

Canadian Council on Health
Services Accreditation



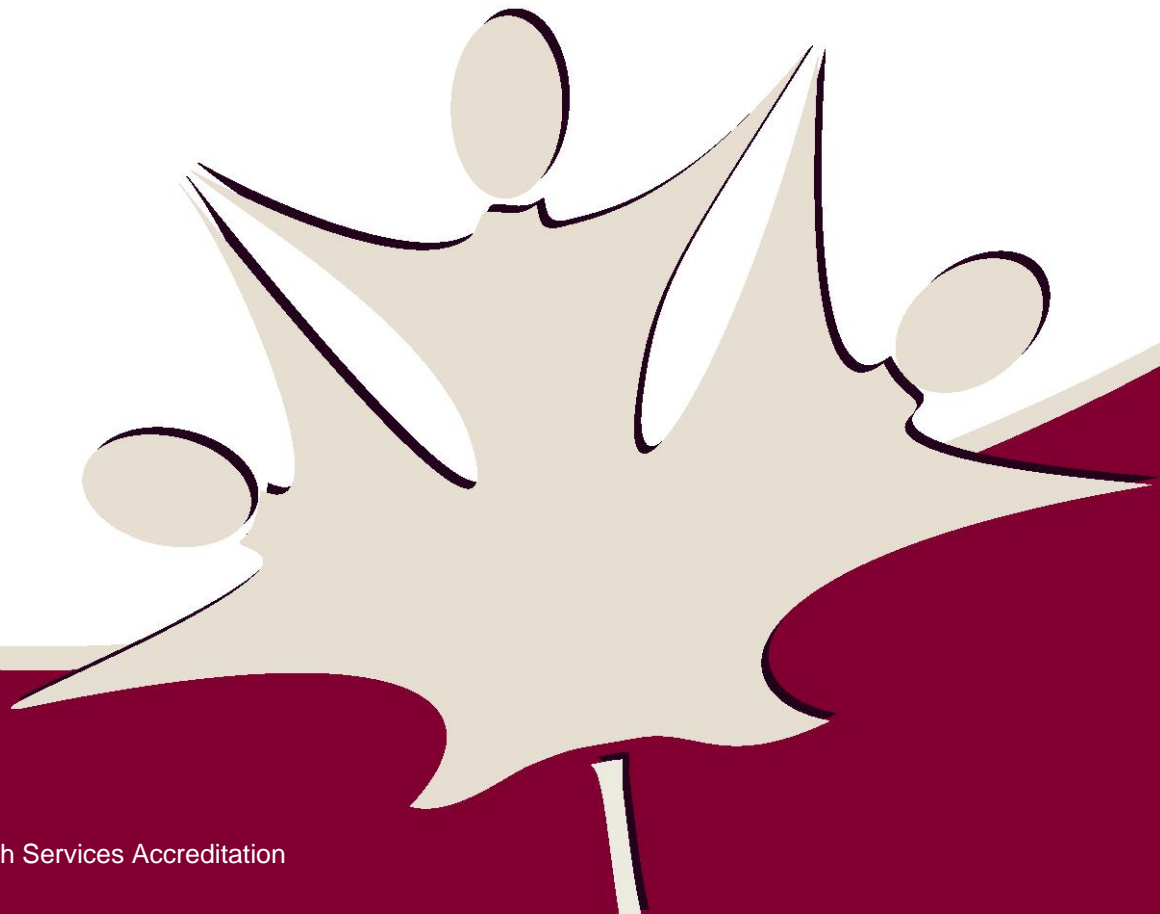
Conseil canadien d'agrément
des services de santé

Accreditation Survey Report

Community Hospital O'Leary

O'Leary, PE

September 16 - 21, 2007



CONFIDENTIALITY STATEMENT

The results of this accreditation survey are documented in the attached report, which was prepared by the Canadian Council on Health Services Accreditation (CCHSA) at the request of Community Hospital O'Leary.

This report is based on information obtained from the organization, as well as from other sources. CCHSA relies on the accuracy of this information to conduct the survey and to prepare the report.

This confidential report is intended for the organization only. The information herein may be disclosed at the organization's discretion; however, CCHSA assumes no responsibility for its release or subsequent use. If the reader of this notice is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this report is strictly prohibited.

Any alteration of this report is strictly prohibited and could result in a criminal conviction for fraud pursuant to the Criminal Code of Canada.

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ABOUT THIS REPORT

This report provides guidance for future quality improvement initiatives by documenting the findings from the organization's recent accreditation survey. The report is divided into four main sections: 1) Survey Summary; 2) Survey Details; 3) Team Findings; and 4) Future Direction.

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



Leading Practices

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



Recommendations

Recommendations are areas highlighted for improvement due to low compliance with the criteria. Recommendations are tied to a criterion and are given a risk rating related to the likelihood and severity of a potential adverse event, and urgency of addressing the issue.



Key Recommendations

Key recommendations are recommendations that are rated high urgency and need to be addressed as a priority.



Repeat Key Recommendations

Repeat key recommendations are recommendations that are rated high urgency and cover areas/issues that were the subject of a recommendation in the previous accreditation survey.



Total Recommendations

Total recommendations are the total number of recommendations related to a team, a quality dimension or descriptor, or a standard sub-section.

Risk Ratings

Ratings assigned to a recommendation, which measure the degree of risk related to non-compliance with a standard, based on the surveyor's assessment. The surveyor assesses the likelihood of an adverse event occurring, the severity of the event should it occur, and how urgently the recommendation must be addressed in order to avoid the occurrence of that adverse event.

H High

M Medium

L Low

Quality Dimensions

The dimensions define what CCHSA means by "quality". Please see the Appendix A for a full description of the Quality Dimensions and the corresponding descriptors.



Responsiveness



System Competency



Client/Community Focus



Worklife

SURVEY SUMMARY

The Accreditation Decision

Further to the survey held September 16 - 21, 2007, the Board of Directors of the Canadian Council on Health Services Accreditation (CCHSA) advises the Community Hospital O'Leary that it has been granted:

Accreditation with Report

Introduction

Every three years, as part of the accreditation process, health services organizations take part in a self-assessment followed by a survey visit. The survey itself includes a review of documentation, team interviews, facility tours and focus group meetings with various stakeholders. This accreditation process allows CCHSA and the organization to evaluate the quality of the organization's services by comparing them to nationally accepted standards.

This summary provides a synopsis of the results of the accreditation survey of Community Hospital O'Leary. It is CCHSA's intention that the comments and recommendations in the report will help the organization improve the care and service it provides to its clients. The information can be shared with internal and external partners such as stakeholders, staff, visiting family, volunteers, the public, and the media.

Survey Profile

The health organization is in O'Leary, PE. The survey was conducted by surveyors and included focus group interviews, team interviews, and onsite visits. Documentation from all teams was also reviewed.

The following teams participated in the accreditation survey:

Physical Environment Team, CHO
Leadership and Partnership, CHO
Acute Care Services, CHO

Survey Objectives

The organization's objectives for this accreditation survey are:

- 1) To promote and broaden a provincial perspective of continuous quality improvement.
- 2) To identify what it does well, learn from each other, and support and compare best practices provincially and nationally.
- 3) To support relationship building and partnerships across the continuum of care.
- 4) To promote and strengthen the knowledge of patient, resident, and client safety practices.
- 5) To have a survey visit experience that leaves the staff with a sense of pride and optimism.
- 6) To learn practices that reflect the national standards and models of innovative service delivery.
- 7) To assist the province in moving forward in continuous quality improvement.
- 8) To acknowledge the range of health staff and services that exists within the teams and the Prince Edward Island (PEI) health system.
- 9) To ensure debriefs are comprehensive and provide a balanced review of strengths and areas for improvement.

The objectives set out by the organization were met as surveyors spoke with teams, staff, clients. They also toured a number of facilities and interviewed a number of focus groups throughout PEI. Surveyors had the opportunity to provide information and share learnings. They were also able to acknowledge the work and accomplishments of the teams during the team interviews and at the debriefing and through this survey report. Recommendations and areas for improvement were also identified to guide the teams in the upcoming months and years on their journey towards quality improvement.

Organization Profile

Successes and Challenges

Successes

The organization is at the beginning stages of integration and it is trying to standardize processes. Some teams have already established provincial standards and others are at the first stages of implementation. Best practices and evidence-based best practices are being implemented in several areas of the organization.

Staff are striving to provide good quality care and there is a real concerted effort at team building and collaboration across sites.

There is good evidence of a positive work life and wellness culture throughout the organization and the teams. This is a positive environment for care and service delivery.

Challenges

The change in government has created significant gaps. The organization needs to create a provincial approach across the continuum for different program and services areas.

