ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Interior Health Authority

Kelowna, BC

On-site survey dates: September 27, 2015 - October 2, 2015

Report issued: March 1, 2016

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

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About the Accreditation Report

Interior Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in September 2015. 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's President and CEO

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 Accreditation Specialist 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,

Wendy Nicklin
President and Chief Executive Officer

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Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

Interior Health Authority's accreditation decision is:

Accredited (Report)

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

1.2 About the On-site Survey

- **On-site survey dates: September 27, 2015 to October 2, 2015**

- **Locations**

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

1 Capri Community Health Centre
2 Cara Centre
3 Cariboo Memorial Hospital
4 Castlegar and District Community Health Centre
5 Cottonwoods Extended Care Centre
6 Cranbrook Health Centre
7 David Lloyd Jones
8 Dr FW Green Memorial Home
9 East Kootenay Regional Hospital
10 Enderby Community Health Centre
11 Gordon Road Wellness Centre - Nelson
12 Hillside Psychiatric Centre
13 Kamloops Community Dialysis Unit
14 Kamloops Community Mental Health Centre
15 Kamloops Promotion and Prevention
16 Kelowna General Hospital
17 Kelowna Health Centre, Ellis Street
18 Kirschner Road
19 Kootenay Boundary Regional Hospital
20 Kootenay Lake Hospital
21 Lillooet Hospital and Health Centre
22 Orchard Haven
23 Penticton Regional Hospital
24 Pleasant Valley Health Centre
25 Pleasant Valley Manor
26 Princeton General Hospital
27 Queen Victoria Hospital
28 Royal Inland Hospital
29 Rutland Dialysis
30 Shuswap Lake General Hospital
31 South Hills Centre
32 South Okanagan General Hospital

33 Summerland Health Centre
34 Sunnybank Centre
35 Swan Valley Lodge
36 Three Links Manor
37 Vernon Downtown Primary Care
38 Vernon Health
39 Vernon Jubilee Hospital

- **Standards**

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

  System-Wide Standards

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

  Population-specific Standards

  5 Public Health Services
  6 Population Health and Wellness

  Service Excellence Standards

  7 Reprocessing and Sterilization of Reusable Medical Devices - Service Excellence Standards
  8 Critical Care - Service Excellence Standards
  9 Home Care Services - Service Excellence Standards
  10 Ambulatory Care Services - Service Excellence Standards
  11 Medicine Services - Service Excellence Standards
  12 Rehabilitation Services - Service Excellence Standards
  13 Community-Based Mental Health Services and Supports Standards - Service Excellence Standards
  14 Ambulatory Systemic Cancer Therapy Services - Service Excellence Standards
  15 Obstetrics Services - Service Excellence Standards
  16 Mental Health Services - Service Excellence Standards
  17 Perioperative Services and Invasive Procedures Standards - Service Excellence Standards
  18 Long-Term Care Services - Service Excellence Standards
  19 Emergency Department - Service Excellence Standards

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Canadian Patient Safety Culture Survey Tool: Community Based Version
  3 Worklife Pulse
  4 Client Experience Tool

1.3 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)	125	2	0	127
 Accessibility (Give me timely and equitable services)	111	3	0	114
 Safety (Keep me safe)	575	30	9	614
 Worklife (Take care of those who take care of me)	185	2	0	187
 Client-centred Services (Partner with me and my family in our care)	250	10	2	262
 Continuity of Services (Coordinate my care across the continuum)	88	2	0	90
 Appropriateness (Do the right thing to achieve the best results)	805	63	8	876
 Efficiency (Make the best use of resources)	66	5	1	72
Total	**2205**	**117**	**20**	**2342**

1.4 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	42 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	1	73 (100.0%)	0 (0.0%)	1
Leadership	46 (100.0%)	0 (0.0%)	0	84 (98.8%)	1 (1.2%)	0	130 (99.2%)	1 (0.8%)	0
Infection Prevention and Control Standards	40 (97.6%)	1 (2.4%)	0	29 (93.5%)	2 (6.5%)	0	69 (95.8%)	3 (4.2%)	0
Medication Management Standards	74 (94.9%)	4 (5.1%)	0	56 (87.5%)	8 (12.5%)	0	130 (91.5%)	12 (8.5%)	0
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Public Health Services	45 (95.7%)	2 (4.3%)	0	68 (98.6%)	1 (1.4%)	0	113 (97.4%)	3 (2.6%)	0
Ambulatory Care Services	36 (100.0%)	0 (0.0%)	6	71 (94.7%)	4 (5.3%)	2	107 (96.4%)	4 (3.6%)	8
Ambulatory Systemic Cancer Therapy Services	45 (93.8%)	3 (6.3%)	2	91 (92.9%)	7 (7.1%)	1	136 (93.2%)	10 (6.8%)	3

