newcomers come to PEI, consideration of different population demographics, language and cultural needs will need to be addressed.

The organization has worked very hard in trying to plan and implement a policy system, however there are a great number of policies related to key organizational functioning (such as facility maintenance for example) that are not yet part of the Medworxx system. Staff report having had many challenges related to finding policies. Many clinical areas have outdated binders, which can lead to errors. Improvement is anticipated as the Medworxx system vendor has made changes to the search functionality. This work is imperative to ensure that all levels of staff have access to current policies and procedures.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.12	Information about trends in ethics issues, challenges, and situations is used to improve the quality of services.	

Surveyor comments on the priority process(es)

The Clinical and Organizational (C&O) Ethics Committee and Research Ethics Board (REB) support the values of Health PEI through the creation of an Ethics Support Decision Tree and the Ethical Decision Making Algorithm. These tools should facilitate directing inquires to the appropriate team, whether it is C&O Ethics Committee, REB, or the provincial Whistleblower
The C&O Ethics Committee and the REB are made up of dedicated and passionate people with a variety of clinical and non-clinical backgrounds. The committees strive to be inclusive and aware of the geographic and work-site of members to ensure robust representation as well as having committee members locally available when consults are made.

The C&O Ethics Committee is available to receive consults in both an urgent and non-urgent manner. Overall, the utilization of the C&O Ethics Committee consult availability is low. The committee is creating ethics scenarios to inform leadership, the Board and staff in general. The goal is to enhance knowledge of ethics concerns and raise awareness of the availability of the C&O Ethics Committee.

The C&O Ethics Committee and REB align with other regional and national ethics board. The REB follows established, standardized processes to approve research within Health PEI. The REB has established a positive relationship with the University of PEI REB to facilitate research associated with both organizations. The Ethics Support Decision Tree will facilitate determining when quality improvement initiatives may cross into realm of research.

The C&O Ethics Committee is not yet trending data related to ethics consults. Increasing awareness of the work of the committees and, what ethics dilemmas are is hoped to improve the utilization of appropriate ethics consults.

Priority Process: Communication

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

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

Health PEI is commended on its work on communications, particularly with some of the community partners that work together – for example EMS (Emergency Medical Services) and Heart and Stroke in coordinated responses and communications. Various communication strategies are used to communicate internally and externally, such as the communication plans and tactics, face to face, walk abouts, e-mail, monthly bulletins, Provincial Medical Advisory Committee (PMAC) and the staff resource centre on line to name a few.

Media spokesperson training and public communication education is provided to leaders. There are protocols on ensuring announcements are made in government prior to a broader release. The staff work closely with government to align efforts, such as the new website for PEI, including Health PEI.

Acute care has an electronic health record, with twenty three solutions. There is a client registry program, ISM used by government and for case management, a provincial drug information system, PACS system, corporate systems such as Oracle, numerous small data bases and clinical service systems. Many of the systems are legacies and others are new, but not necessarily integrated. There are plans underway to move away from Dictaphones to a voice recognition software, that is seen as a positive improvement.

There was a delay in implementing the policy plan while the search function in Medworxx was repaired. Staff indicate that there are numerous inventories of policies that require categorization and education and training to be successful. A new policy analyst position planned will be important in ensuring that the updates, revisions and migrations of policies takes place.

New privacy legislation that came into effect in July 2017 is rolling out. Privacy and confidentiality of client information is protected and front line staff receive orientation on the principle of “need to know” and have role-based access which is audited. While patient access to their records is more readily available through health records in acute care, patients report having experienced challenges receiving their records in some primary care settings.

Communications staff has worked hard on developing a social media policy and are working to ensure encrypted e-mail accounts are available to physicians working within Health PEI. Issue notes are used to communicate with government and a briefing book for all senior managers includes key messages, key dates, factors and updates that ensures awareness and clarity of information on projects and services.

Staff and physicians have access to evidence and information through the library at the QE Hospital, as well as some journals on desktops.

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		
3.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!

Surveyor comments on the priority process(es)

The team with oversight for support services, maintenance, facilities planning, biomedical, facilities management and infection prevention control is proactive and collaborative in monitoring and addressing patient and staff needs. Patient experience surveys provide some input, and service areas submit work requisitions electronically and can track progress on work orders. The facilities are clean and the buildings are generally in a good state of repair. Patient wandering systems, and locked units are used to keep patients safe. There is a notable discrepancy for some of the older facilities, where it is more difficult and costly to retrofit and update. The team appreciates that the aging infrastructure is a challenge, especially with limited capital funding. Building condition assessments of all facilities, particularly the rural and smaller ones should be completed to make informed planning decisions.

Maintenance budgets and project needs are addressed through submissions and presentations to finance. In 2017, face to face opportunities were provided on each site to present in person the needs and requests. Priority items regarding fire, life and safety rise to the top of the needs and larger projects over $500,000 are packaged and submitted to Health PEI for Senior Management Group sign off and are then submitted to treasury. There is project management support available for larger projects, and P3 (Public, Private, Partnerships) have not been used to date for Health PEI.

Processes are in place to annually/regularly assess steam boilers, generators, medical gases, fire alarms, sprinklers, ceiling lifts, ventilation, elevators, sterilizers. Contracts are in place to ensure this work is completed. In May 2017, a preventive maintenance software system was transitioned into use. A policy identifies which devices require maintenance and the frequency based on risk stratification. There is preventive maintenance scheduling and a reported strong relationship with clinicians in order to ensure access to equipment in specialized areas. Equipment that has a FAC number makes the history of maintenance work easier to track.

Infection, prevention and control works closely with facilities staff. Examples were shared about construction barriers, baseline air monitoring and the infection control nurse follows up if there are challenges. A floods and mitigation policy is in draft and there has been a delay in finalizing it onto the new Medworxx policy system. Isolation rooms and air exchange are problematic in some areas. Newer

operating rooms and some areas are able to monitor and ensure requirements are met, while other areas are tested only annually and there is no way to confirm numerically.

When asked about patient and family input into designs, examples such as the Chapel/patient lounge change, public WIFI access and nuclear medicine change rooms and washrooms were shared. The organization aims for LEED silver for new builds and a number of environmental improvements continue with recycling and increased efficiency products.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A comprehensive coordinated and systemic approach to emergency management has been developed. Under the leadership of the Director of Emergency Health and Planning/Designated Emergency Service Officer, a solid emergency management framework has been produced and rolled out. An organizational all hazard and emergency response plan is in place, along with individual site plans. Threat and vulnerability assessments have been conducted for each site.

Ongoing collaboration occurs with designated Ministry staff, the office of the Public Health Officer and relevant community agencies. The Incident Command System is in place. Emergency management education is provided to all levels of the organization and tabletop and operation-based exercises are conducted regularly. Recent experiences with site power outages have provided real time opportunities to use the emergency response plan.

Detailed incident debriefings occur after each emergency incident with recorded recommended actions and identified responsible persons. The Provincial Business Continuity and Emergency Management Coordinator investigates emergency incidents and develops, implements and maintains viable protection and recovery strategies.

A public information plan is in place. There has been significant progress in the implementation of the emergency management plan. The organization is encouraged to continue to enhance the coordination of the system plan by clearly articulating the roles and responsibilities of the system and site staff including the development of a joint communication structure.

Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
3.3	Timely access for clients is coordinated with other services and teams within the organization.	!
3.8	Standardized processes and procedures are followed to coordinate timely inter-facility client transfers and transfers to other teams within the organization.	
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
13.4.5	The approach specifies targets for improving client flow (e.g., time to transfer clients to an inpatient bed following a decision to admit, emergency department length of stay for non-admitted clients, transfer of care times from emergency medical services to the emergency department).	**MAJOR**
13.4.8	Client flow data is used to measure whether the interventions prevent or reduce overcrowding in the emergency department, and improvements are made when needed.	**MINOR**

Surveyor comments on the priority process(es)

The organization faces significant patient flow challenges in a variety of areas related to increased demand for services, increased complexity of the patients seeking care and bottlenecks related to access. The organization has identified significant challenges related to timely access to Mental Health and Substance Use expertise, in particular Psychiatry and Psychology assessment for ED and inpatients. They also experience long delays for their patients waiting placement in Long Term Care (LTC). One of the hospitals surveyed had 16 of their 30 beds currently occupied by patients waiting for placement in LTC. This lack of flow into the LTC sector causes a bottleneck for other acute care services and has implications for patient and family referral behavior. In one instance, a family drove their mother to the QEH, bypassing the hospital closest to their mother's community care center in hopes that she would be

admitted in Charlottetown (which is where the family lived); ultimately the family left the QEH ED without being seen due to long wait times and went back to Kings County Memorial Hospital where she was admitted until a LTC space becomes available (resulting in a 45 minute drive each way in order to visit their mother).

Health PEI has put a number of innovative strategies in place to try and decrease demand and increase efficiency related to patient Flow. These strategies include the creation for a provincial patient flow position, the establishment of a clinical decision unit in the ED to allow some patients to receive some additional care in hopes of avoiding an inpatient admission as well as the creation of a paramedic@home position that allows paramedics to respond to individuals in need in the community in the hope of offering care that may prevent the need to access acute care services. The paramedics have access to online medical consultation (OLMC) physicians who are typically ED physicians working within the Health PEI system. Other strategies including a First Available Bed policy for LTC, and a twice weekly multiagency collaborative team the "Bridge" address flow issues and allow for innovative problem solving at an individual patient level.

There was evidence of a concerted effort to work at a site level to optimize flow, and optimism that new programs and processes that have just been put in place will benefit intraprovincial and interprovincial patient flow. As an example, the new utilization report related to bed availability has resulted in increased transparency related to the availability of Mental Health beds and a corresponding increase in conversations to help understand discrepancies between beds shown as "available" on the bed report and actual beds available to move a patient to.

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: Cancer Care		
3.8	Radiotherapy only: Information about equipment maintenance schedules is provided to clients and families.	
Standards Set: Reprocessing of Reusable Medical Devices		
3.5	Appropriate environmental conditions are maintained within the MDR department and storage areas.	!
6.7	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
7.9	Policies and SOPs are regularly updated, and signed off according to organizational requirements, as appropriate.	!

Surveyor comments on the priority process(es)

Reprocessing of medical devices was surveyed at both the Queen Elizabeth Hospital (QEH) and Prince County Hospital (PCH). Reprocessing services are not contracted out at these sites and loaned devices are managed appropriately. Single use devices are not reprocessed.

There is very strong clinical leadership at both sites, reporting directly to senior level staff. Clinical managers are very supportive of Medical Devices Reprocessing Department (MDRD) staff and their roles, and in turn, staff feel supported and encouraged by their managers. All staff in the MDRD are certified medical device reprocessing technicians (MDRT) and rightfully take pride in the quality of their work.

Immediate-use (flash) sterilization is done approximately 5 times per year in the operating rooms (OR) by OR staff and is documented. A specific policy and procedure does not exist. Staff report that they follow the Operating Room Nurses Association of Canada (ORNAC) standards. The team is encouraged, in consultation with MDRD staff, to develop a policy and procedure for immediate-use sterilization, detailing acceptable indications and contraindications, quality control measures, documentation, etc.

There has been considerable progress made since the last survey with respect to reducing risk and increasing patient safety by eliminating reprocessing outside of the central department. MDRD personnel at each site now have oversight of all reprocessing activities in their respective hospital. With respect to reprocessing of endovaginal ultrasound probes, at Queen Elizabeth Hospital, qualified reprocessing staff go to the diagnostic imaging department to reprocess the ultrasound probes in a

properly designed reprocessing area using an automated high level disinfection system. At Prince County Hospital, ultrasound probes are cleaned at point of use and transferred appropriately to the MDRD for reprocessing. The organization is to be congratulated for centralizing reprocessing activities and identifying qualified and accountable leaders.

Qualified medical devices and reprocessing staff work in the ambulatory care areas to reprocess endoscopes. In addition to their medical devices reprocessing certification, they also receive device-specific training from the vendor. There is a comprehensive orientation in place for new staff reprocessing endoscopes, and clinical leaders at QEH conduct endoscope-specific competency testing of all staff frequently throughout the year. There is opportunity to establish general competency testing annually for all staff at both sites. The CSA is one source of templates for such testing.

A number of quality initiatives related to process and outcome were launched in the department. In response to increasing reports of retained bone cement on instruments at QEH for example, staff launched an internal review of their reprocessing process and initiated enhanced inspection while the problem was being corrected. Safety crosses were created at QEH, with indicators deemed by staff to be relevant tracked on a daily basis. MDRD staff at PCH developed a tracking method for staff education, supporting accountability and improving compliance. There are weekly audits of processed trays at both sites (using a shared tool!), with direct feedback given to staff involved. Service volumes and patterns of medical device use are collected on a regular basis to inform service delivery.

Many policies and procedures and Standard Operating Procedures (SOPs) were being updated at the time of the survey. Document storage is different at each site. The team is encouraged to develop shared policies and procedures when appropriate, and consider a document management system to simplify access and facilitate timely revisions.

At Queen Elizabeth Hospital, staff state that although temperature and humidity are monitored manually by the team, no alert systems are in place. Positive pressure ventilation and air exchanges per hour cannot be verified on an ongoing basis. At Prince County Hospital, temperature and humidity are monitored locally by the team (no alert), and centrally by maintenance personnel with an alert system in place. Although the system is designed to keep the sterile storage area under positive pressure relative to contaminated areas, the pressure is not directly monitored.

In addition to mandatory hospital training, staff attend weekly in-service sessions on topics related to reprocessing. Staff will attend in person when possible, but if not possible, they review the educational material at another time and sign off that they have done so. Attendance logs are maintained. MDRD leaders try to sponsor staff to attend national reprocessing conferences when possible.

There is a close working relationship with IPAC colleagues and good working relationships with vendors for staff training and equipment maintenance. Biomedical Engineering staff provide excellent preventative maintenance (PM) services to the MDRD and to the organization as a whole. A new software program will allow for a more robust measurement of quality indicators, improved efficiency, and enhanced customer service. PM records are appropriately maintained. There is an established

equipment procurement process in place which appears to work well, however end-users continue to find the process quite complicated.

Performance appraisals are done regularly and all were up to date at the time of the on-site survey.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

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

Unmet Criteria		High Priority Criteria
Priority Process: Population Health and Wellness		
5.1	The organization has a process to select evidence-based guidelines for its services for its priority population(s).	
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

Chronic Disease Prevention and Management is an objective within Health PEI's strategy. It is in the portfolio of the Vhirf og Family & Community Medicine, & Hospitals West and is paired with a Chief Administrative Officer as a dyad. A director and manager lead many of the operations for chronic disease prevention and management. The organization has also logically included primary care within this portfolio and director's purview. Health promotion remains in the domain of the Department of Health and Wellness.

The organization has looked at its population and identified stroke, diabetes, COPD (Chronic Obstructive Pulmonary Disease), hypertension and cancer as areas of focus. Additionally, smoking cessation (in the form of the Ottawa Model) has been adopted by both acute care and community care.

The organization has developed strategies specific to diabetes, stroke, COPD and cancer that are maturing and it is possible to see early gains. For example, there has been both a reduction in the "Ambulatory Care Sensitive Conditions Rate", which is often a surrogate marker for efficacy of care in the community. Further, over the past two years it has been observed that there has been a 23% reduction in emergency visits by those with COPD. Health PEI should be proud of these results and encouraged to continue on with its strategic direction of promoting improved health outcomes through prevention and education.

The PEI Diabetes strategy has piloted prevention programs and has seen the expansion of medication coverage, as well as insulin pump coverage for children with type 1 diabetes. It appears that this program is making progress in its strategy and maturing as it standardizes care across the province. A patient navigator has been hired for the stroke program and has provided outreach to some marginalized communities, for example the homeless population.

The organization has continued to work with hard to reach populations, which that have found are often high-cost participants in the health care system. They have worked to reduce barriers by translating materials into mandarin and meeting with indigenous communities (as well as providing outreach). Health PEI should continue these efforts and consider expanding their role in other communities that face barriers to health care.

Additionally the organization is aware of the demographic and risk factors contributing to the increasing burden of chronic disease and should continue to focus on this area at the very least, but also continue to invest significantly in prevention and management strategies.

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.

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: Ambulatory 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.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
11.1	An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.	!
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.	
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

Ambulatory Services at Queen Elizabeth Hospital (QEH) covers a broad array of services on multiple areas. More than 60 different services are offered to both local and provincial locations. They are distributed in multiple rooms and clinics throughout an area of 60,000 square feet and serve close to 100,000 patients annually. They include interdisciplinary and single discipline services such as Hemodialysis, Asthma Center, Endoscopy-Cystoscopy-Lithroptripsy, Eye Center, Same-Day Treatment. All areas visited are working diligently to deliver excellent healthcare to their clients.