Health human resources and hiring practices need to be enhanced to meet the needs of this organization. For example, the organization needs to optimize the scope of practice.

Information management needs to be improved and integrated.

The physical infrastructure is a challenge in regards to multiple sites and the age of structures.

The organization needs to optimize and implement the pharmacy review. It also needs to clarify the ambiguity of the community hospital board legislation.


Response to Previous Survey Recommendations

This is the first survey for the Department of Health in PEI. Recommendations made to the previous regions have all been addressed.

List of Recommendations

Recommendations by Quality Dimensions

R Responsiveness

Physical Environment Team, CHO Criterion 5.10  Descriptor: Continuity

Recommendation

It is recommended that Community Hospital O'Leary and the Department of Health review the infection control practices across all sites and programs. The purpose of the review would be to identify and prioritize potential risk areas. The review should include roles, responsibility, and accountability including organizational structure, monitoring and surveillance, reporting, response capacity or containment measures, and external benchmarking.

Organization Rating	Survey Rating	Risk Rating		
3	3	Likelihood H	Severity H	Urgency H

Potential Adverse Event

There are significant risks that outbreaks of nosocomial infection may occur or are occurring and not being recognized. The consequences may be increased morbidity and mortality.

Reason for Urgency

The resources available for infection control vary as does the level of monitoring and reporting and the risk is substantial.

Acute Care Services, CHO

Criterion 6.2

Descriptor: Timeliness

Recommendation

It is recommended that the organization work with the Department of Health and other community partners to examine the issue of access to physiotherapy and other therapy services.

Organization Rating	Survey Rating	Risk Rating		
4	4	Likelihood M	Severity M	Urgency M

Potential Adverse Event

This may lead to less than optimal care and outcomes.

Reason for Urgency

Currently, the wait time for physiotherapy is one year.

Recommendation

It is recommended that the team with other acute care teams to examine the issue of access to diagnostic services. It is further recommended that alternative ways of using PACS to help manage the workload should be explored.

Organization Rating	Survey Rating	Risk Rating					
4	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

Prolonged morbidity and delay in treatment may result. Clients indicated that they have to wait months with conditions that severely restrict their activities of daily living. Reporting for some x-rays is up to eight weeks.

Reason for Urgency

There is a system in place for reporting critical or urgent x-rays using PACS and the on call radiologist. While there has been improvements since prior accreditation surveys, there continues to be significant waiting periods and delays in reporting. While improvements have been made in access for urgent and life threatening conditions, there are still significant delays in accessing services, such as ultrasound and the reading of non urgent investigations.

 System Competency

Recommendation

It is recommended that the organization develop an annual risk management plan, review policies and practices, and dedicate more staff to supporting activities that would help trend issues and incidents. These areas include, infection control and incident monitoring.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

There may be an outbreak of nosocomial infection or other situations that may not be managed appropriately.

Reason for Urgency

The organization has just gone through a re-structuring and needs to ensure that all the necessary risk management elements are in place.

Recommendation

It is recommended that Community Hospital O'Leary work with the Department of Health and other organizations, such as the local municipalities and emergency medical services to conduct a tabletop exercise of the mass causality plans. Consider including other hospitals in Prince County in the exercise as well. The testing of the mass causality plans should be carried out with all hospitals given the changes that have occurred with hospitals and emergency services.

Organization Rating	Survey Rating	Risk Rating		
3	3	Likelihood M	Severity M	Urgency M
Potential Adverse Event		Reason for Urgency		
The organization may not be prepared with a coordinated response in the event of a disaster.		There is increased risk of mortality and morbidity.		

Recommendation

It is recommended that Community Hospital O'Leary work with the Department of Health related to utilization measures and reporting. It is suggested that access and use of physiotherapy services be considered for initial study.

Organization Rating	Survey Rating	Risk Rating		
4	4	Likelihood M	Severity M	Urgency M
Potential Adverse Event		Reason for Urgency		
There may be ineffective use of scarce resources.		This is a long standing issue that has not been resolved. Client and staff focus groups identified timely access to physiotherapy services as a significant issue with direct patient and client impacts.		

Recommendation

It is recommended that the organization work with the Department of Health and others to develop a strategy focused on the determinants of health. Consider an equity issue, such as access to medications which the acute care team identified as barrier for the working poor or access to French language services which the community partners identified as a concern.

Organization Rating	Survey Rating	Risk Rating		
3	3	Likelihood M	Severity M	Urgency M

Potential Adverse Event

Reason for Urgency

There may be inequitable access to service and less than optimal results.

Current issues are identified in the community.



Recommendation

It is recommended that the organization work with the Department of Health to implement the recommendations of the pharmacy review and safe medication practices.

Organization Rating	Survey Rating	Risk Rating		
4	3	Likelihood H	Severity H	Urgency H

Potential Adverse Event

Reason for Urgency

Medication errors may result.

A critical incident has occurred and one factor identified was the staffing pattern and level in pharmacy.

Client/Community Focus

Leadership and Partnership, CHO Criterion 2.1 Descriptor: Communication

Recommendation

It is recommended that the organization develop a communications plan that aligns with an overarching provincial communications plan.

Organization Rating	Survey Rating	Risk Rating		
6	4	Likelihood M	Severity M	Urgency M

Potential Adverse Event

Staff, the public, patients, and community partners may not be engaged in the ongoing planning and design of services which may compromise the effectiveness of these activities.

Reason for Urgency

Community partners and staff in the focus groups indicated that they have not been engaged in a comprehensive communication process.

Acute Care Services, CHO

Criterion 11.5

Descriptor: Respect & Caring

Recommendation

It is recommended that the organization support the Department of Health's initiative to increase awareness and participate in organ donation.

Organization Rating	Survey Rating	Risk Rating		
N/A	4	Likelihood M	Severity M	Urgency M

Potential Adverse Event

Opportunities for organ donation and retrieval may be missed.

Reason for Urgency

Clients and patients are waiting for organ donation.

SURVEY DETAILS

Accreditation Decision Details

The Accreditation status informs the organization whether it has met the CCHSA eligibility requirements for accreditation, and gives the details on the conditions of that status, if any. This status, together with the findings from the self-assessment and the content of the report, give the organization a reference point from which to focus their continuous quality improvement efforts for the next three years.

As granted by the Board of Directors of CCHSA, the Community Hospital O'Leary has achieved the following Accreditation Recognition decision:

Accreditation with Report

Work with the Department of Health to implement the recommendations of the pharmacy review and safe medication practices. (Acute Care Services, CHO team, standard 14.0, criterion 14.5).

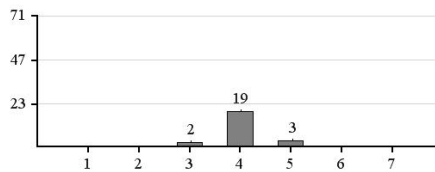
Review the infection control practices across all sites and programs. The purpose of the review would be to identify and prioritize potential risk areas. The review should include roles, responsibility, and accountability including organizational structure, monitoring and surveillance, reporting, response capacity or containment measures, and external benchmarking. (Physical Environment, CHO team, standard 5.0, criterion 5.10).

Overview by Quality Dimensions and Descriptors

The table below provides information on recommendations and ratings organized according to quality dimension and descriptor. For each quality dimension the following information is supplied:

- a frequency distribution showing how often each rating was given by surveyors for each quality dimension
- a listing of the number and type of recommendation for each quality descriptor if a recommendation was written or if the average rating was below 4.5
- the average rating for each applicable quality descriptor

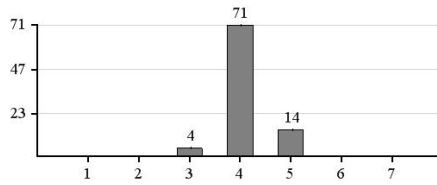
The frequency distribution of ratings for each dimension is particularly useful when quality dimensions have averages that are very similar because it shows how ratings at different levels can result in similar means. This increased specificity provides greater detail of how the organization was rated at particular levels of compliance between quality dimensions. Please see Appendix A for more information on quality dimensions and descriptors.