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 Standards	17 (81.0%)	4 (19.0%)	1	108 (95.6%)	5 (4.4%)	0	125 (93.3%)	9 (6.7%)	1
Critical Care	34 (100.0%)	0 (0.0%)	0	94 (98.9%)	1 (1.1%)	0	128 (99.2%)	1 (0.8%)	0
Emergency Department	42 (91.3%)	4 (8.7%)	1	69 (86.3%)	11 (13.8%)	0	111 (88.1%)	15 (11.9%)	1
Home Care Services	44 (100.0%)	0 (0.0%)	0	51 (94.4%)	3 (5.6%)	0	95 (96.9%)	3 (3.1%)	0
Long-Term Care Services	39 (97.5%)	1 (2.5%)	0	91 (96.8%)	3 (3.2%)	0	130 (97.0%)	4 (3.0%)	0
Medicine Services	31 (100.0%)	0 (0.0%)	0	68 (95.8%)	3 (4.2%)	0	99 (97.1%)	3 (2.9%)	0
Mental Health Services	34 (94.4%)	2 (5.6%)	0	82 (93.2%)	6 (6.8%)	0	116 (93.5%)	8 (6.5%)	0
Obstetrics Services	59 (95.2%)	3 (4.8%)	2	74 (93.7%)	5 (6.3%)	1	133 (94.3%)	8 (5.7%)	3
Perioperative Services and Invasive Procedures Standards	90 (90.0%)	10 (10.0%)	0	85 (96.6%)	3 (3.4%)	0	175 (93.1%)	13 (6.9%)	0
Rehabilitation Services	31 (100.0%)	0 (0.0%)	0	68 (97.1%)	2 (2.9%)	0	99 (98.0%)	2 (2.0%)	0
Reprocessing and Sterilization of Reusable Medical Devices	48 (92.3%)	4 (7.7%)	1	59 (96.7%)	2 (3.3%)	2	107 (94.7%)	6 (5.3%)	3
Total	**801 (95.5%)**	38 (4.5%)	13	1314 (95.1%)	67 (4.9%)	7	2115 (95.3%)	105 (4.7%)	20

* Does not includes ROP (Required Organizational Practices)

1.5 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
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related-Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client and Family Role in Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Critical Care)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Home Care Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client and Family Role in Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Medicine Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client and Family Role in Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Information Transfer (Ambulatory Care Services)	Unmet	0 of 2	0 of 0
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Home Care Services)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Unmet	0 of 2	0 of 0
Information Transfer (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
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 (Ambulatory Systemic Cancer Therapy Services)	Unmet	4 of 7	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports Standards)	Unmet	0 of 4	0 of 1
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	2 of 5	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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)	Unmet	0 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Unmet	3 of 5	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Unmet	2 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Unmet	2 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Ambulatory Systemic Cancer Therapy 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			
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Home Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
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)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care 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: Medication Use			
Infusion Pumps Training (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Home Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Long-Term Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Mental Health Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Safety: Education and Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Unmet	3 of 3	0 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 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 (Critical Care)	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 Standards)	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 Standards)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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 Standards)	Met	3 of 3	2 of 2

1.6 Summary of Surveyor Team Observations

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

The organization, Interior Health Authority (IH) is commended on preparing for and participating in the Qmentum survey program. This health care organization serves an estimated population of 731,000 in the Southern Interior of British Columbia. More than 19,000 skilled and dedicated health professionals and support staff, 1500 physicians and 4800 volunteers promote wellness and provide health care everyday at two tertiary hospitals, four regional hospitals,16 community hospitals, 24 health care centres and 6,566 residential care and assisted living beds. The Interior Health Authority (IH) is responsible for the provision of: hospital, residential and community care; prevention and health promotion activities; off-reserve First Nations Health; Emergency Preparedness; drinking water protection and child care licensing.

Throughout the duration of the on-site survey IH's vision of setting new standards of excellence for the delivery of health services in the Province of British Columbia and the mission of promoting health lifestyles and providing needed health services in a timely, caring and efficient manner to the highest professional and quality standards was exemplified in all areas.

The organization continues to demonstrate its commitment to continuous quality improvement and the accreditation process. Since its previous survey in 2012, IH has worked towards the mantra of: "one IH", by making Interior Health feel like: one single organization and working as one team; improving responsiveness to health prevention and client care issues locally; and enhancing provincial collaboration and improving standardization of practices and processes across the organization. The organization also has realized new expansions and renovations at the Kelowna General Hospital and the Vernon Regional Hospital in areas such as ambulatory care, pharmacy, operating room and in-patient areas. The organization is working collaboratively with family physicians to support primary health care.