Due to the ongoing growing pressures and the need to evaluate planning and resources, an external provincial review was contracted to provide a framework to guide the organization in the delivery of the ambulatory care services. The team reported the process was quite comprehensive and involved many focus groups, stakeholder's consultations and populations analysis. As a result, and after several months of work, thirteen (13) recommendations were provided. Leaders commented that although the report has provided a good value for their development and planning, there were some limitations, such as the absence of workload data that didn't allow the reviewer to identify future requirements for the service. The report was accepted and a work plan was endorsed for a six-month period. The team is commended to for their effort to put together a Work Plan to address the high priority issues and is encouraged to continue working on implementation the outstanding recommendations.

The leadership has developed and promoted a culture of safety, quality and patient-family center care that is evidence throughout the each of their services. Also, there is a culture of mutual respect and team work that invites everyone to participate and collaborate in their daily activities and duties. The team is encouraged to complete their strategic plan, goals and objectives that are specific to the service.

There is a Patient Advisor that sits on the Ambulatory Service Provincial Quality Improvement Committee and provides input in multiple areas, such as service design, resources and new initiatives. The team is encouraged to continue to build on the current approach and gather further input from family and patients who use their services. There are also Patient Advocacy meetings for service such as hemodialysis that meets quarterly.

There are issues with staff recruitment and retention.
At Price County Hospital (PCH), the ambulatory area is outgrowing its space and a plan is in place to build an addition, limited to current growth. It is suggested a review of the growth rate across the Island and the resources for comparison across Island

Priority Process: Competency

The staff receives a comprehensive hospital orientation and depending on the service they are assigned the staff will received additional training. Records of training and competence are maintained. It is suggested to incorporate ethics training to their modules. Continuing professional development is mandatory for all staff, and ongoing professional development is encouraged and supported by management.

Performance appraisals are conducted every two years for fulltime employees. Although the existing rates are quite good, managers and leaders are encouraged to perform these reviews with their employees as per organizational policy. Team members are recognized in several ways for their contributions.

There is coordinated approach for infusion pump safety that includes training, evaluation, and follow ups to issues.

At Prince County Hospital (PCH) the work force in Ambulatory and Dialysis is stable, except for physiotherapists and Occupational Therapists.

Priority Process: Episode of Care

There is an open, transparent, and respectful relationship with each client.

The team has set a criterion to ensure clients with the most urgent needs are seen first. In some services, such as Nephrology, a regular consultation with the specialist may take prolonged periods; however, patients are prioritized and in severe occasion may be seen the same day. The team is commended for their effort to get Telemedicine on track and provide a solution for services where the wait times are above national targets.

The number of “no shows” is low and closely monitored. Patients are called close to the appointment date and followed if unable to reach.

During the survey a couple of tracers were conducted, one in Hemodialysis and another in same day treatment. In both occasions, it was evident that clients and families are actively engaged in their care. They expressed their gratitude for the outstanding and compassionate care they have received and felt love and kindness towards each health provider.

Client’s informed consent is obtained and documented before proving the service. Medication reconciliation is performed with each client and it is properly documented. During the initial assessment, the Best Possible Medication History (BPMH) is generated. This document is available electronically and can be printed.

Falls prevention program was implemented in June 2015. Patients at risk are identified during the initial interview and assisted if necessary. The last report showed significant improvements. The team is commended for this and encouraged to continue working in this very important effort.

It was reported that diagnostic imaging and laboratory testing are available in a timely manner.

In 2016, more than 1,100 clients participated in a Patient Satisfaction Survey for the provincial ambulatory services. The results indicated a high degree of satisfaction (93%) for the care they received.

Specific services, such as hemodialysis have also conducted survey, reviewed results and prepared action plans to address the issues. There is a process to file complains and clients and families are aware of the process. These complains are carefully reviewed and escalated when required.

The charting at Prince County Hospital (PCH) is also paper based; medication reconciliation is done on clinical information system. HPEI has a 'Good Catch Award' for reporting and follow up of near misses; also given in Division Good adherence to standards. The Ambulatory care unit at PCH also has created a unit "Good Catch Award".

The organization is encouraged to improve privacy in the nursing centre, due to patient concerns regarding lack of confidentiality. Patients are lined up in close proximity in a very open area with no access to curtains or screening. A patient expressed a concern about the lack of privacy.

Priority Process: Decision Support

Client records are well organized and updated on a consistent basis. These are maintained in a paper format. Although the team can access some information (e.g. BPMH) electronically and do some viewing with manual charting; there is a risk of being duplicated, inadvertently being used for the wrong client or loss of data. It is strongly suggested that a move to electronic charting be implemented to optimize efficiency and reduce potential errors.

Priority Process: Impact on Outcomes

The team follows evidence-informed guidelines that are appropriate for the services offered.

Safety incidents are reported according to the organization's policy and documented in the client and clinical record as applicable. They are classified and escalated according to their severity. Critical incidents are reviewed by a multidisciplinary team.

Hand hygiene audits are periodically conducted. Overall compliance of the ambulatory service staff is below 60%, far from the organization target. The results are posted and divided by type of health care provider. The team has developed a plan to improve their compliance that includes: the frequency and number of the audits and a new audit app to facilitate the process and documentation. In addition, it is suggested to review the results in team meetings and re-educate or re-train staff if necessary.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Laboratory		
7.1	The organization limits access to the laboratory areas to authorized team members only.	!
7.2	The laboratory has sufficient space to carry out laboratory services.	
9.2	The team regularly monitors and records environmental conditions within the laboratory.	
11.3	The team updates its SOPs every two years or more often if required.	
11.4	The team has a process to review and approve revisions to the SOPs.	
12.4	The team informs laboratory users if a critical result needs to be followed up with access to counselling.	!
27.4	The team uses safety practices when handling, examining, or disposing of biological and chemical materials.	!

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Laboratory

The laboratory is commended for the significant developments in its Quality Management System since the last survey.

The laboratory has a solid, knowledgeable management team supported by pathologists, a biochemist, microbiologist and other specialists. A Provincial Laboratory Educator/ Quality Coordinator role to assist with improving consistency and the further development and maintenance of the quality program across the sites might be considered.

The team works collaboratively with other programs to improve patient care, patient safety, and processes. HPEI has adopted the ‘Choosing Wisely’ national program to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and making better choices to ensure high quality care. In addition, improvements have been made to processes around critical result reporting, inpatient, and STAT testing turn around times. The ‘Urine Culture Initiative’ with Long Term Care facilities, community labs and Microbiology, reduced urine rejection rates and improved the appropriate utilization of urine cultures. The high rate of rejected blood specimens collected by nursing staff at QEH has been identified as an area for improvement.

The staff of the lab are engaged in their various roles. They work together as a team and take great pride in their work. Staffing levels for MLT's is a problem due to a current shortage. Using MLA's to full scope of practice is encouraged to help alleviate workload pressures.
Pathologists are to be commended for their work in implementing a Quality Assurance program including peer review. This is a model that other diagnostic services might look at implementing.

A laboratory safety program is in place. Since the Laboratory is a high-risk area within the organization, it is suggested that the Laboratory Safety Officer or other Laboratory designate sit on the facility Occupational Health and Safety Committee. Hazardous liquids and chemicals and any heavy objects should be stored below eye level (noted in Histology at both sites). Fans should not be used in Microbiology (PCH). The eye-washing station in Histology at QEH is not working properly. It is recommended that a checklist be developed to document the weekly review of the eye wash station. Checklists for routine maintenance and cleaning for each piece of equipment in Histology is are recommended. At Kings County Memorial Hospital, samples are manually uncapped and the space for planting urine samples is tight. The organization is encouraged to review the existing practices and implement evidence based guidelines such as splash shields to enhance patient safety.

The laboratory is well equipped with up to date technology. Humidity is not monitored at PCH. The implementation of a specimen tracking system in Histology has enhanced patient safety. Grossing of critical specimens such as 'breast cases' are done as per standards of practice. Cold Ischemic Time is under 1 hr – excellent turn around time for both small and large cases. Space and or layout is an issue at the Kings County Memorial Hospital is an issue as the lab area is not secure and ECG patients have to walk though. At the QEH, consideration should be given to having a separate room for mycology with its own biological safety hood. Currently the biological safety hood used is in the main area and shared with general microbiology. There is a risk of spores becoming airborne when working up fungus cultures.

There is a comprehensive inventory management process in place for supplies including tracking of reagents from time of receipt to time of use. Chemicals and stains no longer in use should be disposed of (both sites).

The provincial procurement process is very slow and it can take several months from time of approval to time of purchase. This delay can be frustrating and in many cases costly as the projected costs savings are lost or reduced during the delay in time.

Quality Control and Quality Assurance practices meet all standards. Root cause analysis and corrective actions are taken and documented when there are unacceptable or unexpected results.

The laboratory information system (LIS) is used effectively by management and staff not only for the requisitioning and reporting of results but also for tracking of specimens at every step from collection to reporting. The LIS is also used for tracking non-conformities such as rejected specimens and reason for rejection and occurrence data for monitoring purposes. Utilization data to support the Choosing Wisely program is also readily available. Lab staff are diligent in reporting occurrences and tracking vital details such as rejected specimens. Data is available to identify issues and monitor improvements.

Progress has been made in the journey to establish a document control system across the sites. A great tool, (Omni Assistant), has gone live and over 5000 documents are now in the system. The task will now be to ensure documents are reviewed and updated in a timely manner as per the policy as well as what to do with hard copies. Decisions around the hard copy manuals (other than those necessary to be maintained in case of a computer downtime) need to be made. Hard copy policies and procedures (including those directives that are posted as notes for convenience) must be linked to a controlled document.

The Provincial Laboratory Services for Health PEI has developed goals, policies, processes and procedures for quality assurance of laboratory examinations in all laboratories in accordance with regulatory requirements and accepted standards of practice.

The Provincial Laboratory Services participates in external peer evaluation and conducts internal assessments and audits to monitor and evaluate the effectiveness of the quality management system and laboratory operation. Overall client satisfaction rates for patients and clinicians is very positive.

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		
15.6	Outpatient services only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications at ambulatory care visits where the client is at risk of potential adverse drug events. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and how often medication reconciliation is repeated.	ROP
	15.6.7 The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with a complete list of medications the client should be taking following the end of service.	**MAJOR**
19.6	Radiotherapy only: Each client's radiotherapy treatment plan is independently verified by a second professional prior to the first treatment and when there has been a change in the treatment parameters.	!
19.7	Radiotherapy only: Each client's radiotherapy treatment plan is peer reviewed by a radiation oncologist.	!
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		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
5.4	Systemic therapy only: Organizational guidelines for spills of systemic cancer therapy medications are followed.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It is clear that many aspects of Health PEI's Cancer Care is planned with clients and families. There is extensive engagement, both in formal structures and through informal feedback. Clients feel the need to give back to a service that they feel has treated them with exceptional care. It was also evident at two sites that clients were involved in the design and renovations of the physical space.

Partnerships are formed with the Canadian Cancer Society and several other non-governmental organizations (NGOs). Further partnerships exist with other provinces in the provision of care and the program has explored having a double check for radiotherapy treatment plans with Nova Scotia.

In 2014 the Provincial Cancer Coordination Steering Committee was established to implement a three year plan for cancer care and control. This planning continues in the 2016-2019 plan and was created with many inputs including partners (for example, the Canadian Partnership Against Cancer), clients and an environmental scan, to name a few. This strategy spells out actions that are followed both quarterly and yearly. The organization might consider using the SMART (Specific, Measurable, Achievable, Realistic and Timely) objectives framework for futures plans, for further clarity.

Priority Process: Competency

There appears to be extensive training and educational opportunities for staff providing cancer care in the Health PEI system. It is clear that an orientation takes place and for higher risk activities, ongoing and regular education and evaluation is also provided. Staff report education and training on ethical decision making, use of equipment and devices, medications and information systems to name a few. The leaders of the program report that staff come in to educational sessions "at the crack of dawn" as evidence of their commitment to professional development.

The leadership for this service should be commended for providing performance reviews to the majority, if not all, staff on their team(s). Staff consistently reported receiving feedback and opportunities to discuss development goals. Staff participate in webinars and are supported to attend educational opportunities out of province.

The effectiveness of team collaboration and functioning can be extrapolated from regular surveys. Further, regular huddles help teams understand how they are working and if they can improve. The workload of some radiotherapy staff can be reviewed by looking at tasks within the Aria system. The organization is encouraged to look for more formal ways to assess team functioning and workload for all those involved in cancer care services.

Priority Process: Episode of Care

The cancer care team reduces barriers to care by linking patients to support programs from the Canadian Cancer Society and also by helping with navigation of compassionate drug programs for those without coverage. Mandarin is the third most common language spoken and materials have been translated as such (and translation services are available).

Of note, the approval process from the Department of Health and Wellness for new cancer therapies is unclear. Despite this team's best efforts to convey a prioritized list for approval the process is not transparent and it is unpredictable when drugs may or may not be approved. The senior leadership of the organization should advocate for transparency and predictability such that the process can be observed to ensure it is fair, appropriate and effective. This would also allow enhance the program's ability to plan its resources.

Clients report feeling very well informed about their care. They identify the the physician as the person most responsible for their care plan, but are aware through patient education sessions and videos that they are part of a team. They spontaneously highlighted that they indeed felt part of a team. Several patients were unable to advise on any area that might be improved, except for the same turkey sandwiches provided at lunch.

There is a robust patient orientation program that includes both hardcopy materials, but also in-person education. Videos have also been developed for orientation and education. A patient navigator is available to assist patients with questions, concerns and guiding them through the cancer continuum.

Physicians provide clear direction for discharge to primary care providers and the team is developing formal survivorship care plans for clients and providers. Clients report a strong desire to return to cancer services long after active treatment if there is a concern and feel that care in the community may not be as strong for late effects and/or recurrence. The organization is encouraged to continue to support survivorship care in the community, particularly as the volume of cancer cases increases and there may not be a full complement of oncology specialists.

Excellent and consistent use of two identifiers was observed with the chemotherapy patients.

Priority Process: Decision Support

Accurate and up-to-date charts were observed for both in- and outpatient oncology. It appears a standardized set of information is collected at intake and regularly (for example, the Edmonton Symptom Assessment System or ESAS).

Client personal health information is subject to the overarching policy for the entire organization and staff are provided training on this. There were not concerns regarding personal health information observed on the survey of this area.

Priority Process: Impact on Outcomes

There is a standardized approach to select evidence based guidelines that was described during the survey and this included input and participation of clients and families. Clients and families appear to be very involved in many aspects of cancer care at this organization.

An accessible incident reporting system is used regularly by staff. It was observed that even minor near misses (for example writing the wrong date on a form) were logged as incidents. This program should be commended for creating a culture of safety and continue to glean data from incidents reported to continue to create a safe environment.

An ambulatory oncology patient satisfaction survey is administered with a high response rate and many positive results. The team should consider regularly administering this survey to assess their progress.

As mentioned an extensive cancer strategy is outlined with action items and quarterly reports, with an annual report. The strategy ends in 2019. Again, the organization should consider formatting their objectives using the SMART format.

A quality improvement initiative for double checking medications was recognized two years ago and the initiative has been sustained since that time. The organization should be commended for creating a role for an epidemiologist who will no doubt continue to be an integral part of the reporting, planning, and award winning quality improvement work undertaken by this team.

Priority Process: Medication Management

There are many supports for the safe handling and administration of systemic cancer therapy for the cancer care team. The team had a medication preparation area renovated approximately five years ago and it met standards at that point. The standards are changing and the organization will have to take this into account, particularly as medications are not stored in a clean area or anteroom as most recommendations outline. Further the medication preparation area, while and improvement over the former location, is not co-located with the chemotherapy treatment area, and thus the agents are transported in a common hallway, which may increase the risk of spills and exposure.

The organization uses the British Columbia Cancer Agency's guidelines for spills. They should be encouraged to formally adopt these guidelines or create their own.

A pharmacist double checks dosing calculated by physicians on standardized paper order sets and these are then checked again by pharmacy technicians. Nurses then perform independent double checks before medication is administered. Verbal orders are not accepted for entire chemotherapy cycles and verbal orders must be co-signed by the ordering provider. The organization is encouraged to implement an electronic medical records (EMR) with CPOE as they move forward.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.2	The assessment process is designed with input from clients and families.	
12.7	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		
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.	!
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.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

The community-based mental health teams collaborate well with each other and the hospitals to provide a continuum of services for the province. Local leadership across the McGill Centre and Community Mental Health & Addictions Summerside sites is visibly supportive of their respective teams.

The McGill Centre would benefit from some infrastructure investment to improve temperature control and increasing the physical security of the medication room, specifically by securing the window which is close to ground.

Priority Process: Competency

Each community-based team has an onboarding orientation process; however, the methods used to provide service and population specific education and training varies across sites.

Health PEI services use a standardized referral form between all MH&A services which ensures consistency in the transfer of information.

The teams in Summerside are very closely knit and work in a highly collaborative manner.

In speaking with leadership, the assignment and workload of each team is not reviewed in detail. To ensure that resources are functioning at capacity and maximized, HPEI is encouraged to continue on the journey to continually improve access to Islanders.

Priority Process: Episode of Care

The teams have dedicated intake resources to monitor and manage referrals, and use a scoring system to triage and prioritize how quickly clients are assessed.