R Responsiveness

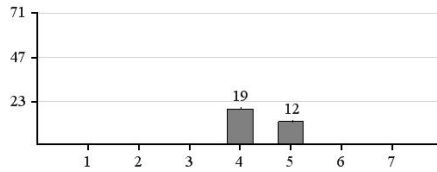
R **TR** **RR** **TR** Avg. Rating

	R	TR	RR	TR	Avg. Rating
Accessibility					4.0
Availability	1			1	3.8
Continuity		1		1	4.0
Equity					4.0
Timeliness	1			1	4.2
Dimension Total					
	2	1		3	



System Competency

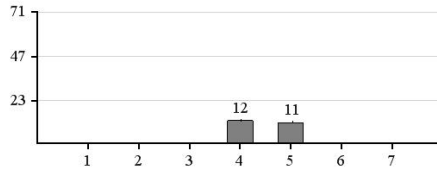
	R	T	PR	TR	Avg. Rating
Appropriateness					4.0
Competence					4.3
Effectiveness	1	1		2	4.0
Efficiency	1			1	4.0
Legitimacy					4.3
Safety	2			2	4.2
System Alignment					4.0
Dimension Total					
	4	1		5	



Client/Community

Focus

	R	T	PR	TR	Avg. Rating
Communication	1			1	4.1
Organization Responsibility and Involvement in the Community					4.3
Respect & Caring	1			1	4.6
Dimension Total					
	2			2	



R **HT** **PR** **TR** Avg. Rating

Culture					4.3
Learning Environment					4.4
Open Communication					4.0
	Dimension Total				
	8	2		10	

Focus Group Feedback

During the accreditation survey, the surveyor(s) met with focus groups representing clients, staff, and community partners. The surveyor(s) asked specific questions to each group to help assess how the organization is meeting the standards, as well as allow for comments about the overall experience. This report section provides a summary of the comments from each of the focus groups.

Client Focus Group

The acute care client focus group west included a family member of someone receiving respite care at SMH, a family member of someone who passed away at SMH, a patient with experience in outpatients and emergency at Western, and inpatient at Western, Summerside, and Halifax, an outpatient at CHO, and CHO emergency transfers.

A patient was in an isolation unit for two weeks and the medications were explained. They explained the other treatment that was required. The family member was instructed how to gown to enter.

One patient signed consent to be restrained in bed but does not recall doing this or the six-week period when it happened. The patient had several falls in hospital. He was advised about how difficult it would be to get out of bed and walk so he would ask for help before trying to become mobile. They instructed him on how to use the walker and they took every conceivable measure that they needed to take. He was discharged to an inpatient rehabilitation (rehab) unit before going home and the process was explained. They expected his arrival and the charts had been transferred. Information from the rehab unit came back to the local community for ongoing care.

The inpatient at Western was transferred to Summerside and was advised not to get out of bed without help. The patient ended up back in the Western hospital with a recurrence and was transferred to Halifax. A nurse in Halifax said "not another one!" which was the only negative experience.

Two patients said they got MRSA from Halifax. There were two more examples of getting an infection from Summerside. The patients said they would be comfortable complaining about care if a problem arose. There was a discrepancy between what a nurse told her and what the doctor told her.

The identification bands are checked even though they are known because this is a small community.

The patients have the procedure explained before giving consent.

The wait for MRI was explained.

They appreciate respite care at SMH and the staff were very caring and kind.

The staff at SMH long term care help residents have fun during recreational activity.

The acute care staff at SMH are very caring and the registered nurse sat with the patient because he seemed "down".

The CHO outpatient department staff are polite and nice.

The family doctor is very responsive in getting specialist care organized in a timely way.

Client Focus Group (Continued)

There was concern about how many times they have to tell their story. Two patients said that they were asked about allergies every time they were admitted or seen at outpatients even though they had been there before.

They described some continuity issues with locums coming and going.

One patient was discharged with an infection and when it got worse they had to go to emergency to have it swabbed.

Staff wash their hands but the doctors are not seen washing their hands.

One patient had to wait a year and a half for a knee replacement and one year for a shoulder replacement. There is a concern that PT does not have enough help. PT assessed her and gave the patient more urgent care because of her condition.

One patient was in a research trial and the staff explained the risks of medications. The patient was told that if she did not take a drug she would be in a wheelchair.

One client had difficulty getting follow up related to medications because of having no family doctor.

They have to wait a long time to see the same doctor or if they see one right away they have to repeat their story. There is not enough continuity with the locum physicians.

They would like to have nurse practitioners because there is no female doctor here to do physicals.

The response and care is great for urgent and emergent care, but chronic ongoing care has long waits and is not as good.

Staff Focus Group

The staff focus group included nurses, pharmacists, the diagnostic imaging manager, administrative support, the clinical leader, administration, housekeeping and physiotherapy. Many were long serving employees.

The mission, vision and values were done after a community needs assessment a few years ago.

A staff satisfaction survey was done in 2006 provincially and the issues are being addressed on a temporary basis such as security.

Satisfaction survey results were shared a few months ago. The results were discussed at the management level and some discussion is started at that level.

Staff have input and are involved when changes are made. Most of the time, staff are consulted. Staff are listened to within reason. They are not consulted for some things on the provincial side, such as the electronic health record.

Team work is fantastic and an interdisciplinary approach is important.

Department head meetings are planned to occur on a monthly basis but because of some conflicts, they occur six times a year. Staff can bring issues forward and then share them with other departments. The nurse coordinator is a good person to go to.

There is a lot of opportunity for new staff. New graduate nurses have mentors and good one-to-one training.

When new equipment is introduced the company usually does the training.

Most staff have had a performance appraisal in the last two years. The staff complete the form and meet with their direct supervisor. It includes their goals and objectives. They review the previous goals and look at new goals for the future.

Staff wellness resources are available in the community.

Prevention programs in the hospital include flu shots, stress management courses, mask fit testing, and staff can use the treadmill in the physiotherapy room.

The staff work well together. Everyone is involved and they get the job done. They share a lot. There is good camaraderie like an extended family. There are high standards of care.

Security was a big concern for staff with drugs coming in. Now there is a security guard on the site and the doors are locked.

They would like to see consistent times for the weekend non urgent clinics.

Infection control resources should be enhanced. There are gaps in infection control in some areas for resources such as nurses and education. Needle stick injuries in the community are also an issue. They need to track needle sticks and infections. This resource could be on line or by phone and not necessarily on site. They could use the example of poison control. There is a needless system for IV administration.

Staff Focus Group (Continued)

They need to reduce the duplication of services through one site facility.

Staff are frequently overwhelmed.

The feedback loop on communication does not always provide information back when issues are reported for patient safety.

It is hard to get to education sessions because of the difficulty in filling the position when the staff person is away. Funding is provided at a maximum amount per year. CPR training and emergency procedures training and updates are paid by the employer. There are opportunities for training in Nova Scotia. There are no opportunities for trauma or specialized training.

Community Focus Group

The community partners focus group included representatives from the auxiliary, the Stewart Memorial Hospital Foundation, the Canadian Physiotherapy Association, West Prince Pastoral Care Association, the Western Hospital Health Care Auxiliary, Lennox Island Health Center, and the First Nations Health Service.

Two individuals had participated in accreditation interviews previously.

There is good communication at the local level around pastoral issues.

The Department of Health is not communicating with the community. The Stewart Memorial Community Hospital Board recently forced one of the physicians to leave and go to O'Leary. The temporary superintendant was not informed of the action by the board.

There is concern with the appointed boards.

There are instances when communication from the Department of Health is lacking. There was an incident two years ago related to the accreditation department. Even before the report was released there were rumours that the emergency department would be closed. There was a sign indicating that it was the site of the future health center for Tyne Valley. The foundation is not kept informed by Department of Health. This has impacts on the foundation and how they invest their funds. They were not aware of the delay by the Department of Health in the construction of the new health center because there were not enough funds in the budget.

The Department of Health is often very good about consulting on issues at the start of the government's mandate but the experience has been that there is a failure to follow up on the issues within the timelines of the mandate.

There is concern that the local community health boards do not release the minutes of their meetings in spite of requests to do so. There is poor communication about their decisions.

The PEI Health Sector Council was recently established and its focus is to advocate in relation to health services.

Once the plan has been adopted there are problems in how the plans are implemented and communicated. When they work with the Department of Health there are commitments to change service.

There is a health service in French and they communicate with the DOH. There is a process of exchange with the Department of Health. There is a need to improve communications at the CHO O'Leary Hospital O'Leary board.

There is a lot of frustration with the health system in particular the limited availability of services in French for young people and seniors. There is no mechanism and it is not natural to offer the services in French. In a crisis people often want to be able to express themselves in their first language.

Department of Health communications related to the public health services have been very good for the First Nations; however, for home care the relationship is not very good. There is work occurring with public health to allow the nurses working for the First Nations to access the immunization information system.

There is concern that decisions are occurring behind closed doors and that there is not good or open communication.

Community Focus Group (Continued)

There is a need for a long term plan that looks at better integration of services. There are plans for sharing a physician in Tyne Valley.

There is a need for improved communication.