The organization has also enhanced its internal and external engagement strategies. It has developed a comprehensive strategic and operational plan which is aligned with ministerial directives as well as the organizational needs. Four goals are guiding the organization with the overall commitment that every person matters.

The four goals are: 1. improve health and wellness by implementing health promotion and prevention initiatives; working with First Nations and Aboriginal partners to plan and deliver culturally sensitive health care services to improve the health and wellness of Aboriginal people; implementing actions to improve the health of Interior Health's population; and deliver patient and family centred care. 2. deliver high-quality care by collaborating with primary and community care to meet population and individual health care needs; implementing health improvement strategies for targeted populations across the continuum; providing efficient, effective acute care services that are linked across the continuum of care and by delivering evidence informed quality and safety initiatives and pursue zero never events. 3. ensure sustainable health care by improving innovation, productivity and efficiency by implementing innovative service delivery models; developing priority plans and implementing transparent decision-making process; enhancing information management and information technology (IM/IT) solutions and by building research and education capacity. 4. cultivate an engaged workforce and healthy workplace by enhancing health and safety in the work environment; improving employee, physician and volunteer engagement and by building leadership capacity.

There is a sense of caring and pride that is noted across the organization. There is also a commitment towards excellence, innovation, and quality service delivery by the leadership and physicians, staff members and volunteers. The board is highly engaged and committed to the key priorities of the organization. It is clearly

evident that the board members really care and take their responsibilities seriously. Along with internal and external stakeholders the board and senior leadership team have ensured extensive engagement and consultation with the development of the organization's strategic plan.

The organization is commended for the ongoing work in maturing the quality and safety agenda. Interior Health has implemented a quality management structure whereby the organization has access to experts in quality and patient safety, human factors, risk management, enterprise risk management, patient care quality and patient experience. Successes in quality have included physician integrated leadership development, medical advisory committees that focus on quality, implementation of clinical care management guidelines, implementation of 48/6 model of care and the establishment of patient safety investigators.

The organization has made strides in establishing numerous of performance metrics and targets. Although some are reported and monitored there is still an opportunity for further development of meaningful and timely process and outcome performance metrics and increased transparency at the site and unit levels. Although some units have developed and posted a few performance indicators such as hand-hygiene rates and 48/6 metrics, there are many sites and units where there is a notable lack of real-time performance indicators at the team/unit level. In some areas the staff members were not aware of the targets set for each of the performance indicators.

The organization continues to make progress with Accreditation Canada's required organization practices (ROPs). There is evidence across many areas in the organization where the ROPs have been successfully implemented. Having said that however, variable compliance with several ROPs is noted for example, although there are processes in place for the transfer of information on discharge from acute care to residential care, it was noted during the survey visit that this practice is not consistently followed. As well, it was observed during the survey that hand-hygiene practices were lacking. The organization needs to ensure that there is ongoing compliance to the ROPs, and to also support those areas where they have not been fully implemented.

During the survey community partners acknowledged their appreciation to IH for its expertise, collaboration and engagement. They also acknowledged that IH must consider cultural diversity and socio-economic status in the service planning and delivery. Meaningful engagement is an imperative. The partners indicated that it is critical that IH continues to keep the dialogue open with all stakeholders, particularly as the organization transitions to a new chief executive officer (CEO). The partners also acknowledged that IH is well-respected in the community and that they appreciate the annual visits that the Board Chair and CEO make to their community.

Although IH is seeing the benefits from new and renovated infrastructure at various locations across the health authority, there still remain challenges with physical space due to aging infrastructure, lack of storage space and over-capacity as well as needs for capital equipment. The organization will need to look at strategies to minimize or mitigate these risks.

Interior Health is fortunate to have a talented and dedicated workforce of physicians, employees and volunteers. The organization is commended on developing a talent management strategy to invest in leaders of the future. There is also commitment to ensuring there is investment in ongoing education for staff, including access to online learning modules. There is evidence that performance appraisals have been completed for the management staff. It is also evident that most unionized staff members had not received a performance appraisal in recent years. On a formal basis, the organization is encouraged to ensure that this important feedback is provided to staff.