Careful attention has been made to ensure medication reconciliation is implemented in each service.

The teams currently follow the CAMH suicide Risk Assessment (SRA) protocol; however, Health PEI will launch an electronic version of the Columbia SRA protocol in the ISM system in the coming weeks. Some teams had very clearly documented care plans for each client; however, other teams referenced the physician orders and plans embedded in progress notes, rather than having distinctly clear care plans outlined for clinicians to quickly reference. An individualized care plan should be developed and consistently documented clearly for all clients in every service.

It is clear that clients are actively engaged in their care across services.

Priority Process: Decision Support

The ISM electronic record used by the community-based teams is consistent across the province.

Many of the required tools for assessment and documentation are available. The exchange of client information is facilitated.

Health PEI is encouraged to use the data available in this platform to support its efforts to review caseload and volume data to support its ambitious change management efforts to standardize its approaches.

Priority Process: Impact on Outcomes

The services offered are evidence informed; however, when discussing the selection of guidelines no systematic method was articulated.

The teams proactively assess and monitor for risks with clients and rapidly respond to changes in status that increase risk to mitigate those and document updated plans.

Quality improvement efforts are underway in service areas, specific timelines with measurable objectives are not always clearly articulated or easily understood by staff. Quality improvement efforts are evident at the local level; however, it was not always clear whether measurable objectives and available data were used to set benchmarks and monitor outcomes. Health PEI would benefit from investing in more robust decision support for the clinical teams to achieve this.

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	The required level of staffing is determined and maintained to provide consistent quality of service at all hours of the day and on all days of the week.	
Priority Process: Competency		
3.4	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.	
Priority Process: Episode of Care		
6.1	Standardized criteria are used to determine whether potential clients require critical care services.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, 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 services in Health PEI are operated very much at a site level with the local leadership teams determine priorities for improvement and education. At each site, there was a concerted effort to ensure that bundles of care were in place and periodically monitored for compliance. There are clear functional partnerships between administration, nursing and medical staff that allow each site to provide quality care.

Staffing concerns were identified at both sites with the result that funded beds are unable to be regularly used to provide patient care. This was cited as a concern by leaders at both sites given the current

challenges in patient flow throughout the organization. Flow is further impaired due to difficulties in finding supportive community placements or supports for long term ventilated patients.

Both units operate as open units which creates some challenges for the site leadership related to continuity of care, creating standard work, determining priorities for improvement and maximizing the value of rounds. The leadership have patient family experience surveys in place, and patients and families are incorporated into many aspects of care planning including collaborative rounds. In one case at PCH the staff came in on their own time to allow a wedding to happen on site for a patient who was unable to leave the ICU to attend the main ceremony/reception for her Daughter's wedding.

Variability in the care model between the two sites results in different services being offered by the ICU; specifically the PCH was not able to maintain a Registered Respiratory Therapist (RRT) service and due to the lack of 24/7 Respiratory Therapist support is unable to move to the Registered Nurse/ Respiratory Therapist (RN/RT) model that has been successfully piloted at QEH.

Priority Process: Competency

There are formal approaches to ensuring the delivery of evidence informed competent care in place at both sites surveyed. The units at both sites are termed "open" units. Physicians go through a standard credentialing and privileging process; each unit has a medical lead and have 24/7 access to physicians with critical care expertise. Physicians participate in unit initiatives and support the implementation of evidence informed protocols including the Safer HealthcareNow! bundles related to central line infection, ventilator acquired pneumonia and venous thromboembolism.

The QEH conducts weekly education rounds that are well attended by the multidisciplinary team on a variety of critical care topics.

At both sites, there has been a significant investment in education. The QEH ICU has a full-time educator and the PCH shares an educator between the ED and ICU (located close together in the facility). The access to an educator ensures that new staff members receive an orientation that is tailored to their needs and allows the educator to take time to work hands-on beside the new staff. The educators manually track course completion and compliance with mandatory and required education. They do this tracking on an excel spreadsheet that they must manually maintain and update. Given the high turnover and the significant amount of education that is required in the ICU setting opportunities to implement a learning management system should be explored.

The hands on approach of the leadership at both ICUs helps ensure that on any given day the experience and skillsets of staff are included in staffing decisions.

Priority Process: Episode of Care

The services provided at both of the intensive care units are provided by a qualified and competent interprofessional team. The teams have leveraged the Clinical Information System (CIS) assessment

screens and order sets to ensure that key quality processes are in place with a corresponding ability to monitor compliance. Processes related to medication reconciliation, and the Safer Healthcare Now! bundles are consistently followed and well understood by the clinical team. The CIS prompts clinicians to complete other assessments intended to support the provision of safe care including the falls risk assessment and Braden pressure ulcer risk assessment. The leadership teams at both sites attempt to support the provision of quality care in other parts of the system through educational rounds, simulation and code blue responses.

The Rapid Response Team model in place at the QEH has been successfully piloted with sixteen activations over a three month period, with five of those patients subsequently being admitted to the ICU. The outreach is appreciated by local teams and contributes to a positive professional environments. Site leaders at the QEH believe that the positive experience of staff who work with the RRT presence may result in easier recruitment to ICU lines in the future. The organization is encouraged to look at how the RT/RN RRT model that is in place at QEH could be adopted at PCH.

The teams at both sites have increasingly involved patients and family members in the design of unit processes. As an example, both units have embraced the Health PEI family presence policy and now have open access on all units. The QEH hospital attempts to maintain a quiet time in the afternoon; this was based on feedback received from patients and families who appreciated the "time out" during the day. Teams are attempting to move towards standard interprofessional bedside rounds at both sites but express that day to day variability in schedules, partly due to the open nature of the units, makes this difficult. Staff and patients report favourable experiences when interprofessional rounds are performed at the bedside with patients and families.

Priority Process: Decision Support

The ICU environment at both sites is characterized by a hybrid chart in which portions of the chart are contained in the Cerner CIS and others in a paper chart. Staff generally understand which portions of the chart can be found in which format; however, some information is duplicated and in some cases transcribed (allergy information for example). The hybrid chart creates some difficulties with respect to data abstraction and in ensuring continuity of care across the system (paper portions of the chart must be copied and sent with patients even when they are moving to another Health PEI site that shares the same electronic health record.

The CIS and CPOE have been in place since before the last accreditation survey in 2013 and are well used by physicians and staff. The information system serves to ensure that decision support is a routine part of clinical decision making on the units.

Priority Process: Impact on Outcomes

The organization has put numerous quality initiatives in place and has incorporated best practice critical care protocols into routine unit processes at both hospitals. The organization has good process and compliance data during the implementation phase of new initiatives but does not have recurrent reporting of these data and has very few outcome level data to use in their quality management program.

The provincial critical care quality team is encouraged to continue with standardization around evidence -based practices.

Priority Process: Organ and Tissue Donation

Health PEI does not provide transplant services within their facilities. Donor tissue and/or organs are transplanted in either New Brunswick or Nova Scotia.

Health PEI does have a medical lead for their organ and tissue program and has protocols and policies in place to help ensure that suitable donors are identified, a standard approach is followed to approach donor families and arrangements can be made to facilitate transplantation.

Staff have received training and are able to access support as needed to help ensure that the organization's donation process is followed and that all aspects of the process are documented.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
6.7	The team annually reviews and updates the Policy and Procedure Manual.	
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
15.6	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
15.6.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
15.6.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

A Strategic planning process for Diagnostic Imaging (DI) was undertaken in 2015 and a three-year Master Plan was developed by the Strategic Planning Committee. Goals were established for 1. Staff Education, 2. Improving Service Access and Wait Times, 3. Integration of Services and Communication Improvement.

As a result, an Education Plan was developed in conjunction with staff and several education opportunities at both the provincial level and site level have resulted. Education days have been held as well as lunch and learns etc. Staff interviewed indicated the enhancement of educational opportunities was greatly appreciated and worthwhile.

Two sub-groups have been established, The Integration of Service & Communication Committee and an Improved Service Access & Wait Times Committee.

The Integration of Service & Communication Committee has been busy identifying gaps in communications both internal and external to DI and suggesting improvements. They have made good progress in making changes to communication strategies to ensure that those who 'need to know' across the organization get the information they need in a timely and efficient manner and not as an afterthought. There has been good engagement of the strategies across the province. This is a whole cultural change to reduce 'silos' and better understand each other needs.

The Service Access and Wait Time Committee has been active in identifying the many reasons for the extended wait times and looking for opportunities for improvement. Wait times can currently be several

months for CT, MRI and Ultrasound non-urgent cases. Several factors such as staffing levels and productivity, hours of operation, booking processes, and “no shows” were identified and work done to gather the data needed to guide the improvement process. It is noted that a major contributing factor affecting wait times temporarily in Ultrasound has been multiple maternity leaves. Shift start and stop times for hours of operation were adjusted where possible to create additional booking spots in these areas. A great deal of time daily is spent to triage orders for Ultrasound, MRI and CT to ensure that those who are priority are seen in as timely as possible. Another wait time improvement initiative is underway to reduce ‘no shows’. An electronic calling system has been requested which provides booking notices and reminder calls allowing patients to respond easily by pressing a number to indicate they plan to come or chose not to. Booking spots can then be filled in advance from a waiting list.

A project to compare X-ray procedures on infants using the traditional ‘chair’ for positioning vs a ‘Pigg-o-Stat' specially designed for infant x-ray procedures was completed. The study was carried out by students and the outcome was that the use of the Pigg-o-stat device for positioning infants resulted in less radiation dose, and better images. Students did a presentation to staff on the results which was well received.

A policy for the reporting of critical results has been implemented which defines the situations where a direct call from the radiologist to the ordering physician is required. The requirement to document that communication needs to be added to the policy.

DI within the health system has been attempting to decrease the number of unnecessary exams by adopting the national ‘Choosing Wisely” initiative. Several process changes have been made. A recent initiative is an effort to educate referring physicians about proper orders for lumbar spines. It includes noting ‘inappropriate requests for lumbar spine imaging’ comments, on the imaging report. The note states that “although we did complete the exam, the request did not follow the Choosing Wisely guidelines” ... in the hope that in the future they will reconsider their requests.

Data is also being collected on referring physician practices and report cards issued. These compare a physician’s ordering practices to their peers.

Indicators show that an average of 80% of breast biopsies are negative. This is costly in both, time and money. More important there is a significant impact on the patient (and their family) who not only go through the procedure, but also may experience the psychological stress of waiting for a result. This needs to be further investigated to determine why this is occurring and actions taken to reduce this number.

A QA program for Radiologists including peer review similar to what Pathologists have implemented is suggested. Many hospitals have adopted this practice and in some provinces, it is mandatory especially in Breast Screening Programs.

DI equipment is well maintained. Consideration should be given to extending hours of operation where feasible to increase capacity and reduce wait times. There is a request in process to replace the aging MRI

which experiences frequent downtime contributing to longer wait times. In addition, the voice recognition system utilized by the Radiologists is somewhat outdated and cumbersome. VR software has come a long way over the past few years. Sub optimal software increases risk for reporting errors and inefficiencies in the reporting process.

Staff are friendly, patient-focused and knowledgeable. Radiologists are in short supply and some work is now being referred out as a result. Without a sufficient complement of Radiologists on site, the only other option is to refer studies to another service.

A critical result reporting policy is in place. Radiologists document the notification to the referring physician on the report, however the requirement for that documentation is not included in the policy. It is recommended that the policy be updated to include that requirement.

Policies and Procedures still primarily available in hard copies which are difficult to properly update and maintain. Implementation of a document control program is suggested.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	
Priority Process: Competency		
4.5	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.	
Priority Process: Episode of Care		
10.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
	10.6.2 The approach identifies 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**
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
16.5	Guidelines and protocols are regularly reviewed, 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.	!
18.9	There is a process to regularly collect indicator data and track progress.	
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

Health PEI has strong leadership at the site level. Site leaders employ multiple strategies to collect and share data about their performance and engage their teams in identifying opportunities for improvement. There is site to site variability with respect to staffing models and hours of operation. This variability is well understood within the team and local processes are in place to ensure that there is an appropriate mix of skill level and experience maintained at the site. As an example, the ED at the Queen Elizabeth Hospital made the determination to move to an exclusively RN model based on the clinical needs of their patients and the size/complement of the ED. At Western Hospital, the team introduced a Collaborative Emergency Centre model that pairs a RN and an advanced care Paramedic to allow the facility to maintain 24/7 service.

At a provincial level, the Provincial Emergency Department Quality Team has a leadership role in looking at opportunities for HPEI wide initiatives. These initiatives range from administrative (advocating for over capacity spaces and strategies in each facility) to clinical (targeting better door to antibiotic times for suspected sepsis patients and introducing the qSOFA sepsis assessment as one mechanism to address variability).

Priority Process: Competency

The emergency departments at all sites visited had solid processes in place to review credentials and qualifications and ensure that qualified staff are caring for ED patients in Health PEI. The scope of services, staffing and hours of operation vary between sites, however in each instance the variability is consistent with the local population needs and available funding.

There has been a significant investment in clinical educator and quality improvement support for the ED. Educators are present on the unit, lead many aspects of orientation and have sufficient capacity to tailor orientation and education programs to the needs of each staff member. Nursing supervisors at the sites help fill clinical gaps that may occurs when patients require care that involves technical skills that may be rarely used (for example establishing access to an implanted venous access device). Health PEI offers numerous clinical courses to its staff, however they struggle at time with being able to provide sufficient opportunities in a flexible enough format to ensure that all nursing staff can access the recommended education for any given role. There remains some confusion for staff between the education that is required versus that which is mandatory, the difference having implications with respect to how the training is funded.

Overall the staff were well able to articulate their competence and learning gaps and identify how they would work with leadership to address identified learning needs.

Priority Process: Episode of Care

The HPEI ED leadership team makes every effort to optimize service for the clients they serve. Site specific strategies are in place based on population needs such as the innovative Collaborative Emergency

Centre at Western Hospital which ensures that the local population has access to 24/7 care and that the paramedic and RN who staff the department after hours can call in or consult with a physician as needed.

The team has developed many medical directives and has standardized most of these across all sites. These medical directives allow RNs to initiate needed care and diagnostics in a timely and consistent manner for a pre-selected group of acute ED presentations.

In all sites visited the team engages patients and family members in all aspects of their care. The approach to include patients in decisions related to their care in the ED begins at triage/registration and continued through to their discharge or admission. In each case a documented plan is in place for the patient and staff communicate the plan at transitions.

Many initiatives have been put in place in the ED including the suicide risk assessment, falls risk assessment and standardized handover approach. The departments visited demonstrated a high level of compliance with completing the associated form or task, however there remains an opportunity to determine whether the newly implemented approach is having the desired effect (for example, determining whether the nurses on the floor receive the information they need from the ED nurse at handover). The existence of a provincial quality team provides an ideal forum for these sorts of evaluations and quality measures to be contemplated.

Priority Process: Decision Support

The provincial leadership team for the Emergency Department has taken a key role in identifying the decision support strategies across all sites. The team successfully identifies and prioritizes opportunities for improvement and advocates for resources to achieve their objectives.

This provincial approach to quality has allowed the team to begin to standardize care across sites and to address key quality opportunities such as improving compliance with recommended sepsis guideline timelines and implementing a standard suicide risk screening tool. Staff have access to many resources to support their clinical practice, however the resources are not stored in a single repository and as a result staff must search through multiple databases to find clinical resource information.

The provincial leadership team is limited in their ability to implement a quality management program by inconsistent performance measurement data availability. Data is typically available upon request (CIHI data for example), or generated through primary data collection at the site level. Primary data collection is often associated with improvement projects and is not sustained following completion of the project. This inconsistency in data availability makes it difficult for the leadership team to understand how their performance varies over time. The leadership team is also challenged to make site to site comparisons because of the different data systems available at each site, as an example only the Prince County Hospital ED has National Ambulatory Care Reporting System (NACRS) data.

Priority Process: Impact on Outcomes

There is a clear commitment by the Health PEI ED leadership to adopt a quality management approach. Work has begun on a number of fronts to move towards standardizing the care, as possible across all sites. The provincial ED quality committee is the structure that helps the organization select opportunities for improvement and support continued local variability where it makes sense.

The use of clinical data related to high impact clinical presentations such as sepsis, stroke, chest pain serves to engage staff in a more general conversation about quality. The ED participates in the organizations quality and safety program, identifies cases for review and helps implement recommendations that result from quality assurance activities.

There is a clear focus on staff and patient safety at each site, however there remains opportunities to ensure that good ideas and learning at a single site (code silver/lockdown for example that is being implemented at PCH) are shared with other sites for consideration. The security teams in each ED are engaged and although a contracted service operate very much as part of the Health PEI ED care team.

The introduction of patients into the ED Quality Committee should result in a more patient centred approach to identifying and selecting future quality improvement opportunities.

Priority Process: Organ and Tissue Donation

Health PEI does not provide transplant services within their facilities. Donor tissue and/or organs are transplanted in either New Brunswick or Nova Scotia. Health PEI does have a medical lead for their organ and tissue program and has protocols and policies in place to help ensure that suitable donors are identified, a standard approach is followed to approach donor families and arrangements can be made to facilitate transplantation.