The Department of Health does not have a long term plan. The long term plan is four years.

The health system needs to change. They have all had enough of surveys and studies being done and then no action or change.

The board needs to be accountable to the community. They believed that the board need to be elected.

The association has made recommendations about the impact of communication challenges on the delivery of health care.

There was concern about who in the Department of Health was directing the health care and whether it is the Minister of Health or staff within the Department of Health.

There was concern that the determinants of health are not discussed at the local level.

There is concern over the continuity of care among people in the community. People have one doctor now and then a different doctor in six months.

There was an opportunity to participate on the West Prince ethical committee that operated for five years. There was a significant investment in training and orientation. With the latest change all the work was lost and all the time, energy, and money were lost.

There needs to be ongoing communication with the ethics committee.




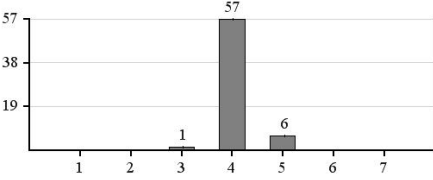
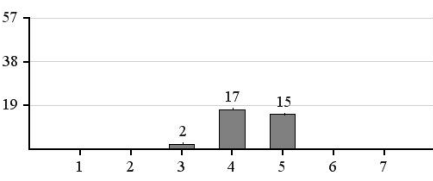
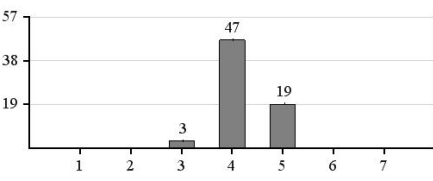
TEAM FINDINGS

Overview by Teams

The table below provides information on leading practices, recommendations and ratings organized by team, with the following information:




- a frequency distribution showing how often each rating was applied within a team
- a table listing the number and type of recommendation for each team
- the average rating for each team

The frequency distribution of ratings is particularly useful when teams have means that are very similar because it shows patterns that are not always evident using averages. Using this graph the organization can compare how often a team was rated at a particular level of compliance.

		R			TR	Avg. Rating
Leadership and Partnership, CHO						
		2			2	4.1
Physical Environment Team, CHO						
		1	1		2	4.4
Acute Care Services, CHO						
		5	1		6	4.2
Total		0	8	2	0	10

Leadership and Partnership, CHO

Rating at the Sub-section Level

	1	2	3	4	5	6	7		R			TR	Avg. Rating
Addressing needs		█	█	█									4.0
Having a positive relationship with the community		█	█	█					1			1	4.0
Meeting the organization's mandate		█	█	█									4.0
Being accountable to all stakeholders		█	█	█									4.0
Being ethical		█	█	█									4.0
Having a clear direction		█	█	█									4.1
Managing risk		█	█	█					1			1	4.1
Promoting a client safety culture		█	█	█									4.0
Promoting quality of worklife		█	█	█	█								4.4
Being a learning organization and achieving positive outcomes		█	█	█									4.0

Recommendations

 Leadership and Partnership, CHO Criterion 2.1 Descriptor: Communication

Recommendation

It is recommended that the organization develop a communications plan that aligns with an overarching provincial communications plan.

Organization Rating	Survey Rating	Risk Rating		
6	4	Likelihood M	Severity M	Urgency M

Potential Adverse Event

Staff, the public, patients, and community partners may not be engaged in the ongoing planning and design of services which may compromise the effectiveness of these activities.

Reason for Urgency

Community partners and staff in the focus groups indicated that they have not been engaged in a comprehensive communication process.

Recommendation

It is recommended that the organization develop an annual risk management plan, review policies and practices, and dedicate more staff to supporting activities that would help trend issues and incidents. These areas include, infection control and incident monitoring.

Organization Rating	Survey Rating	Risk Rating		
3	3	Likelihood M	Severity M	Urgency M

Potential Adverse Event

There may be an outbreak of nosocomial infection or other situations that may not be managed appropriately.

Reason for Urgency

The organization has just gone through a re-structuring and needs to ensure that all the necessary risk management elements are in place.

Key Findings

Addressing needs	Criteria	Organization Rating	Survey Rating
1.0 The organization anticipates and responds to the community's changing needs and health status.	1.1	4	4
	1.2	5	4

Strengths:

The team included board members, senior administration, the medical director, the director of nursing, and staff representation. Two board members were unable to attend. The leadership team consists of the management and board members.

The community needs assessment and community profile included in the self-assessment was very helpful.

Utilization data is tracked annually and is reported to the board including length of stay (LOS) and case mix groups (CMG).

Patient feedback is obtained through patient satisfaction and the complaints process.

A review of acuity and utilization of the emergency department led to a re-configuration of services so that some patients can be seen in a clinic rather than emergency.

Community forums were held to discuss the single hospital proposal.

There is a community partner feedback survey.

The annual board meeting is open to the public.

Areas for Improvement:

Develop a closer relationship with the heart and stroke foundation to jointly address promotion and prevention and improve access to care.

Develop a closer relationship with primary care.

Key Findings (Continued)

Having a positive relationship with the community	Criteria	Organization Rating	Survey Rating
2.0 The organization has broad and meaningful linkages and partnerships with other organizations and with the community.	2.1	6	4
	2.2	6	4
	2.3	6	4
3.0 The governing body and managers promote, support, and participate in ongoing community development.	3.1	5	4

Strengths:

Local communication vehicles have been identified. These include; the newsletter, staff meetings, annual meetings, annual reports, community forums, and the local newspapers.

The Community Hospital O'Leary (CHO) proactively identified community partners and notified them of the needs assessment. They were invited to put up booths in the hospital lobby.

Staff are invited to speak to community groups.

Board meetings will become open to the public with an opportunity for questions. The annual meeting is open. The organization hosted the community needs consultation.

There was good attendance at the community needs assessment and a single facility consultation process. There were 1200 in over ten sessions.

The community has responded to appeals and requests from the board related to parking on hospital property and a donation to long term care.

Joint meetings between the boards of the CHO and Western are held.

Community services use hospital space and the hospital collaborates with several community based agencies.

They circulate a newsletter in the community to inform the public about community services, such as meals on wheels and narcotic anonymous.

Client education material is circulated in the community.

Members of the Leadership and Partnership committee are active participants in community organizations.

Key Findings (Continued)

Areas for Improvement:

Develop a formal strategy for communicating with the communities served and with potential community partners. The communication strategy should specifically address the issue of access to board meetings and minutes.

Improve communication on physician hours and the location of service.

Work with the Department of Health and other community health boards on a communications strategy and plan that supports the strategic plan of the department and the business plan of the board.

Key Findings (Continued)

Meeting the organization's mandate	Criteria	Organization Rating	Survey Rating
4.0 The organization's mission gives it direction.	4.1	4	4
	4.2	4	4

Strengths:

The vision, mission, and values statements are complete and are being disseminated.

Areas for Improvement:

Provide staff input as planned.

Key Findings (Continued)

Being accountable to all stakeholders	Criteria	Organization Rating	Survey Rating
5.0 The organization is effectively and efficiently governed.	5.1	5	N/A
	5.2	4	N/A
	5.3	6	4
	5.4	4	4
	5.5	5	4
	5.6	5	4

Strengths:

The Hospital Authority Act clearly defines the scope and the board has been oriented to this. Its role was communicated to the community, staff, and volunteers at the annual general meeting.

The board members receive education about roles and responsibilities, governance, and business planning. They receive workload data, vacancy rates, medical compliance with medical records in a timely fashion, with access to national standards such as the Canadian institute of health information (CIHI).

There is a formal evaluation of the administrator.

The board has submitted a joint request with two other rural boards for an infection control service. It is more efficient to collaborate.

Areas for Improvement:

Ensure that the board communicates openly with staff, the public, and community partners and move forward with plans to have open board meetings.

Provide more educational opportunities for stakeholders.

Increase the clarity about the roles and responsibilities of the board and the Department of Health.

Develop a mechanism to evaluate the board's performance. Informal monitoring occurs through regular contact and discussions.

Key Findings (Continued)

Being ethical	Criteria	Organization Rating	Survey Rating
6.0 The organization delivers services and makes decisions in accordance with its values, and with its own code of ethics or other recognized codes of ethics.	6.1	4	4
	6.2	4	4
	6.3	4	4

Strengths:

The new mission and values are consistent with the former mission and values. They reflect the staff who work in CHO.

Workshops are being held with staff to build on the values statement supported by the employee/employer committee.

The board has adopted a draft code of ethics that the organization and its staff are using.

Areas for Improvement:

Develop a process for the resolution of ethical dilemmas.