Overall, patients and families are satisfied with the care and service they receive from services and programs provided by Interior Health. They commented that staff members, physicians and volunteers are courteous and respectful; those receiving this care have the confidence and trust in Interior Health. Change can be expected to be an ongoing and dynamic occurrence in health care. The cohesiveness of governance and leadership coupled

with meaningful staff, physician, volunteer and community engagement and effective communication strategies will assist Interior Health in realizing its vision: “that every person matters”.

Section 2 Detailed Required Organizational Practices Results

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 The team transfers information effectively among service providers at transition points.	· Ambulatory Care Services 12.3 · Obstetrics Services 12.4
Safe Surgery Checklist The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure.	· Perioperative Services and Invasive Procedures Standards 13.3 · Obstetrics Services 9.9
Medication reconciliation at care transitions With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.	· Community-Based Mental Health Services and Supports Standards 12.4 · Rehabilitation Services 7.5 · Ambulatory Systemic Cancer Therapy Services 9.15 · Emergency Department 9.3 · Obstetrics Services 9.6
Patient Safety Goal Area: Medication Use	
Antimicrobial Stewardship The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	· Medication Management Standards 2.3
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	· Emergency Department 16.3 · Obstetrics Services 18.2

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 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.

3.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Interior Health (IH) is fortunate to have a committed, engaged and knowledgeable board and which is also committed to monitoring the targets and accomplishments of IH. The board members celebrate and recognize the organization's achievements and performance. The board is active in challenging the organization to do the best that it can and to remain true to the vision, mission and values of the organization. The board is diligent in examining the metrics it is receiving from the leadership as well as the opportunities for efficiencies and quality improvement.

The board has a great deal of trust in the chief executive officer (CEO) and the leadership team. The briefings that are brought forward by the leadership team are comprehensive and provide the needed information for the board to make recommendations and decisions. The board works to govern, question and support the ideas and recommendations that are brought forward by the leadership team. All major decisions undergo a comprehensive process that examines quality, safety and risk and all decisions made by the board are carefully monitored. The enterprise risk management as well as the ethics framework assists the board in their deliberations and decisions.

The board is committed to ensuring quality and safe patient care. The management of quality is governed by the quality committee of the board that regularly receives and reviews the organization's performance dashboard. The board also receives regular reports on key quality initiatives that are occurring across the organization. The organization is currently awaiting final direction and approval from the Ministry of Health whereby all provincial health authorities will be required to utilize a common performance dashboard. The board also has Governance, Human Resources and Audit and Finance committees to assist in the governance of the organization. The board has an in-depth appreciation of the organization's talent management and workforce strategy. The human resources (HR) dashboard is reviewed by the board on a regular basis.

All board members receive a comprehensive orientation as well as ongoing education. Performance review of the board members and the board chair occurs. Following each board meeting, the members will evaluate the effectiveness of the meeting and make improvements or changes accordingly to improve future meetings. The board has a process to review the performance of the CEO on an annual basis.

It is evident that this board takes the roles and responsibilities seriously. The board truly cares about IH and is passionate about ensuring that: "every person matters and every community matters". There is an atmosphere of openness within the board. The board ensures that it keeps in touch with the community and

the population that IH serves. The board utilizes various strategies to reach out to others such as participation in Long Service Awards Ceremonies, regular meetings with local municipalities, Foundations, Regional Hospital Districts, the Partnership Accord Leadership Table, as well as the annual CEO and Board Chair site visits.

There have been significant accomplishments throughout IH, creating a sense of pride by staff members, physicians, volunteers and the community at large. As the organization welcomes a new CEO in the near future, stakeholders have requested that the board ensures a smooth transition and a sense of stability in the organization during this time of change.

3.1.2 Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Interior Health (IH) has a robust strategic planning process which follows a clearly articulated framework. The goal is to develop and implement infrastructure, programs and services to meet the needs of the populations and communities served within IH. The team has undertaken an integrative approach to the planning process, beginning at the direction given by the province and cascading that at the strategic and organizational level and then to the operational/program level ensuring that data, monitoring and evaluation processes are in place.

The planning process is focused on the population and service needs for those individuals with chronic conditions, mental health and substance use and the frail elderly. From a population and public health perspective, the organization has developed annual health profiles for local health areas. These profiles clearly provide a picture of people residing in the community and also the health services being utilized by the community. These profiles are accessible to the public and are assisting the organization in service planning.

The organization has undertaken an engagement strategy with internal and external stakeholders to ensure that there is an awareness of the strategic plan and the direction that the organization is taking. During the community partners discussion and as an example, it was affirmed that the board and the organization had consulted extensively with the regional hospital districts as the IH strategic and organizational plans were being developed. The organization has invested in "IAP2" training for staff members to be prepared in effective public engagement.