Staff have received training and are able to access support as needed to help ensure that the organization's donation process is followed and that all aspects of the process are documented.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
10.7	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		
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

The Home Care Program provides a range of services including home care, home support, adult day program, adult protection, palliative care and long-term care admission. Services are provided by a dynamic and professional team of nurses, home support workers, care coordinators, physiotherapists, occupational therapists, social workers and dietitians.

Client-centred care is provided. Clients, their natural supports and the care team work in partnership to achieve the goal of maintaining individuals at home for as long as possible.

Based on current trends and needs, there is a focus on the frail elderly, palliative care and post-acute care. Goals for the 2017/18 year have been established based on the results of the recently conducted Client Experience Survey. They include improvements in emotional support, advanced care planning discussions and hand hygiene for all staff.

Home care services are widely available across the province. Program leaders indicate that partners play a key role in the referral process. As well, the Home Care Program works cooperatively with its partners to provide and transition services as appropriate.

Within the current structure, the team strives to ensure client needs are met in the best possible way. Community services care options, both public and private, are reviewed with clients and families during care planning. The Home Care program leadership has identified resource needs and gaps in service. Increased support by the Infection Prevention and Control (IPAC) team will be provided soon. Service expansions to better meet client needs have also been identified. The team is encouraged to continue advocating for enhanced home care services.

Palliative care services are greatly expanding within the home care program and the team has embraced the challenges and rewards this brings.

Priority Process: Competency

Clear roles and responsibilities are in place. Staff report that this provides a strong basis for their team approach and uses each team member's scope of practice to the fullest.

Infusion pump training is in place. Education is documented. Flow sheets are used to ensure all pertinent data is documented. The team may consider additional evaluation methods to confirm effectiveness, for example, reviewing Smart Pump data. This could be achieved in partnership with biomedical or pharmacy support.

Orientation and education is provided. Team members indicate that they are supported in professional development and educational opportunities. This fosters an atmosphere of continuous improvement.

SBARs are widely used as a key communication tool both within and between teams.

The ethics framework and process is understood by team members. Examples of its use were cited by team members and leaders.

In larger centres, off hours support is provided by registered nursing staff. Team members indicate that this is an excellent and needed resource, allowing them to ensure time sensitive client information is communicated effectively.

Managing client and staff safety is a priority for the Home Care Program. Many processes and initiatives have been developed to ensure a safe environment for clients and staff. Leadership involvement occurs where concerns or issues are identified.

Priority Process: Episode of Care

There is a central intake for all home care clients. This has streamlined the process and effectively connected clients to the most appropriate program resource. The team is highly client and family centred

and mindful of allowing the client to lead their care and service choices. Families are embraced as an integral part of the care team. Staff clearly communicate the scope of the services they can provide and offer other available alternatives. Transparency and adherence to guidelines are main values to the program.

Clients feel that each care provider they encounter is knowledgeable about them as individuals and about their plan of care. Client experience survey results demonstrate a high level of satisfaction with several key indicators such as respectfulness, privacy, positive communications and sensitivity to needs. Opportunities for improvement are the teams focused goals for this year.

Clients and families stated that they are aware of the complaints process but indicated that any concerns they have are managed to their satisfaction by their care providers.

The team is very innovative in assisting clients in meeting their needs, especially in terms of acquiring necessary equipment and supplies. This work is commended.

Much effort has been undertaken related to required organizational practices. The program is commended for their dedication to client safety and evidence informed practice. All new clients receive medication reconciliation on admission. This is done consistently and several discrepancies have been noted over time, reinforcing the need for this important safety process.

A falls prevention approach is in place. Effectiveness is evaluated through comparisons of admissions to the emergency department due to falls of home care clients compared to the general population. A provincial Falls Committee meets regularly to review data. Results are shared with all staff through the program Quality Team.

Skin and wound care program is in place. Excellent multidisciplinary team work has advanced this area of practice. Standardization of resources and supplies is ongoing. A baseline evaluation was obtained through audit. Ongoing evaluation is planned. Decreased frequency of dressing changes and decreased treatment time were noted as improvements.

Palliative care in the home is rapidly expanding, innovative solutions to maintain clients at home are in place, including paramedic support outside of home care service hours.

There is a well-developed process for the transition of care. The team is encouraged to evaluate this process and identify improvement opportunities in this area.

Priority Process: Decision Support

Client records are a mix of paper based and electronic. This is a potential risk as it results in duplication of records or the need to ensure the most up to date information is in hand. Interface with other electronic systems is a challenge. Improvements in this area are encouraged.

Assessment and chart forms are standardized throughout the program. Documentation is thorough and timely. Requirements for document storage and transportation are well understood by team members who are vigilant about protecting the integrity and privacy of records.

Current care plans and client records are kept in the clients' home. They are assessable to clients and families for their review if they wish.

Priority Process: Impact on Outcomes

The provincial Clinical Standards Committee provides expertise in standard development for the Home Care Program. This ensures standards are evidence informed and standardized across the province. A reporting structure is in place to share committee outcomes.

Safety is a priority for the Home Care team. Safety incidents are reported and investigated. Improvements are made as required.

Through client experience surveys, client feedback and the concerns process improvement opportunities for care and services are identified. Staff indicate that they also have opportunity to identify improvements at staff meetings and client conferences.

Individual sites have piloted quality initiatives such as COACH (Caring for Older Adults and in the Community and at Home) and falls prevention. These initiatives have then been adopted provincially.

A variety of process and outcomes indicators have been identified by the Home Care program and are being monitored. Evaluation and process improvements are planned and/or ongoing. The team is encouraged to continue in their quality journey.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
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.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Provincial Palliative Care Program should be commended for their excellent work. They have grown a program that moved from community and integrated itself into acute care. Clients and families are clearly involved in the planning and evaluation of palliative care services in PEI. In fact, documents are now bearing a "family approved" logo to indicate they have been reviewed and endorsed by clients/family.

The palliative care program should also be recognized for innovative practices that help meet the needs of the clients, community and organization. For example, paramedics providing after hours care at home for patients in the Provincial Integrated Palliative Care Program. This program helps keep palliative care patients at home and out of the emergency department. This is both a success for client and family centred care, but also helps with sustaining other resources in the Health PEI system.

A strong leadership team that includes outstanding physician engagement has been key in the success of the program. Much thought goes into recruiting members of the team for current priorities, but also for what priorities might lie ahead.

Hospice PEI is responsible for recruiting, training and retaining volunteer services. They have approximately 200 volunteers across the province who participate in an extensive training program.

The Palliative Care Unit in Charlottetown is 2 years old and a well-designed facility that supports the palliative care needs of the clients and families. It has single rooms with bathrooms, each room has a large window facing a lawn and treed area. Multiple kitchen and outdoor spaces provide the opportunity for groups, family visits and special events, like weddings. This unit is the largest in the province, but others, like O'Leary were noted to be excellent places for Islanders to receive care as well.

Priority Process: Competency

Training and education are strengths for this program. Pan-organizational training is provided to all staff. The Provincial Palliative Care Program also has an annual two-day conference that attracts approximately 200 providers and has scheduled national and international leaders in palliative care to speak. At this educational event recognition of staff occurs, but also occurs informally on a regular basis at the Charlottetown Palliative Care Unit.

There is an extensive training program for volunteers that covers an introduction to palliative care, grief and bereavement and spiritual issues, to name a few.

Infusion pump training takes place, is evaluated at the level of the pump trainee and an evaluation of the overall approach takes place to inform improvements.

Priority Process: Episode of Care

The Health PEI Palliative Care Framework and Action Plan was developed in 2015 and outlines gaps that needed attention. For example, 75% of the population wished to die at home, but only 19% did. This program has created an operational plan to improve the situation.

This program has focused on integration across disciplines, taken a client- and family-centred approach to care and this has led to a reduction in barriers to care. For example, a palliative home care drug pilot paved the way for the acceptance of a palliative care approach (and care coordination) by many clients/families, while providing them with lower drug costs. Work continues to educate the public about the nature of palliative care and dispel myths about it.

Another vision is seamless care and an acute care pilot followed patients from acute care into the community and informed better transitions.

Clients and their families report outstanding care. There are multiple stories in local media about the excellent care provided. A client seen on the survey said, "since I've come here I've improved 100%". When asked another client about areas for improvement they said, "we'd have to search hard to find one" and couldn't name one after contemplating for some time. Clients also consistently reported being asked for two (2) identifiers.

It is clear medication reconciliation is taking place. This is outstanding - congratulations!

Priority Process: Decision Support

Accurate, up-to-date and organized paper charts are used on the palliative care unit. A standardized set of health information is collected and staff follow Health PEI's confidentiality policy. Staff are aware and report training on the confidentiality policy.

Health PEI should consider implementing and electronic medical record (EMR) in the program that is interoperable with that of other health care services. This would likely lead to some efficiencies, but also further integration with other community partners (paramedics, for example) and those of acute care.

Priority Process: Impact on Outcomes

A Provincial Palliative Care Quality Team has been formed to further integration of the palliative care across PEI. As mentioned, extensive educational events have been undertaken to mature and grow capacity across the island. Part of this strategy includes the identification of champions in every area that palliative care is provided.

The quality team had aligned itself with Accreditation Canada's Required Organizational Practices (ROPs) and has focused on prioritization of volunteer standards. Other goals include initiation of advance care planning which has led to 100% planning for all clients in the program.

A rewrite of a client and family survey to include national standards was undertaken this past year. The survey was administered and will act as a baseline for improvement. However, since these are national standards, current results can be compared to those of other provinces. The program will also be using clinical indicators based on this of the Canadian Partnership Against Cancer's national standards. Clinical indicators will include % of cancer patients with chemotherapy in the past 14 or 30 days of life, percentage of patients with completed goals of care and cancer patients and palliative care patients who died in acute care, for example.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
4.7	IPC policies and procedures are updated regularly based on changes to applicable regulations, evidence, and best practices.	!
7.7	Safety engineered devices for sharps are used.	!
8.4	Team members, and volunteers have access to dedicated hand-washing sinks.	
14.1	There is a quality improvement plan for the IPC program.	!

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The Infection Prevention and Control service underwent external review in 2015 and recommendations were made to the province to enhance IPAC services. As a result, the service was expanded provincially to include eight Infection Control Practitioners (ICPs) across the province. Of these, one currently holds the Certification in Infection Prevention and Control (CIC) designation, and there are plans for at least two more ICPs to obtain certification in the next year.

In September 2017, the role of Provincial IPAC supervisor/coordinator was established to serve as a system-wide IPAC resource, facilitating communication and coordinating services across the province. This person is also a member of the provincial IPAC committee and reports directly to a member of the senior leadership team.

Where provincial screening or management guidelines exist (eg. Methicillin Resistant Staphylococcus Aureus, MRSA), they are incorporated into facility-and region-specific policies and procedures as appropriate. There are plans to work towards standardization of all IPAC policies, procedures, protocols and practices across the province. This initiative is strongly encouraged since policies and procedures are currently being developed in duplicate at both QEH and PCH. Working together to develop policies and procedures offers significant opportunity to standardize practices and improve efficiencies.

There are plans to roll out new IPAC software to select acute care sites beginning January 2018. This tool will facilitate collection and reporting of nosocomial infections including C. difficile and MRSA for example.

There is a provincial IPAC committee with diverse membership including acute care, long term care and laboratory services. This committee has been in somewhat of a holding pattern pending completion of IPAC restructuring. There are also site-specific hospital committees which meet at regular intervals throughout the year. There are plans to resume regular meetings of the provincial committee with membership to include chairs of the site-specific committees.

The team collects nosocomial MRSA and C. difficile rates as well as hand hygiene compliance rates. These data are reported quarterly to the Infection Control Committee, the senior leadership team, local medical advisory councils, managers, and staff. Data are also reported to Health PEI twice per year. Unit-specific infection rates and hand hygiene compliance rates were observed to be posted on several units during the on- site survey.

Surveillance at individual sites is conducted by the nursing staff and the ICP responsible for that site. Syndromic screening (eg. gastrointestinal or respiratory symptoms) is done by clinical staff and reported to the IPC if there are concerns about a possible cluster or outbreak. There is opportunity to formalize and document surveillance protocols and to standardize screening and reporting practices including what would be reportable to whom and how, from a particular unit or site. Staff involved in reporting suggest that clear and consistent direction in this regard would be helpful.

Surgical Site Infection (SSI) rates are reported, with cases primarily identified by lab culture reports and subsequent chart review. There is opportunity to enhance surveillance of SSI, resources permitting, with more targeted surveillance. Safer Healthcare Now! offers resources for post-discharge SSI surveillance that may be helpful.

Although there is not a designated IPAC medical director at this time, a medical microbiologist does support the team by providing medical consultation to the IPAC program. This individual is also able to facilitate timely and appropriate laboratory support to the program, and leads the organizational antimicrobial stewardship program which supports the efforts of the IPAC team and vice-versa. IPC staff feel at times as though they are imposing on this individual when they ask for help. It is suggested that the organization create and support a permanent medical director role to support the IPAC program as is standard of practice for an organization of this size.

The IPAC team embraces client and family-centred care (CFCC). For example, they have included a patient advisor on the quality team and have had their hand hygiene pamphlets reviewed by patients for language and comprehension. The antimicrobial stewardship (ASP) program has involved patients in a social media campaign to raise public awareness about appropriate antibiotic use.

General IPAC training is provided to all staff at orientation and job-specific elements are provided accordingly. Not all staff that should be mask-fit tested based on their clinical role, have been tested. It has been challenging to engage physicians in routine IPAC training and mask fit testing. Physician compliance with hand hygiene is low. IPAC training received by external contractors is not verified nor do they receive standardized/customized training by the organization that they will be working in.

Audits of compliance with hand hygiene and use of personal protective equipment (PPE) are conducted on a regular basis with real-time feedback provided to staff.

IPAC personnel are usually consulted in a timely manner to provide input on new construction and renovation activities.
The IPAC service has developed strategic partnerships with external agencies including for example, the Chief Public Health Office as well as IPAC colleagues and experts in New Brunswick, Newfoundland and Labrador, Nova Scotia, and other Canadian provinces. ICPs across the province communicate regularly via teleconference with subgroups including long term care and acute care.

With recent restructuring and with the right resources, the IPAC program is positioned to create a sophisticated and integrated province-wide program, and the team is anxious to get started! In the words of one team member during the on-site survey, "This is our time!"

Standards Set: Long-Term 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 residents and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.8	A process to monitor the use of restraints is established by the team, and this information is used to make improvements.	!
9.19	Information relevant to the care of the resident is communicated effectively during care transitions.	ROP
9.19.5	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 resident records) to measure compliance with standardized processes and the quality of information transfer • Asking residents, 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
12.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from residents and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from residents and families.	
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

The long-term care program provides a range of services in addition to traditional geriatric long-term care. They provide care for restorative, respite, 'young' and dementia residents. The team includes nurses, occupational and physical therapists, dietitians, support workers, administrative staff, and volunteers. They provide holistic and person-centred care to residents and their families.

Broad program goals have been developed and are related to patient safety. Manor goals and objectives vary. The team is encouraged to develop cascading goals and specific objectives for the entire program. There are strong partnerships between programs and with broader community stakeholders. Team leaders participate in many provincial committees and working groups. This provides opportunity to advance long term care objectives and enter meaningful dialogue related to resident care.

The team regularly assesses its resource needs and gaps in service. There are several current and planned initiatives to enhance resident care. These include strategic planning to build on the recently developed provincial plan, expanding the medical model of care to include nurse practitioner care, and developing a staff competency program.

All manors visited have a bright, clean, and uncluttered environment. Dining is a pleasant experience. Staff are warm and welcoming and residents appear engaged in their daily activities.

Priority Process: Competency

Team member roles and responsibilities are well defined. Each member of the team clearly articulates their contribution to resident care. Communication between team members is effective and respectful. Team leaders are actively present to provide support as required. Consultation to a variety of experts is timely. The team has access to geriatrician, geriatric mental health, and others.

Staff indicate that education and training opportunities are available. Resident safety education is prioritized. Infection prevention and control, and transfer, lifts and repositioning education occur. The team is encouraged to provide additional education related to restraint use, especially regarding use of side rails. As well, monitoring the use of restraints and identifying opportunities for improvement with the process would be beneficial.

Wander alert systems have been installed to allow residents maximum mobility within the manor in a safe way.

Performance reviews include professional development goals. Teams are adopting a 'champion' model where interested team members are designated local experts in areas such as skin and wound care or falls prevention. This builds capacity within each manor.

The standard communication tool used is the SBAR (situation, background, assessment, recommendation). These are used at transition of care at all manors and are used for referrals and medical requests at some manors. Staff indicate that it is a helpful tool in focusing communication.

Priority Process: Episode of Care

There is an extensive 'Move In' package, containing resident assessment tools and information for residents and families. The program is commended for their resident centred emphasis during this significant life change. Staff consistently discuss residents in a respectful manner, avoiding labeling and bias. Creative methods, such as wordless, are used to communicate the uniqueness of each resident. These practices vary at individual manors. The team is encouraged to share and spread these practices across all sites.