Develop a business ethics policy, such as the request for proposal rules for contracts and purchases.

Key Findings (Continued)

Having a clear direction	Criteria	Organization Rating	Survey Rating
7.0 The organization has a clear direction and achieves the desired results.	7.1	4	4
	7.2	4	4
	7.3	3	4
	7.4	4	4
	7.5	4	4
	7.6	5	4
8.0 The organization is characterized by open communication and good working relationships.	8.1	5	4
	8.2	4	4
	8.3	5	5
9.0 Human, financial, and physical resources are appropriately allocated throughout the organization.	9.1	4	N/A
	9.2	4	N/A

Strengths:

For the purposes of rating the community hospitals, they were assessed on the basis of operational or business planning not strategic planning, for which the department is responsible.

CHO has developed a business plan that is aligned with the provincial strategic plan. The community partners and staff were involved with the development of the goals and objectives.

There are some good forums, events, and processes in place to support good communication.

Management attendance at conferences and workshops is supported.

There are several good examples of support for healthy living.

The community hospital boards are bound by the Treasury Board and the Department of Health finance rules. The CHO cannot allocate resources independently. The boards and administration have a limited ability to re-allocate resources due to Department of Health and government regulations. They must apply to the Treasury Board to create a new position even if the funding is found.

Areas for Improvement:

Improve the access to services such as Mental Health and Addictions (MHA) and oncology.

Conduct regular department head meetings to facilitate communication.

Conduct management succession planning.

Develop an approach for allocating limited resources within a constrained environment.

Key Findings (Continued)

Managing risk	Criteria	Organization Rating	Survey Rating
10.0 The governing body and managers prevent and manage any risks to the organization.	10.1	3	4
	10.2	3	3
	10.3	N/A	4
	10.4	N/A	4
	10.5	4	4
11.0 The organization's financial resources are protected and controlled.	11.1	4	4
	11.2	4	4
	11.3	4	4
12.0 Contracted services are delivered according to the terms set out in the contract.	12.1	5	4
	12.2	5	4
13.0 The governing body and managers prevent and manage sentinel events, adverse events, and near misses.	13.1	4	4
	13.2	6	5
	13.3	6	5
	13.4	4	4
	13.5	4	4
	13.6	4	4
	13.7	6	4
	13.8	4	4
	13.9	4	4

Strengths:

There is a provincial research committee in place. The local board should still be made aware of projects that its patients might be involved in because of potential operational impact, such as workload.

There is good investigation and follow up of medication incidents.

The board and senior management have basic risk management measures in place.

Treasury Board policies and Department of Health financial policies are followed.

The new Department of Health centralized purchasing requires tendering process for purchases over a defined limit.

There is evidence of good debriefing and follow up with policy changes after a sentinel event.

Key Findings (Continued)

Areas for Improvement:

Work towards developing a research process and identifying key areas. The clients reported that they were involved in research studies being done at O'Leary.

Develop an annual risk management plan, review the policies and practices, and dedicate more staff to support activities that would help trend issues and incidents such as infection control and incident monitoring.

Address the team's inability to produce the last two audited statements.

Key Findings (Continued)

Promoting a client safety culture	Criteria	Organization Rating	Survey Rating
14.0 The organization monitors and improves client safety on an ongoing basis.	14.1	4	4
	14.2	3	4
	14.3	3	4
	14.4	4	4
	14.5	3	4

Strengths:

The board is a strong advocate for patient safety. It has engaged staff to identify the need for more infection control, and has built this into the business plan which is still waiting approval by the Department of Health.

Patient safety issues are discussed at management meetings, department meetings, and staff meetings.

Professional staff are endeavouring to stay linked to provincial and national bodies to keep updated on best practice.

Areas for Improvement:

Provide more resources for infection control.

Document the results of evaluating the safety initiatives.

Key Findings (Continued)

Promoting quality of worklife	Criteria	Organization Rating	Survey Rating
15.0 Organizational culture enables staff to strive towards care/service excellence for all clients.	15.1	5	5
	15.2	5	4
	15.3	5	4
	15.4	4	4
	15.5	5	5
	15.6	5	5
	15.7	4	4

Strengths:

There are many good examples in the self assessment of support for a positive staff culture.

Areas for Improvement:

Continue to work with staff to improve the culture which suffered during the recent restructuring.

Key Findings (Continued)

Being a learning organization and achieving positive outcomes	Criteria	Organization Rating	Survey Rating
16.0 The organization has a clearly defined and coordinated quality improvement system to continually monitor, evaluate, and improve quality.	16.1	4	4
	16.2	3	4
	16.3	4	4
	16.4	5	4
	16.5	3	4
17.0 The organization achieves the best possible results or outcomes.	17.1	4	4
	17.2	4	4
	17.3	4	4
	17.4	4	4

Strengths:

The culture supports a quality improvement approach.

They have identified priorities in the strategic and business plans.

The team has created a no-blame environment so that people feel it is safe to report incidents.

Areas for Improvement:




Provide more dedicated resources to monitor and improve quality. The team has identified some quality control activities such as diagnostics, but there are limited resources.

Work with the Department of Health to develop a robust quality improvement (QI) program.

Work with the ministry and the Department of Health to develop more formal processes and indicators to measure organizational effectiveness at the operational level.

Physical Environment Team, CHO

Rating at the Sub-section Level

	1	2	3	4	5	6	7		R			TR	Avg. Rating
Providing a suitable environment		██████████											4.6
Minimizing adverse events		██████████							1	1		2	4.3
Respecting the environment		██████████											5.0
Being a learning organization and achieving positive outcomes		██████████											4.0

Recommendations

R Physical Environment Team, CHO Criterion 5.10  Descriptor: Continuity

Recommendation

It is recommended that Community Hospital O'Leary and the Department of Health review the infection control practices across all sites and programs. The purpose of the review would be to identify and prioritize potential risk areas. The review should include roles, responsibility, and accountability including organizational structure, monitoring and surveillance, reporting, response capacity or containment measures, and external benchmarking.

Organization Rating	Survey Rating	Risk Rating					
3	3	Likelihood	H	Severity	H	Urgency	H

Potential Adverse Event

There are significant risks that outbreaks of nosocomial infection may occur or are occurring and not being recognized. The consequences may be increased morbidity and mortality.

Reason for Urgency

The resources available for infection control vary as does the level of monitoring and reporting and the risk is substantial.

Recommendation

It is recommended that Community Hospital O'Leary work with the Department of Health and other organizations, such as the local municipalities and emergency medical services to conduct a tabletop exercise of the mass causality plans. Consider including other hospitals in Prince County in the exercise as well. The testing of the mass causality plans should be carried out with all hospitals given the changes that have occurred with hospitals and emergency services.

Organization Rating 3	Survey Rating 3	Risk Rating
		Likelihood M Severity M Urgency M

Potential Adverse Event

The organization may not be prepared with a coordinated response in the event of a disaster.

Reason for Urgency

There is increased risk of mortality and morbidity.

Key Findings

Providing a suitable environment	Criteria	Organization Rating	Survey Rating
1.0 The organization's physical environment contributes to the well-being of clients, staff, and visitors.	1.1	6	5
	1.2	5	5
2.0 The organization uses equipment, supplies, medical devices, and space safely, efficiently, and effectively.	2.1	5	4
	2.2	6	5
	2.3	6	4
	2.4	6	4
	2.5	5	5
	2.6	5	5
	2.7	4	4

Key Findings (Continued)

Strengths:

The organization has adapted to having part of the facility air conditioned by adjusting patient placement as required. Air conditioning is supplied to the new wing of the long term care, with the exception of nine resident rooms.

The building is thirteen years old.

There are pictures and words on the signage.

They comply with the smoke-free legislation.

The facility has an arrangement with the surrounding farms so that when there is pesticide use, the hospital is informed so the air handling system can be shut down before the application and for one to two hours afterward. There are policies to shut down air intake in the event of wood smoke concerns that can arise during the winter months.

There is a decontamination room just off the ambulance bay, with shower units and drains that can accommodate wheelchairs or a stretcher if the door is open.

The facility has a negative pressure room. The facility has an isolation room with a positive pressure entry cubicle that has a sink.

There is a tendering process, which has resulted in cost savings of thirty to forty percent. Central purchasing provides consistency in equipment being purchased across the sites.

Tender requirements usually include staff training. Ongoing training is absorbed into orientation and continuing education.

There are weekly and daily equipment mechanical checks.

They discard single use items.

There is back up for electricity, phone, and med air. During the course of the visit, there was a power outage and the backup power came on within twenty seconds.

Food safety training is provided and the staff follow universal precautions. Personal protective equipment is available.