It is evident that the organization’s strategic plan is guiding the planning and decision making at the leadership and board level. There is a clear expectation that all clinical and non-clinical support programs must have their goals and objectives and program plans aligned with the organization's strategic plan. All business case proposals must be aligned with the strategic plan. Every strategic objective has an assigned executive leader and there is a defined work plan to achieve each of the objectives. Regular reporting on the progress of the work plan is required. There is also an enterprise risk management process in place and the strategic risk registry is reviewed and refreshed annually.

A health systems summary is published on an annual basis. This summary provides information related to the burden of care, physician supply, utilization rates, and cost of care and human resources indicators such as nursing hours per patient day. The organization is commended on having a culture of using data and evidence, both qualitative and quantitative, to drive the planning, decision-making and evaluation occurring in the organization. The organization is also congratulated on having an identified change management model (CAP model), and where highly strategic initiatives are required, this model is being utilized.

3.1.3 Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Financial planning and control has been strengthened by increased automation of reporting of performance metrics, which is done using the tool: “iManage”. While still in its infancy, this tool has increased accountability of management by enabling deep dives of actual performance into key corporate priorities such as sick and over time.

The organization has a well-defined process for the development of both operating and capital budgets. Clearly defined roles and responsibilities are outlined in the organization's policy and procedures. It is noted that these policies and procedures are inclusive of the roles of governance as well as management. It is noted that the budgeting process is informed by other structures such as the use of the ethics framework which is inclusive of business decisions, ministry of health (MoH) priorities, and results of community engagement. The organization completes short/immediate term operating and capital budgets as well as longer term capital and operating budgets based on effective environmental scans inclusive of population health. The information presented to the board for consideration, including budgets and proposed investments, is complete thus enabling effective oversight and discussion as required.

The organization has adopted a number of processes to strengthen its approach to resource allocation mechanisms and resource optimization. Recently, the organization adopted a framework which includes program-based marginal analysis. This framework allows the organization to quantify opportunity costs, marginal costs and benefits. Less complex issues can be assessed using tools such as the budget strategy work sheet, which is completed by a program manager in concert with the business consultants. Use of common evaluation and priority criteria such as those contained in the document: "Charting the Course: Interior Health’s Planning Principles and Considerations for Change" is ensuring alignment across the organization. The organization has also completed an assessment post-implementation of strategies such as "Home first, Breath Well" and post-occupancy of capital projects. The organization is encouraged to continue to complete post-implementation financial analysis in the ongoing change initiatives.

The organization utilizes a number of processes to ensure appropriate financial control. These processes are noted to be at the corporate level (internal audit functions) and in individual program and services such as period variance reporting. The organization completes all necessary financial reporting such as an external audit and in addition, completes a number of additional reviews. The results of these reviews are posted on the organization's web site to ensure full transparency. By law, the organization is required to achieve a balanced budget, which it has done for a number of consecutive years. The organization's financial health is good however, it is noted that financial challenges may occur with the costs associated with the ministerial directives such as reducing wait times for surgery.

3.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a dynamic, energetic and knowledgeable team leading and supporting the human resources (HR) functions within Interior Health (IH). The department is organized into four divisions: Human Resources Strategic Services; Labour and Employee Relations; Transformation and Innovation and Change, and Workplace Health and Safety.

The HR department's operational plan is aligned with and supports the BC Ministry of Health's strategic policy paper entitled: "Setting Priorities for the BC Health System" as well as two key goals of IH which are: to ensure sustainable health care by improving innovation, productivity and efficiency and to cultivate an engaged workforce and a healthy workplace.

The department has implemented and evaluated several initiatives to support a safe work environment and the creation of a healthy workplace which has recognized IH as being an 'Employee of Choice in British Columbia' for the third year in a row. The team believes that the organization's significant commitment to engaging, listening and recognizing staff members has contributed to this provincial recognition. The organization is also congratulated on exceeding the targets as it relates to lost-time injuries.

There is an accountability framework for HR management which clearly articulates the accountabilities at the board, vice president, senior executive team and line management levels. In addition to a comprehensive workforce plan there is also a detailed medical staff resources plan for IH.

The senior leadership team recently endorsed several strategies to support the front-line managers' current workload and span of control. The Vernon Jubilee Hospital will be a pilot site for IH to test out several of these strategies. An evaluation of the pilot will take place and depending on the results, the strategies could be spread to other sites across IH. The goal is to look for strategies that will give time 'back' to the managers in order that they can be visibly present for their staff.