Resident preferences are respected and these variations are evidenced in the plan of care. Plans are updated regularly through multidisciplinary reviews that include residents and families, as they are able. The recreation teams provide appropriate activities which are enjoyed by residents. The team has identified that additional evening and weekend activities for residents would be desirable. They are encouraged to explore this opportunity with their recreation team, volunteers and residents.

Families are encouraged to be involved in care. Interactions with staff can occur daily, visiting times are flexible, and meals can be provided. Staff are sensitive to those residents with fewer visits and assignments are aligned to add consistency and build relations with care providers.

In many manors, medications are thoroughly reviewed for indication and efficacy. This process is encouraged at all sites, especially as it relates to anti-psychotic use.

Standardized forms for transition of care are used. The team is encouraged to monitor the effectiveness of the information provided during transition through audit and feedback.

Much effort has been undertaken related to required organizational practices. The program is commended for their dedication to resident safety and evidence informed practice.

A medication reconciliation process is in place. Compliance is monitored and results are positive. It is suggested that a process be adopted that addresses resident medication administration needs in the immediate (1-2 day) absence of a signed medical order. The falls prevention program is well established. Falls rates are reviewed and improvement opportunities identified. Suicide risk is assessed and treatment plans are in place. Risk assessment is captured on several assessment forms, such as the nursing database, move in assessment, and behavioral assessment form. The team is encouraged to review the risk assessment with a view to amalgamating the assessments for ease of access.

Priority Process: Decision Support

The long-term care record is paper based. Records are lengthy and charts cumbersome. The team acknowledges this gap. Encouragement is given to move to an electronic solution.

Documentation audits are conducted. Results are reviewed with the team.

The ethics framework and process are known to staff. Issues that staff have experienced were identified by team members. Most stated that the formal ethics process has not been accessed and that issues are resolved at a local level.

Priority Process: Impact on Outcomes

The provincial Clinical Standards Committee provides expertise in standard development for the Long-Term Care Program. This ensures standards are evidence informed and standardized across the province. A reporting structure is in place to share committee outcomes.

Resident safety is a program priority. Safety incidents are reported and investigated. Improvements are made as required.

Staff indicate that they also have opportunity to identify improvements at staff meetings and client conferences.

A variety of process and outcomes indicators have been identified by the program and are being monitored. Evaluation and process improvements are planned and/or ongoing. The team is encouraged to continue in their quality journey.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria				High Priority Criteria
Priority Process: Medication Management				
2.3	There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.			ROP
		2.3.5	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	**MINOR**
2.5	A documented and coordinated approach to safely manage high-alert medications is implemented.			ROP
		2.5.4	The policy includes procedures for storing, prescribing, preparing, administering, dispensing, and documenting each identified high-alert medication.	**MAJOR**
2.10	The interdisciplinary committee develops a process for using sample medications.			
4.4	The effectiveness of training activities for medication management is regularly evaluated and improvements are made as needed.			
7.1	The type of alerts used by the CPOE include at a minimum: alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.			!
7.4	The CPOE is regularly tested to make sure the alerts are working.			!
7.5	Alert fatigue is managed by regularly evaluating the type of alerts required by the CPOE based on best practice information and by collecting input from teams.			
8.1	There is a process for determining the type and level of alerts required by the pharmacy computer system including, at minimum: alerts for medication interactions, drug allergies, and minimum and maximum doses for high-alert medications.			!
8.2	A policy on when and how to override alerts by the pharmacy computer system is developed and implemented.			!

8.4	The pharmacy computer system is regularly tested to make sure the alerts are working.	!
8.5	Alert fatigue is managed by regularly evaluating the type of alerts required by the pharmacy computer system based on best practice information and with input from teams.	
12.1	Access to medication storage areas is limited to authorized team members.	!
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.	!
14.7	A policy that specifies when telephone and verbal orders for medications are acceptable and how they are to be transcribed is developed and implemented.	!
15.1	The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose.	!
16.3	There is a separate negative pressure area with a 100 percent externally vented biohazard hood for preparing chemotherapy medications.	!
16.4	Sterile products and intravenous admixtures are prepared in a separate area with a certified laminar air flow hood.	!
19.1	When the pharmacy is closed, designated team members are provided with controlled access to a night cabinet or automated dispensing cabinets for a limited selection of urgently required medications.	
19.2	A pharmacist or other qualified team member verifies, as soon as possible, that the correct medications were dispensed after hours.	
19.3	The system for dispensing medications when the pharmacy is closed is regularly evaluated and improvements made as needed.	
22.1	There are criteria for determining which medications can be self-administered by clients.	
22.2	Established criteria are used to assess whether a client is able to self-administer medications.	
23.3	An independent double check is conducted at the point of care before administering high-alert medications.	!

Surveyor comments on the priority process(es)

Priority Process: Medication Management

In Health PEI the medication management system is progressing well on its safety and quality journey. The addition of CPOE and electronic chart throughout the acute sites is now an established tool for the standardization of order entry and medication administration. This system allows off-site pharmacists to review, verify or correct medication orders in a timely fashion. Central, automated, patient-specific unit dose packaging provided for all acute sites from Queen Elizabeth Hospital standardizes the medication system so all clients can receive the same level of service. The system normally permits a 24-hour supply of oral medications but has capacity to increase to 48 hour supply when needed, i.e. winter storm event.

Pharmacy services provided by Provincial Pharmacy to long term care were not directly reviewed as part of this survey. It appears there is consideration to extend the use of the Cerner into long term care facilities which would enhance standardization and safe medication ordering as well as improve the ability to audit and potentially correct concerns.

The Antimicrobial Stewardship Program is progressing well and is being well received. Standard order sets and pathways are available and appear to be routinely referenced. Unfortunately, the 2014 rather than 2016 antibiogram is the only one available from the stewardship webpage. Reports for long term (14 days or longer) antibiotic use are now being reviewed to ensure appropriateness of treatment and step down to the most specific agent possible. Recommendations from the program are largely acted upon. The program needs to begin the next phase, which is evaluating the results of their efforts and continuing to grow and improve.

The high-alert policies, although new, appear to be adopted in almost all locations. The color-coding of different alerting levels is a simple but effective tool to raise awareness. A more systematic and complete approach to the use of TALLman lettering in all areas is recommended, not just on order sets and labels.

The team will need to make ongoing evaluations to verify the approach to high-alert medication identification is effective at reducing occurrences and near-misses. The independent double-check policy will enhance the safety of nurse selection, preparation and administration of high-alert medications. There is not a similar program currently in place to aid staff in the pharmacy in the correct selection or stocking of high-alert medications. Consider processes to improve the selection of high-alerts within the pharmacy by pharmacy staff. Annual audits are now being conducted for high-alert medications. Next steps may include evaluation of double checking and processes to reduce errors and near misses with high-alert medications.

The organization is applauded for the current plan to move to a single, province-wide smart pump to enhance the same and standard administration of IV medication. Specific consideration of smart pumps that interface or integrate with the Cerner system enhances the safety associated with smart pumps.

The Cerner system has become the backbone of the medication system closing the loop between order and administration with CPOE and electronic medication administration capture. I believe this system

has also enhanced the ability to reduce or eliminate dangerous abbreviation use as well as evaluate where dangerous abbreviations are seen. There may be hurdles to adding long term care and chemotherapy to the CPOE system; however, there will be many benefits as well.

The level of autonomy that a pharmacist has in making decisions on the supply of non-formulary medications in specific and select situations is impressive. This approach reduces needless waits in the system by allowing pharmacists to process orders for many non-formulary medications in a timely manner.

Pharmacy managers are aware of enhanced regulation coming soon regarding aseptic compounding. The ability to compound aseptically and meet the regulations will be challenging and expensive. To facilitate the use of safe sterile compounds, consider increasing the purchase of custom compounding by regulated drug preparation premises. Safety can be enhanced and nursing time potentially re-deployed through the purchase of larger volume custom compounds like ceFAZolin or piperacillin-tazobactam or other high use parenterals.

The surveyor has assessed medication management on previous surveys, and could appreciate the progression and enhancement Health PEI is bringing to its medication management system.

Standards Set: Medicine Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team members and leaders are to be commended for their commitment to client and family engagement. There are many examples of the input of clients and families both formally and informally. This includes two Family Representatives who are members of the Medicine Quality Team. There are regular Client Satisfaction Surveys completed which are used to solicit feedback from clients and families to inform service and program design and changes. The input and engagement of a client resulted in improvements to the bariatric services provided across Health PEI. The client was very proud of her work in redesigning the bariatric room and felt her input was valued, appreciated and implemented. A client has been recruited to participate on the Senior Friendly Strategy. The team members and leaders are encouraged to continue to provide opportunities to proactively engage clients and families in the Medicine Program.

There is strong collaborative partnership with Home Care and other community organizations. This supports transition planning for clients and families. Clients and families are actively involved in their care planning. The team members noted that transitional planning may be challenging because of the limited housing options. The team members and leaders are encouraged to continue to work with partners to strengthen the transitional program and services provided to clients and families.

There is clarity about the community and populations served. For example, in Souris, because there is no emergency or urgent care department, the medical patients are sub-acute. The clinical teams on the medical units are comprised of a wide range of health disciplines, including a Child Life Specialist for pediatrics. For pediatrics at Queen Elizabeth Hospital, excellent partnerships have been formed with IWK (Izaak Walton Killam) in Nova Scotia for clinical services and tremendous community financial support is evident through the foundation with the new pediatric outdoor play space. The play space included input from patients/families and stakeholders such as PEI parks. Examples of space and service re-design are notable at Souris Hospital, where a new patient lounge has been constructed and WIFI access for inpatients has been made available through a donation.

Providing a comfortable environment for clients and families is a priority of the team members and leaders. This includes the provision of private spaces for clients and families. There is evidence of a strong team committed to providing a quality services to clients and families. The clients and families spoke highly of the care provided.

Priority Process: Competency

There is a strong commitment from the leaders to support education and training for the team members to pursue ongoing professional development. The team members are to be commended for their commitment to attend educational and training opportunities. The education and training provided includes fire safety, violence prevention, WHMIS, hand hygiene, palliative care, and gentle persuasive approach, to name just a few. The team members are supported by clinical educators. The clinical educators assist the team members in attaining core competencies. There is a strong orientation process available for team member including a six-week orientation and preceptorship. Some units have annual education and team building sessions to increase knowledge and build capacity. Electronic learning modules have been created to help staff access education when it’s timely for them on-line. One suggestion is to consider some form of “learning hub” where education could be provided and tracked, rather than manual tracking by educators on the units. The leaders are encouraged to continue to support innovative educational opportunities for the team members.

The leaders and team members are to be commended for their commitment to infusion pump safety. There is strong evidence of the completion of infusion pump training and education.

The team members noted that they are aware of the process to follow if ethical concerns arise. There are posters and information available on the Medical Units regarding ethics and the ethical framework. The leaders are encouraged to continue to support ethics education for team members.

The leaders are to be commenced for their commitment to complete performance appraisal. Team members commented that their performance appraisal was completed. The leaders are encouraged to continue to complete performance appraisals for team members which will assist in identifying opportunities for professional growth.

Priority Process: Episode of Care

The leaders and team members are to be commended for their commitment to quality patient and family care. Clients and families report receiving exceptional care. A client noted, "The nurses are excellent. They are kind and gentle. They would bend over backwards for you." Another client stated that she felt engaged by the team members in planning for her care and had confidence in the staff. Furthermore, they described being treated with dignity and respect with their wishes honored. A client commented on the importance of the improvements to the bariatric room and stated that she would like to see additional bariatric rooms as there will be an increased demand for this service.

The leaders and team members are acknowledged for their strong commitment to reducing falls. Improvements are shared across the organization. The leaders are encouraged to continue to implement and evaluate the Falls Prevention Program and to make changes as appropriate.

The leaders and team members are committed to working effectively as an integrated inter-disciplinary team. The team members are supported by a Clinical Leader, Clinical Educator, Social Workers and members of the rehabilitation team. There are strong working relationships developed with Home Care, Primary Care, Stroke Care, Income Support and Senior's housing. Multi-disciplinary rounds occur on a weekly basis. Family meetings are also held. The clients and families reported being engaged in planning for discharge. However, placement options may sometimes be limited. The leaders and team members are encouraged to continue to engage clients, families and partners in transitional planning.

The leaders and team members are passionate about the Senior Friendly Strategy. Posters describing senior friendly activities are located throughout the sites. It was apparent that the team members are committed to improve the mobility of their clients. This was viewed very positively. One client stated, "I have 4 walks a day. I really look forward to it. The staff are very kind."

The team members are responsive to the needs of clients and the organization. It can be challenging to have adult "off-service" patients on pediatric wards and is not best practice, however every effort is made to vet the patients for safety prior to admission. Client's families are listed as "partners in care" on the white boards, and patients and staff report feeling included in their care and discharge planning. Some units continue to use taped report for information transfer, while others are using electronic methods or bedside handover. The leaders are encouraged to spread some of the successful learnings from quality improvements re: information transfer at shift change.

Priority Process: Decision Support

The leaders and team members are committed to ensuring quality client information is used to support quality and safe client care. Accurate and up-to-date electronic health records were noted.

Standardized information is collected. Team members are confident in their use of the Cerner electronic health record. Education and training is provided to the team members on the Cerner electronic health record. There is an adequate work stations for team members. The team members valued the electronic

prompting to complete re-assessments. Although there are standard protocols/order sets available, some physicians choose not to use these tools electronically and there are still situations where verbal/telephone orders could be reduced. The leaders are encouraged to continue to support the development and implementation of electronic health information systems.

Leaders and team members are committed to protecting the privacy of client information. Clients are supported to access their health information in a client-centered manner. The leaders and team members have described receiving education and training on protecting personal health information. The leaders are encouraged to continue to adhere to the highest standard in protecting personal health information.

Priority Process: Impact on Outcomes

The leaders and team members are committed to selecting evidence-based guidelines to support care. The Medical Quality Team participates in selecting evidence based guidelines. This involves reviewing evidence based practices. Power Plans are developed and available. However, electronic protocols/order sets are not consistently used by physicians in Medical Units.

The electronic incident reporting system is used regularly by team members. The leaders review incidents and make changes as appropriate. Clients and families are involved in this process. The leaders and team members foster an environment of openness and disclosure of patient safety incidents. The learnings from the patient safety incidents are used to improve the quality of the service provided. Team members feel comfortable reporting incidents, although there is concern among physicians that new graduate RNs may feel “scared off” by the process, so ongoing education about the just culture and training will be helpful. The leaders are encouraged to continue to provide opportunities for team members to attend professional development regarding patient safety and a just culture.

Client satisfaction surveys are completed on a regular basis. The leaders and team members are responsive to client feedback and have made improvements based on the surveys. There are several examples of changes made to the program and services based on client feedback including changes to equipment. The Pursuing Quality & Excellence – Quality Boards are helpful in staff and patients/families to visualize quality improvement activities and data in a transparent way.

The Health PEI Strategic Plan is posted on the Quality Boards. The leaders and team have identified objectives for the Medical Service. The leaders are encouraged to continue to evaluate quality improvement initiatives and to implement successful initiatives across Health PEI.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.6	Processes and policies to meet the diverse needs of the clients and families served are established with input from clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
1.10	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, 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		
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The inpatient staff across all three sites (Hillsborough, QEH and PCH) are very committed to serve this population. Health PEI is encouraged to develop more robust, evidence-informed programming for the inpatient settings with input from patients and families to ensure active, structured treatment during hospitalizations. The PCH site is not a designated facility under the Mental Health Act (MHA). Despite this, some people are admitted involuntarily under MHA forms, sometimes for prolonged periods. Health PEI is encouraged to put the necessary measures and investments in place to have the PCH inpatient facility appropriately designated to ensure safety, compliance with legislation regarding patient rights and avoid significant liability risks.

Priority Process: Competency

All staff are trained in 'Non-Violent Crisis Intervention' and advanced Code White response. The teams at all sites work very collaboratively with each other, with patients and families and with the community teams. The Cerner system is quite robust compared with many in use across Canada. Many of the methods for documentation are guided by standardized formatting. Health PEI is encouraged to also

build in a standard, formalized "Transfer of Accountability" form electronically in Cerner to ensure that on each patient transition the sending and receiving clinician/Nurse is guided to ensure all relevant clinical and risk information is exchanged in a clear, consistent, concise manner.

Priority Process: Episode of Care

HPEI is well positioned to master bed utilization because its systems permit real time occupancy across hospital sites daily. It is not apparent why some beds remain vacant for days or longer in some sites while patients at another site such as PCH are admitted but remain in the Emergency Department. Enhanced bed management protocols to ensure equitable access to PEI residents is encouraged.

It is evident that the teams actively engage clients and their families (when desired) in the planning and delivery of treatment. The teams consistently refer to the provincial ethics committee. However, the teams would benefit from additional resources being available on site in the form of a full time Ethicist who would participate in interdisciplinary team meetings on a consulting basis. Patients at the Hillsborough Hospital have very limited access to Family Practice Physicians.