The administrator meets regularly with the auxiliary and the foundation to discuss the budget that has been approved by the Department. The approach has been to expend the hospital budget first, and if there is a need the foundation is approached. The foundation is approached for major cost items such as Century tubs for long term care.

There are two boilers and one is a back up. There is the potential to use the steam boiler that usually runs the autoclave. It can also provide backup in the event that both boilers fail.

There are two wells and the water is tested quarterly by environmental health across four sites. There is sufficient bottled water supply on site to last one day which would allow them time to bring more in.

Key Findings (Continued)

There are reports on positive follow up of issues raised by environmental health and the workers compensation board in the evidence binder.

The organization has established processes for dealing with events or situations that required air exclusion.

Areas for Improvement:

Develop an inventory of equipment and establish a preventive maintenance schedule. Work with other community health boards and the Department of Health to develop the inventory so that it can be updated through the coordinated central purchasing system. This will help support the handling and management of safety alerts and equipment recalls as there would be a province-wide inventory of equipment.

Conduct regularly scheduled fire inspections with follow up on any recommendations and ensure that a copy is available for administration. The Community Hospital O'Leary (CHO) has regular inspections by the fire marshal, but the last report could not be found and the administrator did not recall seeing it. When the fire marshall's office was contacted for a copy, they said that an inspection was overdue and scheduled one for the following week.

Address the cooling problem in half of the building as noted by the team.

Provide regular education and more documentation about who attends education sessions.

Follow up on the lighting problems in the pharmacy area.

Key Findings (Continued)

Minimizing adverse events	Criteria	Organization Rating	Survey Rating
3.0 The organization minimizes potential hazards and risks wherever the clients receive services.	3.1	5	5
	3.2	4	4
	3.3	5	4
4.0 The physical environment supports staff physical, mental, and emotional health.	4.1	5	5
	4.2	6	5
	4.3	5	5
	4.4	4	5
5.0 The organization prevents and controls infections.	5.1	3	4
	5.2	4	4
	5.3	5	5
	5.4	3	4
	5.5	6	4
	5.6	3	4
	5.7	4	4
	5.8	N/A	N/A
	5.9	4	4
	5.10	3	3
6.0 The organization is prepared for disasters and emergencies.	6.1	3	3
	6.2	5	4
	6.3	6	5
	6.4	5	5
	6.5	N/A	N/A

Strengths:

There is a new incident policy.

The organization has a negative pressure room.

Three staff are certified as sterile processing technicians.

There is a regional infection control group. They use the current Canadian infection control guidelines.

Food safety training is done annually.

The self assessment shows that the organization and the team have made good use of local expertise and connections such as the fire department to assist with the call system. There is a fan-out system, a back up generator, walkie talkies, a decontamination shower, an evacuation plan, and access to trained staff in Child and Family Services for critical incident debriefing.

Regular fire drills are held. Maintenance is responsible for ensuring the appropriate safety checks and assessments are done such as the fire marshal's assessment, fire panel check, and sprinkler testing.

Key Findings (Continued)

The organization has sufficient instruments to continue for a whole day if there is a sterilizer break down with back up materials from Western Hospital.

There was an incident approximately two years ago when the nursing staff noticed what they thought was a propane leak. The nursing staff notified administration and the fire department. The propane was turned off and they considered evacuation. The fire department ventilated the building and the odour did not recur. The propane supply company also attended.

Areas for Improvement:

Review the infection control practices across all sites and programs to identify and prioritize potential risk areas. The review should include roles, responsibilities, and accountability including organizational structure, monitoring, surveillance, reporting and response capacity, containment measures, and external benchmarking. The resources available for infection control vary as does the level of monitoring and reporting. There are significant risks that outbreaks of nosocomial infection may occur or are occurring and are not being recognized. This could lead to increased morbidity and mortality.

Work with the Department of Health and other organizations, such as the local municipalities and emergency medical services to conduct a tabletop exercise of the mass causality plans. Consider including other hospitals in Prince County in the exercise as well. The testing of the mass causality plans should be carried out with all hospitals given the changes that have occurred with hospitals and emergency services. The team has identified a lack of coordination and knowledge of the broader community disaster plan.

Identify the potential hazards related to staff working alone. While there is a policy for staff working alone, there are some areas that require attention. Potential areas that the team has identified include the admitting area and the emergency nursing area. The hospital has hired a security firm, but it does not intervene with aggressive clients.

Follow up on the findings of the security/safety audit that have been completed. There is no evidence of a hazard policy or procedure.

Assign a dedicated infection control registered nurse and improve the coordination and consistency related to preventing and controlling infections. There is no dedicated infection control nurse west of Summerside.

Work with the Department of Health to develop a process to trend infection rates.

Develop a robust disaster plan that has linkages to the local community, the police, EMS, the fire department across community boundaries to link with a provincial disaster plan. The team developed a disaster plan and tested it in 2006. There were some follow up revisions to the phone fan-out list in May 2007. The plan is focused on the CHO internal organization and does not link with other parts of the community and other jurisdictions.

Key Findings (Continued)

Respecting the environment	Criteria	Organization Rating	Survey Rating
7.0 While providing services, the organization protects and improves the health of the environment, in partnership with the community and other organizations.	7.1	6	5
	7.2	6	5

Strengths:

There are many positive environmentally-friendly examples.

Areas for Improvement:

Purchase spill kits.

Key Findings (Continued)

Being a learning organization and achieving positive outcomes	Criteria	Organization Rating	Survey Rating
8.0 The organization regularly evaluates and improves its processes for managing the environment to achieve the best possible results.	8.1	5	4
	8.2	4	4
	8.3	5	4

Strengths:

The team is working with the province to determine province-wide indicators.

There is regular monitoring of the cleanliness of the environment.

The occupational health and safety officer monitors the incidence of staff injuries.

The provincial infection control team provides information on infection rates for diseases such as influenza.




Areas for Improvement:

Work with the Department of Health to identify the priority health indicators that will be monitored across the sites. This would create the potential opportunity for the environmental health teams to share their experience in identifying and resolving issues. It could allow for a focus on a small number of particular issues in the business plan, such as infection control, energy efficiency, or workplace injury.


Implement a system of surveillance for nosocomial infections.

Acute Care Services, CHO

Rating at the Sub-section Level

	1	2	3	4	5	6	7		R			TR	Avg. Rating
Being a learning organization and achieving positive outcomes									1			1	4.1
Achieving wellness									1			1	3.7
Being responsive									1			1	4.0
Addressing needs									1			1	4.1
Empowering clients									1			1	4.7
Setting goals and monitoring achievements													4.8
Delivering services										1		1	4.0
Maintaining continuity													4.7

Recommendations

 Acute Care Services, CHO	Criterion 3.5	Descriptor: Efficiency
Recommendation		
It is recommended that Community Hospital O'Leary work with the Department of Health related to utilization measures and reporting. It is suggested that access and use of physiotherapy services be considered for initial study.		
Organization Rating 4	Survey Rating 4	Risk Rating Likelihood M Severity M Urgency M
Potential Adverse Event	Reason for Urgency	
There may be ineffective use of scarce resources.	This is a long standing issue that has not been resolved. Client and staff focus groups identified timely access to physiotherapy services as a significant issue with direct patient and client impacts.	

S Acute Care Services, CHO Criterion 4.3 Descriptor: Effectiveness

Recommendation

It is recommended that the organization work with the Department of Health and others to develop a strategy focused on the determinants of health. Consider an equity issue, such as access to medications which the acute care team identified as barrier for the working poor or access to French language services which the community partners identified as a concern.

Organization Rating 3	Survey Rating 3	Risk Rating		
		Likelihood M	Severity M	Urgency M

Potential Adverse Event Reason for Urgency

There may be inequitable access to service and less than optimal results. Current issues are identified in the community.

R Acute Care Services, CHO Criterion 6.2 Descriptor: Timeliness

Recommendation

It is recommended that the organization work with the Department of Health and other community partners to examine the issue of access to physiotherapy and other therapy services.

Organization Rating 4	Survey Rating 4	Risk Rating		
		Likelihood M	Severity M	Urgency M

Potential Adverse Event Reason for Urgency

This may lead to less than optimal care and outcomes. Currently, the wait time for physiotherapy is one year.

R Acute Care Services, CHO Criterion 8.1 Descriptor: Availability

Recommendation

It is recommended that the team with other acute care teams to examine the issue of access to diagnostic services. It is further recommended that alternative ways of using PACS to help manage the workload should be explored.

Organization Rating	Survey Rating	Risk Rating					
4	3	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

Prolonged morbidity and delay in treatment may result. Clients indicated that they have to wait months with conditions that severely restrict their activities of daily living. Reporting for some x-rays is up to eight weeks.