All management out-of-scope staff members that were interviewed during the on-site survey confirmed that they had received a performance appraisal. There is however, still a significant number of in-scope staff members that have not received a performance appraisal for some time. Managers indicated that the current appraisal tool for unionized workers is lengthy and cumbersome. They have suggested that if the tool could be more streamlined it may improve compliance to performance appraisal completion.

The organization can be proud of the investment and commitment it makes in education, particularly in the area of leadership development and management training. A budget of $40 million is designated to support continuing education. There is no doubt that IH believes in its people and is investing in their career development and professional education as well as ongoing educational opportunities to support the organization's quality and safety agenda.

The organization is committed to providing and maintaining a healthy and safe workplace for physicians and volunteers and staff. Provincial standards and criteria have been established to address workplace violence with a targeted focus on high-risk sites areas. Code white teams are available at all IH sites and staff members receive annual training on emergency code response.

The organization has a robust attendance management program which has had a positive impact on reducing overtime. It has also had success in reducing the number of days lost from accepted claims. Dashboards are available for managers to monitor indicators related to sick time, overtime time and lost time. By way of these dashboards managers are able to drill down to the individual staff member.

There are excellent processes in place for the recruitment of staff members, physicians and volunteers. The credentialing process for new physician recruits requires that an impact analysis be completed and signed off. All newly hired staff members and physicians are required to attend an orientation session. All physicians in designated leadership positions have received a performance review. The organization acknowledges it is challenged with recruitment of nursing and allied health positions in the rural areas and innovative approaches will need to be explored.

The organization is currently undertaking succession planning at the senior leadership level. Encouragement is offered to move this activity to cover all levels in the organization to ensure a solid leadership foundation.

The team is excited about a major transformation it is undertaking and which is referred to as the: “Next Generation HR” and which will support IH's “every person matters”. The first step in this journey is to build an HR system with self-serve functionality for managers and employees.

There is evidence that the HR portfolio has been guided by the organization's strategic plan. The organization has stayed true to the goals of attracting and retaining top talent, building capability and capacity, creating the desired culture and enhancing the health care system. The organization has been responsive and innovative to the needs and requests of those the IH supports. The HR team is working to improve life at IH from a cultural perspective. Encouragement is offered to stay the course!

3.1.5 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)

Congratulations are extended for the efforts undertaken to continue to mature and refine the integrated quality management journey. Commendation is given for aligning the quality, risk and accreditation strategies with the organization's strategic goals and operational plans.

The Quality, Risk and Accreditation (QRA) department is successfully leading and guiding a number of initiatives to improve Interior Health's performance as a comprehensive health system. The QRA department has six key objectives which are aligned with the organization's vision and strategic plan. These are 1: fostering an engaged workforce to be leaders in identifying and addressing opportunities for improvement in their everyday work life. 2: aligning and integrating the QRA department with the work of the broader Interior Health (IH) organization. 3: engaging and supporting staff and physicians to provide patient care that is safe, evidence informed, patient-centred, efficient, effective and appropriate. 4: promoting accreditation as one of the central quality frameworks for improving IH as a health system. 5: embedding the risk management process across the organization. 6: utilizing data and system measures to inform continuous improvement.

The organization is building capacity for quality improvement and patient safety via the quality improvement patient safety (QUIPS) unit leaders program. Currently, there are 28 participants in the program. The goal is to partner with front-line leaders to provide them with quality improvement and patient safety training at point of care. The current cohort includes representation from nursing, respiratory, physical and occupational therapy, speech language pathology and pharmacy. Several online learning modules have been developed and more are coming to address key topic areas related to quality, safety and the required organizational practices (ROPs). Some examples of these modules are: Patient Safety Culture; An Introduction to Quality Improvement; Independent Double Checks and Venous Thrombo Embolism (VTE) Prophylaxis. Local quality improvement committees have also been established across IH and are supported by a quality improvement consultant.

The organization has also benefited from establishing the Lean Promotion Office. Besides building capacity related to the principles of Lean, with provision of workshops for staff members, the organization has also used Lean methodology to address operating room change over times and first case start times at the Kelowna General Hospital and reducing the wait times for pre-surgical screening at the Penticton Regional Hospital.

Clinical care management bundles have been a major driver of the quality improvement and patient safety strategy and plan across the organization. These have included a focus on sepsis, stroke care, surgical site infections, safe surgical checklist, VTE prophylaxis, catheter associated urinary tract infections, and colorectal surgical site infections. Other quality initiatives have included enhanced recovery after surgery (ERAS), falls prevention, pressure ulcer prevention and hand hygiene.