The population with severe persistent mental illness has higher rates of co-morbid medical concerns. Health PEI is encouraged to make focused effort to ensure appropriate medical resources are assigned to this site. Likewise, focused efforts to recruit qualified Psychiatrists to PEI are required to meet the demands of the population.

With regard to ROPs: (1) The staff on inpatient settings can clearly articulate and demonstrate documented BMHP and Med Rec upon admission and discharge; (2) The Falls Prevention Program is consistent across sites with identification through the purple colored patient wrist bands, flags in patient records identification at patient rooms and the interventions that are put in place; (3) Positive Patient Identification is alive and well with staff using multiple methods including wrist bands, asking patients their name, date of birth, facial recognition, photo identification; and finally (4) with the Suicide Risk Assessment which is tool embedded in Cerner that is completed upon admission, each shift, when health status changes occur and upon discharge.

The hospitals have very well-established relationships with the community-based MH&A teams to facilitate follow up care.

Priority Process: Decision Support

Health PEI is very fortunate to have the Cerner platform for its hospitals as this is not the case in many jurisdictions, including large urban centers. Health PEI is encouraged to leverage the capacity of Cerner to: (1) standardize care plans; (2) build in a Transfer of Accountability Form to improve communication of treatment goals and reduce risks in transitions of care and to leverage its capacity to mine data for program evaluation and goal setting for services.

Priority Process: Impact on Outcomes

Health PEI is on a journey to develop evidence informed programming for inpatient settings. The organization is encouraged to accelerate this process with engagement of staff, patients and families to select, train, implement and evaluate structured programming for all inpatient settings. Measurable goals should be established to facilitate evaluation of outcomes.

The inpatient units at all sites have safety protocols and demonstrate ongoing efforts to ensure and improve safety for patients, staff, physicians and visitors.

There is evidence of quality improvement projects at the local level on each unit across sites. However Health PEI is encouraged to also rally its resources, specifically the Quality Team to work with the MH&A Program leadership Team to select a few key quality indicators that apply across all units to consistently measure what is deemed important for all inpatient settings.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		
	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**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team members and leaders are to be commended for their commitment to client and family engagement. There are many examples of the input of clients and families in the Obstetrical Program at the Queen Elizabeth Hospital and the Prince County Hospital, both formally and informally. This includes the participation of two Family Representatives who are members of the Maternal Newborn Quality Team. There are regular Client Satisfaction Surveys completed which are used to solicit feedback from clients and families to inform service and program design and changes. The team members and leaders are encouraged to continue to provide opportunities to proactively engage clients and families in the Obstetrical Program.

There is strong collaborative partnership with Public Health to support seamless care for clients and families. This includes regular meetings with Public Health to meet the needs of clients and families. The team members and leaders are committed to the Baby Friendly Initiative and have involved community partners and clients in working towards the attainment of this goal. The team members and leaders

identified the importance and value of partnerships with community groups and agencies. The team members and leaders are encouraged to continue to work with partners to strengthen the program and services provided to clients and families.

Providing a comfortable environment for clients and families is a priority of the team members and leaders. This includes the provision of private spaces for clients and families. There is evidence of a strong team committed to providing a quality service to clients and families. The clients and families spoke highly of the team members and the care they were provided. Clients and families stated that they were treated with dignity and respect and felt they were an important part of the care team.

Priority Process: Competency

There is a strong commitment from the leaders to support education and training for the team members. The team members are to be commended for their commitment to attend education and training opportunities. The education and training provided includes fire safety, violence prevention, WHMIS, hand hygiene, fetal heart surveillance, neonatal resuscitation program, and cardiopulmonary resuscitation to name just a few. The team members spoke highly of the Advances in Labour and Risk Management (ALARM) Program. Most team members have completed the ALARM Program and noted that it has assisted them in understanding the latest best practices in providing care. Additionally, team members commented on the value of collaborating with other members of the team when attending the ALARM Program and making them, “feel good” about the quality of the care they provide to clients and families. The team members are supported by clinical educators. The clinical educators assist the team members in attaining core competencies. There is a variety of creative techniques used by the clinical educators including case studies and hands on training. There is strong orientation process available for team member including a six-week orientation and mentorship support. The leaders are encouraged to continue to support innovative educational opportunities for the team members.

The leaders and team members are to be commended for their commitment to infusion pump safety. There is strong evidence of the completion of infusion pump training and education.

The team members noted that they are aware of the process to follow if ethical concerns arise. There are posters and information available on the Obstetrical Units regarding ethics and the ethical framework. The leaders are encouraged to continue to support ethics education for team members.

The leaders are to be commenced for their commitment to complete performance appraisal. Team members commented that their performance appraisals were completed. The leaders are encouraged to continue to complete performance appraisals for team members which will assist in identifying opportunities for professional growth.

Priority Process: Episode of Care

The leaders and team members are to be commended for their commitment to quality patient and family care. Clients and families report receiving excellent care from the Obstetrics Services at the Queen

Elizabeth Hospital and Prince County Hospital. A client noted, “We had excellent care. We couldn’t ask for anything better.” Furthermore, they described being treated with dignity and respect. Clients and families did not offer any suggestions for improvement.

The leaders and team members are committed to implementing and evaluating the Falls Prevention Program. The data on falls is reviewed by the leaders and team members. The effectiveness of the Falls Prevention Program was evaluated by reviewing the falls incidence on a case by case basis due to the low numbers of incidents. However, the Provincial Maternal Newborn Quality Team is developing a process to evaluate the effectiveness of the Falls Prevention Program and to make improvements as necessary to the program. The leaders are encouraged to continue with their plans to evaluate the Falls Prevention Program and to make changes as appropriate.

The leaders and team members are committed to working effectively as an integrated inter-disciplinary team. The team members are supported by a Clinical Leader, Clinical Educator and Lactation Consultants. There are strong working relationships developed with Public Health and social work. Public Health Nurses visit the Obstetrical Units and meet with clients and families prior to discharge. The clients and families reported being engaged in planning for their discharge to home. The leaders and team members are encouraged to continue to engage clients and families in transition planning.

Priority Process: Decision Support

The leaders and team members are committed to ensuring quality client information is used to support quality and safe client care. The client record includes both an electronic and paper based component. Accurate and up-to-date charts were noted at the Queen Elizabeth Hospital and Prince Country Hospital. Standardized information is collected. Education and training is provided to the team members on the electronic system. There are adequate work stations for team members. The team members commented on the value and importance of the electronic health charts in supporting them in providing quality care to their clients. The team members valued the electronic prompting to complete re-assessments. The leaders are encouraged to continue to support the development and implementation of electronic health information systems.

Leaders and team members are committed to protecting the privacy of client information. Clients are supported to access their health information in a client-centered manner. The leaders and team members have described receiving education and training on protecting personal health information. The leaders are encouraged to continue to adhere to the highest standard in protecting personal health information.

Priority Process: Impact on Outcomes

The leaders and team members are committed to selecting evidence-based guidelines to support care. The Maternal Newborn Quality Team participates in selecting evidence based guidelines. This involves reviewing evidence based practices from other health organizations and adapting them to meet the needs of the Obstetrical Service. Power Plans are developed and available.

The electronic incident reporting system is used regularly by team members. The leaders and team members review incidents and make changes as appropriate. Clients and families are involved in this process. The leaders and team members foster an environment of openness and disclosure of patient safety incidents. The learnings from the patient safety incidents are used to improve the quality of the service provided. The leaders and team members are to be commended for their commitment to create a culture of safety.

Client satisfaction surveys are completed on a regular basis. The leaders and team members are responsive to client feedback and have made improvements based on the surveys. There are several examples of changes made to the program and services based on client feedback including the bereavement program. Quality Boards are present and provide team members, clients and families the opportunity to view the progress of quality improvement initiatives.

The Health PEI Strategic Plan is posted on the Quality Boards. The leaders and team have identified objectives for the Obstetrical Service including the Baby Friendly Initiative, changes to orientation and training, diabetes management, physician involvement, breastfeeding rates, and care transitions. Indicators are developed and tracked. The leaders are encouraged to continue to evaluate quality improvement initiatives and to implement successful initiatives across Health PEI.

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.	
Priority Process: Competency		
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
7.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
10.13	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	
11.11	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	ROP
	11.11.4 The effectiveness of the approach is evaluated regularly.	MINOR
20.15	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.	!
20.17	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		
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
25.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
25.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!

25.11 Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Clinical leadership in surgical services is strong, both in the OR and on the inpatient unit. Leaders are responsive to the needs and requests of their staff and support them in their delivery of safe, quality care to their patients. Although they do collect some data from their discharged patients, there is opportunity to collect or access more robust data about the population that they service and to design services accordingly.

The team does not have current team-specific goals (last were from 2013 and have been achieved) and are encouraged to develop same to inform service delivery at the team level. The team goals should align with the corporate goals and objectives, be clear, have measurable outcomes and success factors, and be realistic and time-specific.

The team endeavours to include clients and families in program design and service provision. There is a patient representative on the quality committee for example, and the teams regularly include patients and families in bedside rounding. Bedside handoff in the OR also includes family members.

Priority Process: Competency

Members of the multidisciplinary surgical services team are well qualified with verified credentials. New staff members receive the standard hospital orientation which includes workplace violence training, and receive specific training for the OR during a flexible mentorship period. Infusion pump training is done on a regular basis. The team does not evaluate their team functioning.

Resources are available for staff to learn of cultural and religious differences to better inform delivery of health care to their patients.

Staff spoken to during the on-site survey were not always aware of the ethics framework nor how to seek assistance managing ethical issues.

Performance appraisals are not done on a regular basis but when they have occurred, staff report feeling supported in achieving their professional development goals.

Priority Process: Episode of Care

Surgical procedures are conducted at Queen Elizabeth Hospital (QEH) (approximately 8000 cases/year) and Prince County Hospital (PCH) (approximately 2500 cases/year). Patients are transferred from PCH to QEH for surgeries not done at PCH (e.g. major orthopedic surgery, urology). Neurosurgery, cardiothoracic surgery, major vascular surgery, and transplant surgeries are not performed on PEI and are transferred to facilities in New Brunswick, Nova Scotia, or in some cases Toronto, where the requisite expertise and facilities exist. Staff and physicians state that the current scope of services available locally with the ability to transfer when necessary, adequately meets the needs of their patients.

The team has identified many barriers to accessing surgical services and are exploring options to reduce or remove these barriers. Lack of availability of a post-operative bed has been identified as a significant barrier and strategies are underway to improve patient flow and bed access.

The process for admission to surgery appears seamless. Preadmission assessments are comprehensive, consultation is available in a timely manner when requested, and laboratory and diagnostic imaging test results are available to providers at each encounter. Patients are provided with the necessary information to prepare them appropriately for their operation, and clients interviewed during the survey recalled an informative consent process, felt well-informed, and understood how their hospital stay and post-operative period would progress.

Use of two client identifiers, marking of the surgical site, and use of the safe surgery checklist was consistent and appeared to be usual practice for all observed. Medication reconciliation is done on admission, transfer, and discharge. Some physicians consistently refuse to complete medication reconciliation at discharge which creates extra work for the nursing staff and risks medication transcription errors. Transfer of client information from the OR to the post anaesthesia care unit (PACU) and subsequently to the ward was standardized and efficient using the handoff tool. There is opportunity to audit information transfer when patients are transferred from the inpatient unit to elsewhere.

Standardized criteria are used to determine whether a patient is fit for discharge from the PACU (Aldrete score for admitted patients and Post Anaesthetic Discharge Scoring System (PADSS) for day surgery patients). Discharged day surgery patients are risk stratified and contacted for follow-up accordingly. There is opportunity to contact discharged patients or referral organizations for evaluating the effectiveness of the transition, to verify that client and family needs were met, and concerns or questions addressed. Feedback received and the overall results of the evaluation would be shared within the organization, and the information used to improve transitions.

“Powerplans”, similar to order sets, standardize care and incorporate evidence-informed practices into patient care. Venous thromboembolism (VTE) prophylaxis is incorporated into most Powerplans and auditing shows impressive compliance with assessment for, and ordering of prophylaxis if indicated.

Communication is strong. Daily team huddles are well attended and provide opportunity for efficient and timely sharing of relevant information. Bedside rounds, an effective quality improvement initiative, was reported by staff to have originated as at PCH and subsequently implemented at other sites.

Priority Process: Decision Support

The client record is primarily electronic with some entries (e.g. medical notes at QEH, anaesthesia record at both sites) remaining paper. Electronic order entry has enabled some degree of standardization of practice using the 'Powerplans' which incorporate order sets. The electronic Handoff tool readily displays essential information and is widely utilized for transfer of information.

A comprehensive, standardized client assessment is collected and is available electronically for multiple providers to access at once. Policies are in place to protect the client data that has been collected. The current information technology (IT) system does not allow the team to readily retrieve and manipulate OR data on select indicators such as start times, block times, or preference cards, in order to improve services.

Priority Process: Impact on Outcomes

Although some data are collected on surgical site infections (SSI), there is opportunity to develop a much more robust surveillance program related to SSI and the team is encouraged to work with Infection Prevention and Control, IT/decision support, and other partners as appropriate to develop their surveillance to inform service delivery and improve patient outcomes.

The team at QEH recognized information gaps in handover which led to the development of a handover tool which standardized information shared at handover. Compliance with the Handoff tool was measured and audits revealed fewer gaps in information transferred. They have also worked with nutrition services to modify preoperative feeding restrictions based on best practices. There are plans to expand the day surgery pilot project to include inpatients.

Bedside rounds were established to reduce reporting time and increase time available for patient care.

Evidence-informed 'Powerplans' are in use which serve to reduce unnecessary variation in service delivery. The process to select and review guidelines is neither standardized nor involves clients and families, but is an informal process between physician colleagues.

Staff are quite comfortable using the incident reporting system and managers respond to concerns in a timely manner.

Priority Process: Medication Management

Medications are managed well in the operating room and on the sterile field. Medication administration is well documented and medication containers used on the sterile field are retained until the end of the procedure as per protocol.

Medications are secured and carts are standardized.

Independent double-checks are conducted before administration of high risk medications.

Multi-dose vials are used in the operating room. The vial observed during the survey was not dated with the date that it was first opened.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
2.3	The organization's workspace complies with manufacturers' recommendations when using POCT reagents and media.	
3.1	The organization orients and trains all health care professionals delivering POCT on the standard operating procedures (SOPs) for POCT.	
3.2	Health care professionals delivering POCT receive ongoing training and development. CSA Reference: Z22870:07, 5.15.	
3.3	The organization evaluates the performance of health care professionals delivering POCT annually. CSA Reference: Z22870:07, 5.1.5.	
3.4	As part of their performance evaluation, health care professionals delivering POCT must routinely demonstrate their competence. CSA Reference: Z22870:07, 5.1.5.	
3.5	The organization documents performance evaluation results in the personnel files of health care professionals delivering POCT.	
4.1	The organization has SOPs for each point-of-care test it performs.	
4.2	Each SOP contains the title and purpose of the SOP, number of pages, unique identification number, date it was implemented or revised, signature of the authorizing person(s) and date of authorization, steps to be followed in the procedure, and the individual responsible for checking, reviewing, and approving the SOP.	
4.3	Each SOP contains the purpose and limitations of the test; step-by-step instructions on how to properly complete the test and use the corresponding instruments; reference ranges for the results, including critical values; criteria for accepting and rejecting samples; quality control procedures; and literature references.	
4.4	The organization places the SOPs in areas where health care professionals delivering POCT can easily access them.	
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.	

5.1	The organization maintains an accurate and up to date inventory of all POCT equipment.	!
5.3	The organization follows a documented process for setting-up, validating, and calibrating all new POCT equipment.	!
5.5	The organization periodically verifies that the POCT equipment currently being used is working properly. CSA Reference: 22870:07, 5.3.2.	!
5.9	When the organization uses different types of POCT equipment for the same procedure, the lab director or suitably qualified health care professional works with a central biomedical lab to verify that each type of equipment gives the same result in all cases.	!
6.1	The organization maintains an accurate and up-to-date inventory for all POCT supplies, reagents, and media.	!
6.3	The organization follows a documented process for testing all new POCT supplies, reagents and media.	!
6.4	The organization periodically verifies that POCT reagents currently being used are working properly, not expired or deteriorated and appropriate for use. CSA Reference: 22870:07, 5.3.2.	!
6.5	The organization promptly removes from storage inappropriate, expired, deteriorated and substandard POCT supplies, reagents, and media and discards them.	!
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.	
8.4	Health care professionals delivering POCT follow the SOP when collecting samples to maintain sample integrity and client safety.	!
8.10	The health care professional delivering POCT documents the date and time of the test, the individual carrying out the test and the results of the test on the result form.	!
9.11	The organization securely retains records of all POCT request forms and their corresponding results for the period consistent with provincial regulations or guidelines.	
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.	!
10.9	The organization participates in an external POCT quality control program. CSA Reference: Z22870:07, 5.6.	