Reason for Urgency

There is a system in place for reporting critical or urgent x-rays using PACS and the on call radiologist. While there has been improvements since prior accreditation surveys, there continues to be significant waiting periods and delays in reporting. While improvements have been made in access for urgent and life threatening conditions, there are still significant delays in accessing services, such as ultrasound and the reading of non urgent investigations.

A Acute Care Services, CHO Criterion 11.5 Descriptor: Respect & Caring

Recommendation

It is recommended that the organization support the Department of Health’s initiative to increase awareness and participate in organ donation.

Organization Rating	Survey Rating	Risk Rating					
N/A	4	Likelihood	M	Severity	M	Urgency	M

Potential Adverse Event

Opportunities for organ donation and retrieval may be missed.

Reason for Urgency

Clients and patients are waiting for organ donation.

Recommendation

It is recommended that the organization work with the Department of Health to implement the recommendations of the pharmacy review and safe medication practices.

Organization Rating 4	Survey Rating 3	Risk Rating		
		Likelihood H	Severity H	Urgency H

Potential Adverse Event

Medication errors may result.

Reason for Urgency

A critical incident has occurred and one factor identified was the staffing pattern and level in pharmacy.

Key Findings

Being a learning organization and achieving positive outcomes	Criteria	Organization Rating	Survey Rating
1.0 The team continually plans and designs its services to meet the current and future needs of the populations it serves, and to achieve the best possible outcomes.	1.1	5	4
	1.2	5	4
	1.3	4	4
2.0 The team uses research, evidence, and best practice information to develop and improve its services.	2.1	4	4
	2.2	4	4
	2.3	5	4
	2.4	5	4
	2.5	6	5
3.0 The team monitors and improves the quality of its services to achieve the best possible outcomes.	3.1	4	4
	3.2	5	4
	3.3	4	4
	3.4	5	4
	3.5	4	4

Key Findings (Continued)

Strengths:

The team has identified priority areas for quality improvement.

They use utilization data to plan patient education. Utilization data is easily available to administrators on the desk top.

The provincial research ethics committee will serve as a foundation for local policies and procedures.

Best practice guidelines are available for staff.

The team researches best practice evidence before implementing a new practice, such as the wandering system and the needleless system.

The team was originally a continuous quality improvement (CQI) team for three acute hospitals in Prince County. It has split into three separate groups to do the self assessment. The team would like to join with its sister hospital, Stewart Memorial, to collaborate in CQI.

Physiotherapy gives resource information to patients about best practice and evidence-based treatments.

They expect a new doctor to arrive who is interested in research, so the team is interested in becoming more informed and in linking with the provincial research and ethics committee.

The registered nurses association of Ontario (RNAO) has recently re-defined the clinical protocols so the team has reviewed and adapted some of these protocols. They will develop a clinical practice committee with pharmacy and the physicians.

They encourage student placements as an effective source of recruiting new staff.

The wait for Physiotherapy (PT) has been a chronic complaint from patients, so a process was developed for a PT aide to prioritize and screen clients. Patients are able to see alternatives to their waiting.

There is an annual report with internal data on utilization.

Key Findings (Continued)

Areas for Improvement:

Continue to meet as the Acute Care West quality improvement team for critical mass and as part of the acute care quality council.

Work with the provincial research committee to establish a process for clients who are participating in research from Halifax or St. John's so that it is appropriate for the patient to receive medication treatment here.

Ensure that the provincial research committee informs healthcare workers and facilities of any research studies that have been approved through the website or other approach. Ensure that this is in place for the new physician, who has indicated an interest in research.

Provide more information and communication about board meetings.

Access more information from the government.

Develop a utilization committee.

Identify ways for the team to join with Western to collaborate in CQI.

Address the issues with medication coverage for migrant workers who are the working poor. They are not eligible for support. Low income injured workers may have to face a Physiotherapy wait list and they cannot afford the private options.

Enhance communication and continuity of care that can sometimes be an issue given that patients are transferred between CHO/PCH and Halifax.

Use the upcoming Electronic Health Record (EHR) to develop some standard protocols. The team had some difficulty getting drug protocols accepted by medical advisory committee (MAC).

Track the average length of stay (ALOS) from the Canadian Institute of Health Information (CIHI). The data was received in June, but there have not been reports since this time.

Increase the effort in prevention related to obesity and smoking.

Key Findings (Continued)

Achieving wellness	Criteria	Organization Rating	Survey Rating
4.0 The team, working with the community, promotes health, prevents or detects health problems early, and maximizes the well-being of those it serves.	4.1	4	4
	4.2	4	4
	4.3	3	3

Strengths:

Many resources have been identified such as flu clinics and smoking cessation programs.

The team has identified vulnerable populations within the community and from the utilization data so it can design services around them.

Areas for Improvement:

Increase the emphasis on preventive screening for certain population groups as some clients indicated that they were reluctant since there was no female physician or nurse practitioner to do their screening.

Improve access and coordination related to diabetes and mental health and addiction services.

Develop measurable goals and outcomes in partnership with the Department of Health and population health.

Key Findings (Continued)

Being responsive	Criteria	Organization Rating	Survey Rating
5.0 The team's services are integrated and coordinated to ensure continuity of service for the populations it serves.	5.1	5	4
	5.2	5	4
	5.3	5	4
6.0 The clients' first contacts with the team lead to the best decision about services.	6.1	3	4
	6.2	4	4
	6.3	5	4
	6.4	4	4
	6.5	4	4
	6.6	4	4

Strengths:

A physiotherapy screening assessment is completed.

There is referral for urgent or life threatening conditions.

New staff are oriented to the services available in the community, and they receive a reference booklet.

Processes are in place to review and prioritize incoming referrals for Physiotherapy (PT), nutrition, occupational therapy (OT), and mental health.

Wait times are monitored and information is communicated.

Areas for Improvement:

Improve the utilization and waiting list information. Waiting times for physiotherapy are over a year and there is a pre assessment or screening by the aide to prioritize clients. Diagnostic imaging (DI) has a six to eight week period before reports. Options exist for improved access and reporting for urgent cases using PACS. Access to family physicians is very restricted resulting in the use of locums and emergency as an alternative care site. There are delays for serious conditions that restrict activities of daily living but are not immediately life threatening.

Improve the completion of patient information on requisitions for DI and pharmacy.

Key Findings (Continued)

Addressing needs	Criteria	Organization Rating	Survey Rating
7.0 The team accurately and appropriately assesses its clients.	7.1	5	4
	7.2	6	4
	7.3	4	4
	7.4	4	4
	7.5	N/A	N/A
8.0 The team has access to diagnostic services that are safe, efficient, and accurate.	8.1	4	3
	8.2	5	4
	8.3	5	5
	8.4	5	5
	8.5	5	4

Strengths:

Standardized, valid, and reliable tools are used to measure pain.

The doctors have implemented a process to manage patients with chronic pain, which has resulted in fewer patients coming to outpatients for management.

Areas for Improvement:

Establish a utilization management committee for diagnostic services.

Key Findings (Continued)

Empowering clients	Criteria	Organization Rating	Survey Rating
9.0 The team works with clients and families to help them actively participate in service delivery and carry out their responsibilities.	9.1	4	4
	9.2	4	5
	9.3	5	5
	9.4	4	4
	9.5	4	4
10.0 The team obtains informed consent before starting any service or intervention.	10.1	5	5
	10.2	5	5
	10.3	5	5
	10.4	5	5
11.0 The team protects and promotes the rights of its clients and families.	11.1	5	5
	11.2	5	5
	11.3	4	4
	11.4	5	5
	11.5	N/A	4
	11.6	5	5

Strengths:

There is good communication with patients about the plan of care and test results.

The patient education approach is based on the literacy level.

This is a small community with strong ties and a culture of support.

Areas for Improvement:

Develop resources for the service delivery teams to address ethical issues.

Link to the provincial complaint system and use a patient advocate or representative.

Evaluate the ability to empower patients and families and determine if the patient satisfaction survey needs to be repeated.

Translate the consent forms into French.

Coordinate organ donation provincially.

Provide more support for patient education.

Improve the access to mental health and addiction services for patients.

Key Findings (Continued)

Setting goals and monitoring achievements	Criteria	Organization Rating	Survey Rating
12.0 The team has an appropriate and integrated service plan for each client.	12.1	6	5
	12.2	5	5
	12.3	5	5
	12.4	5	4

Strengths:

Health education is provided to patient during the process.

A multidisciplinary record with goals of care was developed with patient involvement.

There are weekly multidisciplinary discharge rounds.

The team has initiated focus charting to better document patient progress.