A significant initiative that IH has undertaken is the Ministry of Health mandated 48/6 model of care which requires that the screening and assessment of six basic functional areas plus a 7th which IH added be

completed within 48 hours. These elements include bowel and bladder function, cognition, functional mobility, medication management, nutrition and hydration, pain and psychosocial. The goal of 48/6 is to prevent functional decline and to assist patients in returning home sooner. The organization has successfully implemented 48/6 in 22 Acute Care sites. Compliance measures are collected monthly and reported quarterly.

There is a well-articulated medication reconciliation strategy for the organization which includes ongoing monitoring and auditing. There is an assigned leader that is overseeing the implementation and sustainability of medication reconciliation. It is suggested that as the team continues to move forward with full implementation of medication reconciliation across the organization it further defines within the medication reconciliation policy which ambulatory care clients will require medication reconciliation as well as the frequency. This will ensure clarity for physicians and staff.

Audit data for the clinical care management (CCM) bundles are tracked and reported at an organizational level as well as at the site level. Throughout the organization's on-site survey an absence of daily visual management of performance and outcome measures at the team/unit level was observed, and this is required in order to improve quality and safety of service delivery.

The organization has completed two prospective analyses with the assistance of the Human Factors and Safety specialists. The first analysis assisted the organization in making an informed decision about the choice of a large volume infusion pump. The second analysis related to a decision regarding whether to continue to use insulin vials or single patient use insulin pens in the inpatient setting.

To recognize staff members and physicians in quality and safety, IH provides two awards on an annual basis, one to an individual and one to a group that carried out a project that led to significant improvement in patient care.

Significant effort has been expended to engage patients and their families, staff members and physicians in quality and safety initiatives. There is a total of 451 Patient Voices Network/Patients as Partners registered, and of that number 232 are friends, meaning the person is registered in IH's Patients as Partners website. These registrants have access to webinars, newsletters, and surveys. There are another 219 volunteers, which are people that have taken the orientation course and are eligible to participate in engagement opportunities. The Patient Care Quality Office is also another important vehicle to support these endeavours.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has adapted a number of specific tools to advance the ethics framework. The tools include: DLJ Four Topics method, Standards of Conduct, Safe Reporting and Health Shared Services BC (HSSBC) Fair and Competitive Bidding Process. Most recently the organization introduced: "A pRoject Ethics Community Consensus Initiative" (ARECCI) to assist with the evaluation of quality improvement projects. The introduction of this new tool has provided significant benefits not only to components of data collection in the quality improvements, but also for allowing the organization to distinguish quality improvement initiatives versus research projects. The organization is commended for expanding the scope of ethics to include public health. While only in the development phase, discussions with the organization during the survey demonstrated a need for this increased scope.

It is noted that the revised ethics framework is currently in the roll-out phase and as such, full organization-wide awareness of the elements of the framework is not complete. During this transition phase the surveyor team noted that staff members were able to confirm various historical practices that would ensure appropriate consultation on the ethical matter under consideration.

The organization has a mature process of oversight of ethical considerations of internal research, and also has aligned with the BC Ethics Harmonization Initiative (BCEHI) which has harmonized research with the other regional health authorities and the four largest universities in the province. There are: Simon Fraser (SFU), University of British Columbia (UBC), University of Northern British Columbia (UNBC) and University of Victoria (UVIC).

The organization has opportunities to share the results of the deliberations on ethical issues. Examples include education events, grand rounds, and at provincial events. It was noted that the number of occurrences of specific ethical issues is decreasing, which suggests that the learnings are being cascaded throughout the organization.

The research ethics board achieved significant milestones in 2014-15 that resulted in providing a high level of ethical oversight to a greater number of studies, including a larger number of studies initiated outside of Interior Health.

3.1.7 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)

The organization has a well-defined process for internal communications. As evidenced by the most recent roll-out of the new ethics framework the organization considers: audience of the topic; key dates and timelines; risks and challenges with the communication; and key messages and a detailed action plan for roll out. The roll-out plan is inclusive of target audience, tactic, objective, timelines, and responsibility. While the roll-out process is comprehensive, the organization could consider an evaluation post implementation.

The organization's numerous communication vehicles include Leadership Link, a quarterly conference call with the CEO, and most recently, the introduction of a new electronic newsletter. While the organization uses a variety of forums (MHO Alert, and MQM) the organization has recognized a gap in communication with physicians outside IH. The organization is currently investigating other forms of communication which may solidify this gap. Plus, the organization has reflected on the changing use of social media, and a clearly defined policy exists as well as an approach to which topics are best communicated using the various forms of social media.