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

HPEI created a provincial Point-of-Care Testing (POCT) committee that works in conjunction with an interdisciplinary professional team to set policies and expectations for any POCT conducted across HPEI. The committee meets on a quarterly basis and has reported attendance issues by its members. The effort is led by a strong and committed leader that coordinates and oversees the requirements and quality assurance of the program for all locations in urban and remote areas. Over the years, the team has created new policies, procedures and forms to comply with the standards and improve quality and patient safety. Training is provided to users and refresher courses are periodically offered to ensure competence.

At Queen Elizabeth Hospital (QE), the team reported that POCT was performed for urinalysis, pregnancy, glucose and ketones. These four tests are well controlled and each follows a robust and strict process of quality control, maintenance and external quality testing. Maintenance is consistently done and documented if applicable. The team also performs correlation studies against the main laboratory analyzers and compare the results with acceptable limits to ensure their accuracy.

During the tour to some clinical areas (i.e. Surgery, Pediatrics and Labor and Delivery), team members revealed the use of POCT devices/assays that were not approved and controlled, and hence did not follow the Accreditation requirements for a proper assurance of the validity of the results. For example, in Labor and Delivery, the reagent for pregnancy test was already expired, in Surgery, the team was using a device (i.e. HemoCue) that was never authorized and validated, and In Pediatrics and Labor and Delivery, urine manual strips were used.

These teams and others, are strongly encouraged to work in close partnership with the POCT leader and other stakeholders around the implementation of a robust protocol for each of their POC testing. It is important to determine which tests can be done in the laboratory and which ones should remain as point of care. The POCT committee is encouraged to ensure that all POCT meets all regulations and standards before the tests are fully implemented.

At Souris Hospital, a Nova Glucose meter is used for POCT Glucose testing. The team runs controls and performs maintenance as per protocol. Training and Education is done accordingly. The POCT program at

location will benefit from adhering to the provincial policy of performing periodic correlation studies with the main laboratory analyzer. The hardcopy of the latest version for any POCT protocol should be available for the users and any previous/obsolete version must be removed.

At Prince County Hospital (PCH), unauthorized urine dipping is done without the proper quality assurance program and ongoing support from the POCT lead.

At Kings County Memorial Hospital (KCMH), POCT Glucose Testing is conducted at ED and at the in-patient unit. In addition, the ED team performs POCT for Pregnancy, Urinalysis and Group A Strep testing after the lab is closed and/or when technologists are not available. The process is well controlled and follows all elements of the quality assurance provincial program. It is suggested to involve the POCT users in the testing of the external quality samples. The hard-copy of the latest version for any POCT protocol should be available for the users and any previous/obsolete version must be removed.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	The funding or payment models used create incentives to deliver the best possible primary care services.	
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.	!
3.7	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
8.19	A policy to maintain accurate allergy information for each client is developed and followed by the team.	!
9.2	The assessment process is designed with input from clients and families.	
9.5	When prescribing any medication, the team reconciles the client's list of medications.	!
11.10	There is a mechanism to follow clients through referral and to consult with service providers to follow client progress over time.	
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.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Clinics survey patients annually for feedback and this informs their service delivery model. Gaps in services are identified and addressed through such things as business plans for additional team members. For example, a business plan was created for a psychologist as wait times for psychiatry can be as long as 3 years. Further recruitment of physicians at all sites is a problem and several business cases have been created to expand the nurse practitioner complement.

A major issue for Health PEI is recruitment and retention of physicians and nurse practitioners. Initiatives are in existence to address this issue, however, it will likely serve the organization well to consider both financial and practice (for example, electronic health records) incentives to further its strategy.

Access remains a major priority for primary care and the teams are measuring third next available appointment and no-show rates. These metrics are captured locally and reported at the provincial level. Quality improvement activities are planned accordingly.

It is excellent to see that infrastructure is co-designed with clients and families. For example, stairs were renovated at Harbourside because of patient feedback. Further, both clinic design and service delivery have been influenced by the community of Tyne Valley. The organization is encouraged to bring its client- and family-engagement to the next level for developing such things as job profiles/responsibilities.

Since Community Health is located in the same leadership portfolio, it is not a surprise there are strong connections between primary care and various programs. It was impressive to see in some areas that approximately 70% of diabetics were seen in provincial diabetes program. It is clear these programs (for example, COPD, home care, diabetes and stroke) work closely together and this benefits the clients greatly while also improving access. The organization should be congratulated on this achievement.

Priority Process: Competency

Health PEI should be recognized for the education and training support they provide to their staff. It was clear that in primary care staff are oriented, regularly trained and supported to pursue professional development that improves the care of the clients and families it serves.

Education can be formal - for example, an extensive cultural competency training is available and there is evidence they are taking this training. And informal - team huddles were often a time for staff and leadership to provide some in the moment education. Training in ethical decision making and the framework was evident at most sites, but not all.

Huddles also served as a mechanism to evaluate both team functioning and workload. Additionally the organization has used work load data to determine the average number of patients per day for nurses as well as panel sizes for physicians. Health PEI has used this information for quality improvement activities - for example, those with lighter workloads have been more engaged in community outreach activities.

Throughout the survey it was observed that there is both a strong sense of teamwork and community. This feeling contributed to a sense of pride, trust and excellent care. As an example of trust and collaboration a seasoned physician freely admits to seeking out the advice of team members when he is not aware of a change in guidelines.

It was also clear that staff and leaders have regular performance reviews. This sets Health PEI apart from many other organizations. Congratulations.

Priority Process: Episode of Care

Each site takes steps to reduce barriers for clients to access care. This takes place in many forms. In Tyne Valley the primary care team has a decades' long relationship with an indigenous group and visits their reservation. Harbourside Health Centre has partnered with several communities and even a local college to improve access to care and services. Lastly, the Montague Health Centre works with a program to support clients who are intensive users (Familiar Faces) of health care services to coordinate care and prevent unnecessary ER visits and hospitalizations.

Access continues to be an issue for clients and a priority for this organization. Health PEI should consider furthering after hours clinics and weekend clinics in primary care to reduce the burden on the ER and acute care system. However, this needs to be balanced with the already existing burden of office hours and hospital/ER work that exists for primary care providers at the current time. For example, asking a family physician who completes a 12 hour ER shift at the hospital, which can sometimes extend to 14 or 16 hours to see patients on evenings and weekends might not be reasonable at this time. However, work should be undertaken to support providers and more accessible after hours in primary care.

Approximately 90% of Islanders are attached to a primary care provider. There is a process to connect unattached patients that has been assessed to be ethically sound. The organization should be proud of this process and encouraged to share it as there are very few like it, if any, across Canada.

A good portion of screening and chronic disease management has been standardized and made more accessible too. Islanders can register online to get screened for colorectal cancer and can access many sites for cervical cancer screening across the island. Participants must register to be part of these programs. Health PEI might consider sending letters of invitation to Islanders outside of registration when persons become eligible or overdue for screening. These programs and those associated with chronic disease are certainly excellent ways to improve access overall.

Clients, families and communities inform a good amount of service delivery and design. However, the organization is encouraged to move one step further. This would involve clients and families in planning assessment processes, for example.

Priority Process: Decision Support

The largest gap for primary care at the provincial level is the lack of an EMR. Implementing an EMR would likely help with recruitment and retention of newly graduated health care providers. Safety could also be improved by having a more conspicuous (electronic) cumulative patient profile and the use of a drug database that has alerts for interactions and allergies.

The amount of time spent collecting data for performance in terms of counting third next available appointments and no-show rates would be reduced by moving to an electronic platform. Further efficiencies might be realized with faxing referrals and prescriptions directly from the EMR. It is strongly recommended that Health PEI focus on this one area of primary care as a high priority. Certainly moving from paper based charts to an electronic one will be effortful. However, the end result will help move the organization closer to achieving its goals.

It is noted the organization is planning to pilot an EMR at one site and this is to start in 2018. If not done so already, Health PEI should consider including features such as secure email and online booking to further improve access and efficiency as part of an EMR implementation plan.

Priority Process: Impact on Outcomes

Guidelines are selected by committee at the provincial level. However, providers also endorsed that they select guidelines either themselves or with fellow health care providers. Given that involving clients and families in health service planning and delivery is new for many health care organizations it is not surprising that clients and families are not involved in selecting and evaluating guidelines as of yet. Despite this gap, the primary care program is excellent in engaging clients in planning services, infrastructure as well as quality and safety initiatives. This is certainly further than many other primary care services are doing in other parts of Canada. The primary care team should be recognized for the solid foundation in client/family centred care, but encouraged continue to mature this approach.

It was also evident that a clear culture of safety existed at the primary care sites visited. The provincial incident reporting system appeared to be actively used and part of the leaders' and staff work. Health PEI should be proud of their work in the area of incident reporting and using this information to improve safe care.

Additionally a culture of quality improvement was pervasive throughout the organization. Each site visited had a quality board and quality improvement initiatives. Understandably, many of the initiatives related to work in preparation for the Accreditation Canada Survey. As Health PEI's quality culture continues, further encouragement and support should be placed in not only maintaining Accreditation Canada's standards, but also in innovative activities to advance the organization's strategy. This was not completely absent, as discussion has already started about group appointments for diabetes care - a vehicle to improve access and also focus on one of the most common chronic diseases in the province.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Public Health		
3.7	Public health services are designed to be easily accessible by the population, with input from the community.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leaders and team members are passionate about improving public health programs and services. The work assignments are determined with input from staff to meet the needs of clients. The organization is responsive to the needs of the community though offering such programs as a Needle Exchange Program and extending hours for immunization clinics.

Priority Process: Competency

There is a strong commitment from the leaders to support education and training for team members. The team members spoke highly of the educational and training opportunities. They embraced a culture of continuous learning. The team members spoke highly of peer to peer learning and support networks. Team members were very interested in learning about new Public Health trends. There is strong orientation process available for team members. The leaders are encouraged to continue to support innovative educational opportunities for the team members.

The team members noted that they are aware of the process to follow if ethical concerns arise. There are posters and information available at the Public Health sites. The leaders are encouraged to continue to support ethics education for team members.

The leaders are to be commended for their commitment to complete performance appraisals. Team members commented that their performance appraisals were completed. The leaders are encouraged to continue to complete performance appraisals for team members which will assist in identifying opportunities for professional growth.

Priority Process: Impact on Outcomes

The leaders and team members are committed to selecting evidence-based guidelines to support programs and services. The Quality Team participates in selecting evidence based guidelines. There has been significant progress in developing and implementing standardized programs. The leaders identified the New Beginnings Program and Launching the Little One as examples of this approach. The Quality Team is recruiting two Family Advisors. The leaders and team members are committed to the Baby Friendly Initiative and participate on the Breast Feeding Initiative Steering Committee. Community partners and clients are also represented on this committee.

Client satisfaction surveys are completed on a regular basis. The leaders and team members are responsive to client feedback and have made improvements based on the surveys. There are several examples of changes made to the programs and services based on client feedback including changes to the hours of service for some programs.

The Pursuing Quality & Excellence – Quality Boards are located at both sites. They are helpful for team members, clients and families to visualize quality improvement activities and data in a transparent way. Vision Planning Days have been held. The leaders are encouraged to continue to evaluate quality improvement initiatives and to implement successful initiatives across Public Health.

Priority Process: Public Health

The leaders and team members are passionate about their work. The leaders and team members are committed to working effectively as a team to deliver quality public health services. There is strong engagement and collaboration with the Chief Public Health Office. There is a strong interdisciplinary team including public health nurses, speech language pathologists, dieticians, developmental psychologists, audiologists, lactation consultants, and occupational therapists. The team is supported by administrative support professionals and housekeeping staff who are very client centered. The team offers a broad array of programs including; the New Beginnings Program, Adult Immunization Program, Needle Exchange Program, School Health, Launching Little One, NutriSTEP, Communicable Disease Control, and the Power of Positive Parenting Program. A Dental Health Program is also offered for children at Public Health Summerside and Public Health Sherwood Business Center. The Public Health Summerside site is currently planning to redesign the space used for reprocessing of dental instruments. The organization is encouraged to consider the best practices in reprocessing processes in this redesign.

There are strong working relationships developed with obstetrical Units, community groups and agencies. There is a strong commitment to addressing the social determinants of health and to improve population health. The leaders and team members are encouraged to continue the work of strengthening public health programs and services.

The leaders and team members are to be commended for their commitment to quality Public Health Services. Clients and families report a high satisfaction with the care received. A client noted, “All of my questions are answered. I know who to call if I have concerns.” Furthermore, they described being treated with dignity and respect. Clients and families did not offer any suggestions for improvement. Public Health was described by a team member as, “A great place to work.” Additionally, a team member stated, "We do the best we can for families and we work well together and support each other."

The leaders and team members work hard to increase the accessibility of the public health programs and services. Strategies are developed to facilitate access to programs and services such as extending clinic hours and locating the Needle Exchange Program in an accessible location. The building location for Public Health Summerside is not accessible for clients and families with mobility issues. There are multiple narrow stairways at this site which may limit access to services. The washroom is not accessible for clients with mobility issues. The organization is encouraged to explore options to improve the accessibility of the Public Health Summerside site. Furthermore, the organization is encouraged to involve clients and families in this process.

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		
3.1	Required training and education are defined for all team members with input from clients and families.	!
5.4	There is a policy that guides team members to bring forward complaints, concerns, and grievances.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The provincial rehabilitation unit at Queen Elizabeth Hospital and the restorative care unit at Prince County Hospital work collaboratively to provide 24/7 services. The Queen Elizabeth Hospital site is a participant in the National Rehabilitation Reporting System(Canadian Institute of Health Information) and collects clinical data on functional status and cognitive elements. An interdisciplinary rehabilitation planning committee meets monthly with site representatives to develop and monitor annual goals and objectives, review National Rehabilitation and Reporting System data and monitor quality indicator results. A relationship has been developed with the Heart and Stroke Provincial Stroke Coordinator. Waitlists are monitored and actions taken to support the most appropriate use of unit space. A quality improvement team meets bimonthly to review Accreditation Standards and makes recommendations to the rehabilitation planning committee. A patient advisor has been added to the team.

Priority Process: Competency

A comprehensive orientation and ongoing education opportunities are provided to staff. An annual education day for skills updates and certifications is held and a record of attendance is maintained. Staff provides input on educational topics and tailored educational sessions are provided throughout the year. Presentations on palliative care have occurred and ongoing consultation with the palliative care nurse is available. Patient safety education is prioritized. The commitment to professional education is commendable. Team leader positions are in place to monitor patient results and progress and provide support to team. An interdisciplinary collaborative team is in place. Standardized communication tools such as SBAR and hand-off documentation are utilized. Recognizing the changes to the cultural diversification of the population, cultural sensitivity sessions are provided to staff. Professional profiles have been updated and performance appraisals are in progress.

Priority Process: Episode of Care

Admission criteria are used to determine the admission of patients to the units. A comprehensive assessment is completed on admission utilizing standardized assessment tools. Translation services are available. Patients are encouraged to be actively engaged in their care and goal setting. Family involvement is highly encouraged and consistent with the patient’s wishes. The family presence policy supports family involvement in the patient's goal attainment. The interdisciplinary team meets with the patient and family to set goals and plan for discharge. Weekly interdisciplinary discharge rounds occur with active involvement of the home care liaison. Ongoing discussions on goal achievement are held with patients. Daily goals are recorded on patient’s white board in room. Daily staff bedside rounds include patients, as they desire, in discussions of current action plans; patient input is encouraged.The utilization of best evidence and outcome data by the teams at both sites is commended. At the Queen Elizabeth Hospital, patients'full names are recorded on the activity board across from the desk. It is suggestion that the practice of using complete names be reviewed to ensure that the privacy of the patient is maintained.

Priority Process: Decision Support

The patient’s information and assessments are recorded in the electronic record. Screens are closed when staff are not using the computer. Patients are encouraged to ask questions about their care. A poster is placed in each room informing the patients of their right to ask questions. The patient white boards include an area for family questions to be recorded. Open discussions are encouraged during family meetings and rounds.

Priority Process: Impact on Outcomes

The interdisciplinary planning committee plays an active role in determining and monitoring evidence-informed guidelines for the service. The participation in the National Rehabilitation Reporting System provides an exceptional ability for national bench marking. The committee reviews safety and quality indicator reports including fall prevention, and recommendations for action are developed. Results are posted on unit quality boards and discussed at unit huddles and meetings. Staff are engaged in discussing ways to make improvements. The unit quality board also hosts information on the outcomes of quality improvement activities and education activities. A standard assessment tool is utilized to assess readmission risk. The Health PEI survey results are reviewed for opportunities for improvement. The significant emphasis on quality improvement by both teams is acknowledged.

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

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Regular community campaigns and information sessions in schools are held to improve community knowledge of available services.
The youth addictions centre has ongoing client and family input to the look and feel of the setting that includes art created by residential clients.

Support and services are made available in as discrete an approach as possible to staff who seek help with addictions.

Priority Process: Competency

The care delivery model and related training required for staff is clearly defined in addictions services.