Areas for Improvement:

Enhance the identification of indicators.

Implement monitoring of outcomes.

Develop a process to document the education that is provided.

Integrate all of the disciplines input on the Kardex consistently.

Key Findings (Continued)

Delivering services	Criteria	Organization Rating	Survey Rating
13.0 The team delivers safe, efficient, and effective services.	13.1	4	4
	13.2	5	4
	13.3	4	4
	13.4	4	4
	13.5	5	4
	13.6	4	4
	13.7	4	4
	13.8	5	5
14.0 The use of medications and other therapeutic technologies is safe, efficient, effective, and promotes the best possible quality of life.	14.1	4	4
	14.2	4	4
	14.3	4	4
	14.4	4	4
	14.5	4	3

Strengths:

There have been follow up learnings and practice changes from a critical incident related to medication.

There are daily and weekly checks on equipment to ensure safety.

All registered nurses are updated in CPR and many have ACLS training.

There is a policy of least restraint in place.

There are processes in place so that patients have the choice to die at home or in the hospital.

The team worked on a failure modes and effects analysis (FMEA) process related to medication with the pharmacy.

A medication incident occurred using gentomycin on a stat holiday so no pharmacist was available. There is an interim protocol that allows the doctor to give the first dose, but a pharmacist must be consulted before the second dose. They are developing a provincial protocol that will be ongoing. A critical incident debriefing was done to support the staff. The incident was disclosed by the physician, and it was felt to be humanely handled.

Key Findings (Continued)

Areas for Improvement:

Enhance the processes for organ donation.

Update education on the management of aggressive behaviour.

Work with community programs to help people who choose to die at home.

Implement the provincial policy related to disclosure when it is complete.

Review the volume of near misses and ensure that it represents the actual number.

Ensure that the process for permanent physicians reviewing and signing off referrals made by locums applies in outpatients, emergency, and the hospital. The medical clinic has this process.

Key Findings (Continued)

Maintaining continuity	Criteria	Organization Rating	Survey Rating
15.0 After transition or the end of service, the clients' ongoing needs are met and continuity of service is maintained.	15.1	5	5
	15.2	3	5
	15.3	4	4

Strengths:

Discharge planning occurs weekly with inpatient and home care team disciplines and there are case conferences.

The discharge sheet with prescriptions goes with the patients.

There is automatic follow up of OT, PT, and nutrition on discharge.

Areas for Improvement:

Address the lack of family doctors for referral back into the community after discharge.

Address the long waits for DI results and referral to specialists.

Improve communication and continuity of care when patients are transferred between CHO and PCH and Halifax.

Improve follow up after discharge, such as referral to an orthopedic doctor. Patients with chronic diseases often have to see more than one doctor.

Enhance continuity which is a challenge with locums covering physician vacancies. Primary care is managed provincially and the hospital is managed locally, so it is more difficult to connect patient care.

FUTURE DIRECTION

A template to help focus your quality improvement progress

CCHSA has created a follow-up template to help support ongoing improvement activities following the accreditation survey, to act as a record of progress throughout the three-year accreditation cycle, and to assist in the completion of the follow-up action required as a condition of the accreditation status. This template is now available online through CCHSA's organization portal.

Is it necessary for our organization to use the online template?

For an organization that receives Accreditation with Report or Focused Visit, completion of this online template is mandatory. For an organization that receives full Accreditation, completion of this online template is not a requirement of your accreditation status. However, the organization is encouraged to use the template to support your ongoing improvement activities.

Organizations are asked to respond to the recommendations using this online tool to further automate the accreditation process.

How does the online template work?

The organization is required to use the template for all recommendations, including required organizational practices recommendations, that require further action as a condition of accreditation (i.e. Report or Focused Visit) and provide supporting evidence that the recommendation requirements have been met. The completed template must identify a summary of how the recommendation has been fully addressed and should include attached documents that provide supporting evidence. The organization also has the opportunity to document its plan of action to address each recommendation, target dates, responsibilities and the status of these plans. Full instructions on how to complete the template are included in the Guidelines for Preparing a Report or Focused Visit as a Condition of Accreditation, which are available on CCHSA's organization portal.

Next steps for your organization

Your organization has received Accreditation with Report. Please use the template to support your accreditation status and continuous quality improvement progress.

APPENDIX A

Quality Dimensions and Descriptors

The CCHSA program is designed to evaluate the quality of health care and services. But what is quality? Even a small amount of research will reveal that there are a number of definitions for the concept of quality. In order to make sure that all organizations and teams involved in accreditation are using the same reference, CCHSA defines quality as:

The degree of excellence; the extent to which an organization meets clients' needs and exceeds their expectations.

To help organizations measure the quality of their services to determine what can be improved, CCHSA has identified four dimensions of quality that define what is meant by quality. These dimensions are: Responsiveness, System Competency, Client/Community Focus and Worklife. Each dimension in turn has a number of descriptors that explain what is meant by that dimension. For example, there are five descriptors related to Responsiveness, which include Availability, Accessibility, Timeliness, Continuity and Equity. There are a total of 22 descriptors tied to the four dimensions.

The four quality dimensions and their corresponding descriptors play an important role in the program by offering organizations a framework for measuring quality. These dimensions and descriptors were used to develop the standards and criteria and similarly, the standards and criteria were written to reflect the appropriate dimension and descriptor.

As an organization's teams complete their self-assessments, teams are encouraged to use the dimensions and descriptors as a focusing tool to help guide both the teams' discussions regarding the criteria and the resulting comments in the self-assessments. The dimensions and descriptors are also used in the survey report to assist organizations in identifying general areas of strength and those areas where improvements are required.

The four dimensions and their descriptors are defined in detail on the following pages.

Quality Dimensions and Descriptors



Responsiveness

The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment.

Availability

- Service(s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s).

Accessibility

- The client and/or community easily obtains required or available services in the most appropriate setting.

Timeliness

- Services are provided and/or activities are conducted to meet client and/or community needs at the most beneficial or appropriate time.

Continuity

- Coordinated services are provided across the continuum, over time.

Equity

- Decisions are made and services are delivered in a fair and just way.

Quality Dimensions and Descriptors



System Competency

The organization consistently provides service(s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources.

Appropriateness

- Services meet the needs of the client and/or community population(s), achieve the organization's goals, are proven (evidence-based) to produce benefits, and are based on established standards.

Competence

- An individual's knowledge, skills, and attitudes are appropriate to the service provided.

Effectiveness

- Services, interventions, or actions achieve optimal results.

Safety

- Potential risks and/or unintended results are avoided or minimized.

Legitimacy

- Services and/or activities conform to ethical principles, values, conventions, laws, and regulations.



Efficiency

- Resources (inputs) are brought together to achieve optimal results (outputs) with minimal waste, re-work, and effort.

System Alignment

- The mission, vision, goals and objectives are clear, well-integrated, coordinated and understood both internally and externally. These are reflected in organization plans, delegations of authority, and decision-making processes.

Quality Dimensions and Descriptors

 <p>Client/Community Focus</p> <p>The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities.</p>	<p>Communication</p> <ul style="list-style-type: none"> • All relevant information is exchanged with the client, family and/or community in a manner that is ongoing, consistent, understandable and useful. <p>Confidentiality</p> <ul style="list-style-type: none"> • Information to be kept private is safeguarded. <p>Participation and Partnership</p> <ul style="list-style-type: none"> • The client and/or community actively participates as a partner in decision-making, and in service planning, delivery, and evaluation. <p>Respect & Caring</p> <ul style="list-style-type: none"> • Politeness, consideration, sensitivity and respect are incorporated into all interactions with the client and/or community. <p>Organization Responsibility and Involvement in the Community</p> <ul style="list-style-type: none"> • The organization supports and strengthens the community and its development, and contributes to its overall health.
 <p>Worklife</p> <p>The organization provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well-being, and satisfaction.</p>	<p>Open Communication</p> <ul style="list-style-type: none"> • The organization fosters a climate of openness, free expression of ideas, and information sharing. <p>Role Clarity</p> <ul style="list-style-type: none"> • Staff have clearly defined job scope and objectives, and these are aligned with team and organization goals. <p>Participation in Decision-making</p> <ul style="list-style-type: none"> • Staff input is encouraged and used in decision-making. <p>Learning Environment</p> <ul style="list-style-type: none"> • Staff creativity, innovation, and initiative is encouraged. The necessary training and development, to attain organizational goals and personal/professional development objectives, is provided. <p>Well-being</p> <ul style="list-style-type: none"> • The organization provides a safe, healthy, and supportive environment, recognizes staff contribution, and links staff feedback to improvement opportunities.