Clients and families are engaged in the planning and delivery of services both at the local level and through a provincial consultation and advisory groups.

Priority Process: Episode of Care

There is a plan of care clearly outlined for each client, which has interdisciplinary input as well as input from clients. The goals and expected outcomes of treatment are developed in partnership with clients.

These teams have established evidence-informed models of care which are consistently applied and evaluated.

Clients are empowered to make choices regarding their care. The nature of addictions involves relapses, however the addictions staff are incredibly compassionate and non-judgmental of clients.

In some cases services have been creative in developing agreements with community pharmacies to improve consistency and reduce errors with medication management.

Health PEI should be commended for their success in creating rapid access to services through structured wait list management, compared with many other jurisdictions.

When clients choose to end treatment prematurely their wishes are respected, however they are engaged in dialogue regarding their successes, risk reassessments are completed and documented and safety plans are put in place if appropriate.

Priority Process: Decision Support

The addictions teams use standardized methods to complete assessments and documentation, including manualized, evidence-informed time-limited therapy.

It is evident that the teams clearly communicate and excage information consistely and effectively both in team meetings and in the client records.

Priority Process: Impact on Outcomes

The addictions services are acutely aware of the incidence of co-morbid mental illness and trauma histories with this population and incorporate these facets in their assessments and treatment planning with clients.

Treatment modalities chosen and implemented are evidence-informed and evaluated.

Health PEI should be commended for its successes at incorporating research in addictions by successfully participating in some national initiatives to advance addictions treatment for island residents.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Transfusion Services		
2.1	The team sets targets and tracks response times for elective, urgent, and emergent requests for transfusion services.	!
3.2	The team has position profiles that define each member's qualifications, roles and responsibilities, and level(s) of authority.	
4.1	The team receives comprehensive orientation and training on the team's standard operating procedures (SOPs), ethics issues, information systems and confidentiality, sanitation, workplace health and safety, infection control and hygiene, and quality improvement and safety activities, including preventing sentinel events, adverse events, and near misses.	
8.2	The team regularly monitors and records environmental conditions within the laboratory including temperature and humidity levels.	
25.8	The team follows a process to regularly collect indicator data to track its progress.	
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

The Transfusion Medicine service of Queen Elizabeth Hospital (QEH) in Charlottetown is staffed by experienced, knowledgeable and dedicated technologists. The program is led by a General Pathologist with specialty in Transfusion Medicine who work in conjunction with the chief technologists, providing excellent scientific and technical support and supervision to the program. The service is provided 24/7 by dedicated transfusion medicine technologists who rotate among themselves.

The laboratory is located in a separate controlled area that is well ventilated and illuminated. Although the team monitors the room temperature, it is recommended to add humidity to the regular daily checks. Work areas are well maintained and cleaned twice every shift. The hand washing sink is closed to the laboratory exit. An eye washing station is suggested.

The department is busy, issues around 3,700 units of red blood cells annually and providing support to the rural hospitals province wide. Blood issuing and administration follows a very comprehensive process, that includes the proper identification and labeling of the blood product, the record of the person picking up the product and the documentation of the patient identifiers prior to transfusion. The nursing team

measures and follows strict protocol before administering the blood product that includes, vital signs prior to, during and post a transfusion.

Management reported that there is a laboratory safety committee that meets monthly with multiple representation from each laboratory area. Safety concerns are discussed and issues passed on to management for review and follow up. The attendance to these meetings are in many occasions lower than expected. Safety audits are conducted twice per year. The team will benefit in creating a short list with the main safety elements for review and increase the frequency of their audits.

The team has developed a Massive Transfusion Protocol to assist clinicians in a rapid and timely manner during massive bleeding patients. It is suggested to incorporate this protocol into other corporate codes where a multidisciplinary team responsable for the management and treatment of these conditions. The very positive comments received from physicians in audits of the process indicate that it is effective in providing blood products in a safe and timely manner.

The equipment is calibrated and maintained by the laboratory staff; whereas corrective maintenance is performed by the biomedical engineering team. The fridges and freezer are connected 24/7 to an alarm system.

The laboratory has developed a significant number of Standard Operating Procedures (SOPs) for each of their examinations. These are available in hard-copy and online. The leader is encouraged to work with other clinicians and establish Turn Around Times (TAT) for the main blood products under regular and emergency procedures and track these TATs to ensure these meet the clinician's expectations. The development of other indicators for each of their quality improvement objectives is also recommended.

Although there is a Transfusion Medicine committee that meets on a quarterly basis, it is suggested to review the terms of reference and discuss ways to improve physician and other stakeholders' attendance to the meetings. The team is encouraged to use the Choosing Wisely Canada Transfusion toolkit to continue reducing unnecessary blood transfusion.

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: April 4, 2017 to April 18, 2017**
- **Number of responses: 9**

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	0	N/A
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	11	89	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	0	N/A
3. Subcommittees need better defined roles and responsibilities.	0	0	0	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
3. Subcommittees need better defined roles and responsibilities.	89	0	11	N/A
4. As a governing body, we do not become directly involved in management issues.	0	0	100	N/A
4. As a governing body, we do not become directly involved in management issues.	0	0	0	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	0	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	11	89	N/A
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	N/A
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	0	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	0	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	0	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	0	0	0	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	78	0	22	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	0	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
11. Individual members ask for and listen to one another’s ideas and input.	0	0	0	N/A
11. Individual members ask for and listen to one another’s ideas and input.	0	0	100	N/A
12. Our ongoing education and professional development is encouraged.	0	11	89	N/A
12. Our ongoing education and professional development is encouraged.	0	0	0	N/A
13. Working relationships among individual members are positive.	0	0	0	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	0	0	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	0	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	11	0	89	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	0	N/A
17. Contributions of individual members are reviewed regularly.	0	0	0	N/A
17. Contributions of individual members are reviewed regularly.	0	0	100	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	0	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	0	0	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	22	22	56	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	11	89	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	0	N/A
21. As individual members, we need better feedback about our contribution to the governing body.	0	0	0	N/A
21. As individual members, we need better feedback about our contribution to the governing body.	78	11	11	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	22	78	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	0	N/A
23. As a governing body, we oversee the development of the organization’s strategic plan.	0	0	0	N/A
23. As a governing body, we oversee the development of the organization’s strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	0	0	0	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	0	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	22	78	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	100	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	0	0	0	N/A
27. We lack explicit criteria to recruit and select new members.	0	0	0	N/A
27. We lack explicit criteria to recruit and select new members.	89	11	0	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	100	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	0	0	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	0	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	0	0	N/A
31. We review our own structure, including size and subcommittee structure.	0	0	0	N/A
31. We review our own structure, including size and subcommittee structure.	0	11	89	N/A
32. We have a process to elect or appoint our chair.	11	22	67	N/A
32. We have a process to elect or appoint our chair.	0	0	0	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	0	0	0	N/A
33. Patient safety	0	11	89	N/A
34. Quality of care	0	11	89	N/A
34. Quality of care	0	0	0	N/A

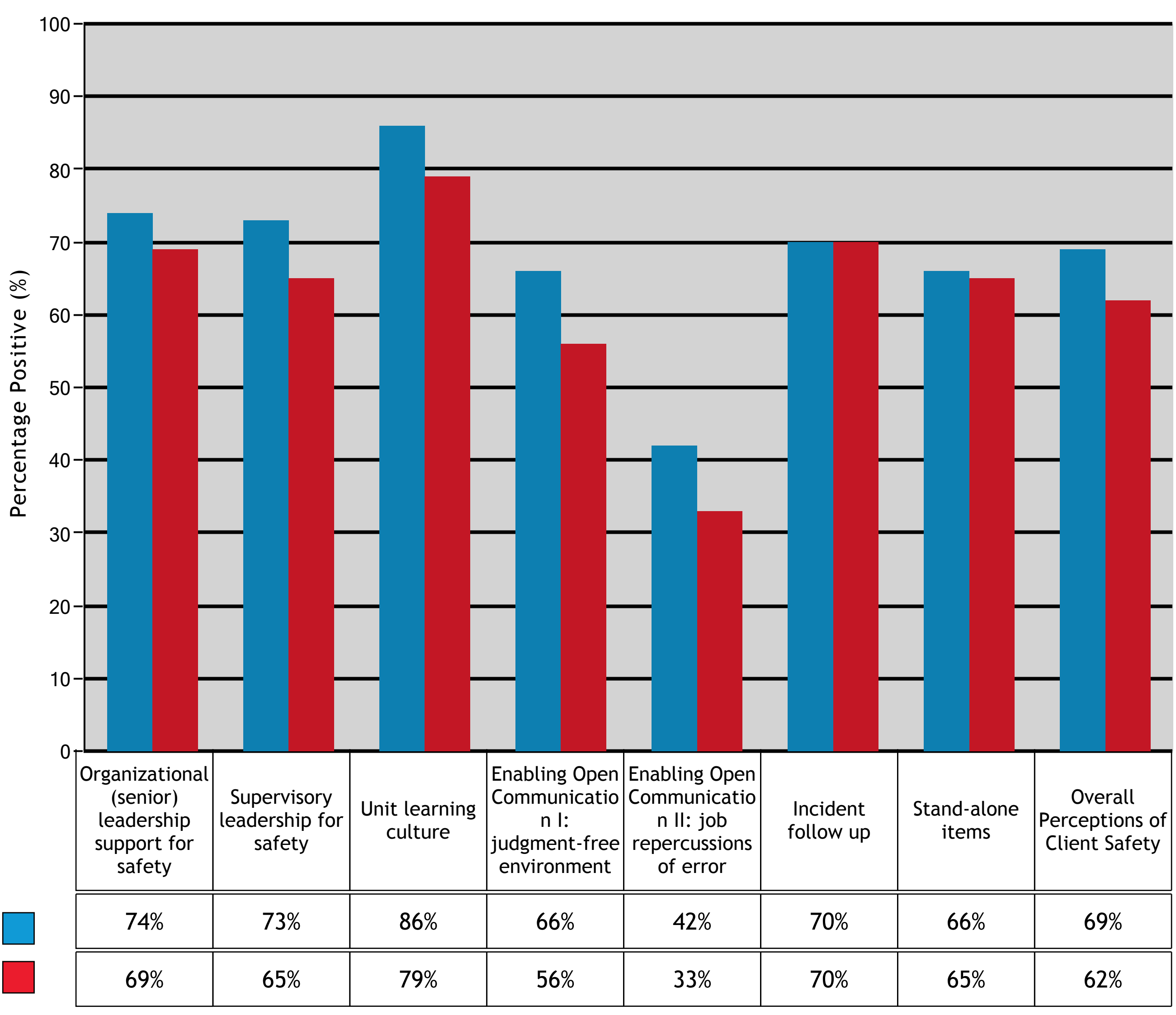
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: January 11, 2015 to February 6, 2015**
- **Minimum responses rate (based on the number of eligible employees): 340**
- **Number of responses: 423**

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
Health PEI	74%	73%	86%	66%	42%	70%	66%	69%
* Canadian Average	69%	65%	79%	56%	33%	70%	65%	62%

Legend

Health PEI

* 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

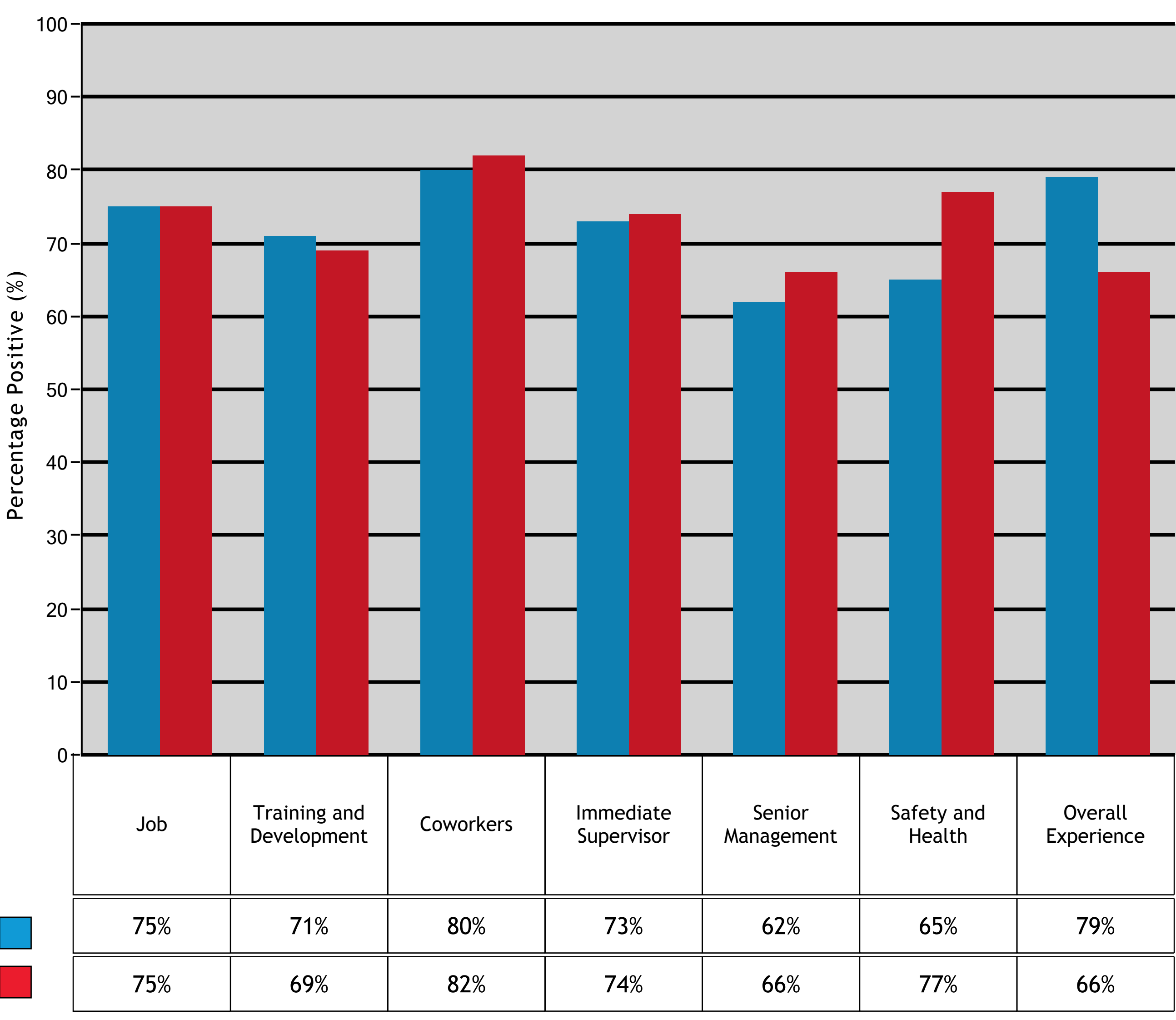
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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: April 11, 2016 to April 22, 2016**
- **Minimum responses rate (based on the number of eligible employees): 355**
- **Number of responses: 933**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
Health PEI	75%	71%	80%	73%	62%	65%	79%
* Canadian Average	75%	69%	82%	74%	66%	77%	66%

Legend

Health PEI

* 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.

Health PEI is a Crown Corporation responsible for the delivery of health services within the Province. The existence of this one organization with responsibility for the development of provincial standards and practices has proven to be a strong foundation for working with Islanders to promote and support improved health.
Health PEI is governed by a Board of Directors who are responsible for operational oversight and monitoring. The Board has recently completed a comprehensive strategic planning process that confirms the vision of one Island health system and improved health for Islanders.
As part of Health PEI's strategic planning process, the organization has established the following three great goals for 2017 to 2020:
Goal One - Improve quality and safety.
Goal Two - Improve access and coordination within community health and mental health/addictions.
Goal Three - Develop innovative approaches to improve efficiency.

Our 2017 Accreditation process has been a valuable learning experience. This external peer review compares Health PEI programs and services to national standards of excellence and reinforces our commitment to using evidence and best practice as the basis for clinical and administrative decision-making. Many of our staff, physicians, and patient/family advisors have spoken about the very positive experience of meeting with the surveyors, sharing information, and learning how we can continue to improve quality and safety.

The accreditation survey report highlights the fact that improving quality and safety is a journey. The survey report highlights significant improvements that have been made over the last four years. This reflects Health PEI staff and physician commitment to embedding continuous quality improvement into our day to day work in order to meet, and strive to exceed, national standards. We will continue to progress with the implementation and monitoring of our Quality and Patient Safety Plans. Improvements to address certain recommendations contained in this report are already underway.

Health PEI's greatest strength is the many committed people who deliver healthcare to Islanders each day. Our many staff and physicians have worked diligently to improve quality and safety and it is to their credit that Health PEI achieved the results reflected in the survey report and is well positioned to address the recommendations of Accreditation Canada.

Health PEI Board, staff and physicians will continue to work together and in partnership with Islanders to improve the quality and safety of our services and the overall patient/client experience.

Sincerely
Denise Lewis-Fleming
Acting CEO, HPEI

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