IH is focused on transparency with the external community and one example is the inclusion of patient experience results on the organization's web site. The organization is supported by appropriate processes for external communications, such as the decision brief which outlines various risks and consultation efforts required to successfully communicate key decisions. The surveyor team noted as the organization evolves there is increased emphasis on the engagement of the community. Examples of this engagement include patient journey mapping, and effective use of the Patient Voice Network. Commendation is given for ensuring the web site is reflective of current topics of interest such as access to information on forest fires and the implications on health.

The website is user friendly. In response to a gap in communications the organization has successfully introduced the role of community liaison. This position has a focus on building relationships to increase trust and accountability with the communities. In consultation with external partners during the survey there were no issues with communication identified. The consensus is they are invited to present their input and they feel well informed. In the future the organization has an opportunity to expand its engagement to other sectors and external stakeholders as it broadens its discussion to issues that impact health.

Insofar as protecting privacy the organization has a number of privacy practices in place to protect a range of financial, patient, and other corporate information. A retention policy clearly delineates the specific expected practices with respect to storage. It is noted that in some cases the patient/resident/client chart will be required to be stored for an indefinite period. As the organization has not moved to a full electronic record, this will create ongoing storage challenges. Note is made of the several avenues the organization uses to communicate the importance of protecting personal health information with patients/residents/clients and families. The organization has well-defined procedures to respond to a request for information. These practices are well known by staff members and are effectively communicated to those requesting such information.

There is access to research-based evidence and leading and best practice information. The organization has an aspiration to: “do the right thing right the first time”. On this journey, the staff members have benefited from the significant investment the organization has made to ensure that evidence-based practices are identified. The surveyor team noted that not only was the information communicated to staff members to assist in their quality improvement activities, design new facilities and support strategic initiatives, these practices are “hardwired”. Specifically, several instances were noted where policy and procedures were redrafted to reflect current best practices. Processes are based on evidence from external sources, and the use of provincial guidelines is incorporated into many clinical and non-clinical models. Also, staff members commented that the current organization structure which is aligned with service as opposed to geography is more conducive to sharing leading and best practices.

3.1.8 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: Leadership	
9.2 The organization's leaders protect client and staff health and safety at all times and particularly during periods of construction or renovation.	

Surveyor comments on the priority process(es)

There exists a mix of physical structures representing a variety of ages, construction and capacity to meet today's needs of an evolving health care system. As laws, regulations and codes change, design and construction for renovations or new buildings will consider the new standards. In addition, the new codes may also trigger renovations to existing facilities for example upgrades are being undertaken for isolation rooms to meet the current standard. To facilitate the development of a multi-year plan, the organization has utilized a number of assessments including: roof reports; independent verification of air ventilation and exhaust following renovations; and VFA facility assessments. In addition to these assessments other jurisdictions such as fire departments carry out regular reviews. Another example of reports informing the priorities of facility planning is the asbestos studies.

With information noted above, the organization is well-positioned to plan and subsequently carry out various facility renewal/expansion projects. The challenge the organization faces is the limited financial resources to respond to the opportunities in a timely way. During the on-site review the surveyor team noted a number of impacts emanating from the deficiencies in physical space. Deficiencies include: overcrowding on medical/surgical units (patients in stretchers in hallways); insufficient storage space for equipment and supplies resulting in items being stored in corridors, and inadequate pharmacy space. These conditions result in safety issues along with issues of privacy and confidentiality and infection control issues. It is recommended that the organization implement interim measures to mitigate the risks, for example congestion, associated with the timing of facility upgrades.

The organization has completed a number of substantial new builds in the recent past, and continues to have numerous ongoing construction projects. The organization is commended for its focus on creating a safe environment for staff members, visitors and patients during the construction. During the on-site visits safety precautions were in place and include fencing and boarding. All areas had a signed form from infection prevention and control (IPAC) attached indicating that the area had met all the necessary requirements to proceed with the project. Also confirmed was IPAC's presence during the start of all projects to ensure patients are protected, and that IPAC meets with all new construction vendors to explain requirements related to protective barriers.

The structural designs are contemporary, patient/resident/client focused, and energy efficient. The organization confirmed that in order to reduce errors, increase efficiencies and ensure common practice is supported in the health care settings, design specifications developed for new construction or renovations consider standardization. This standardization covers both space and equipment and based on Lean exercises and best practices. These designs are a direct result of the skills of IH staff members some of whom have been acknowledged by the Centre for Health Care Design. Also noted is the approach to life cycle planning in construction using the various public private partnership (P3) initiatives.

There are various and numerous measures in place to minimize the impact on loss of utilities. The larger sites have redundancy for the generators, and UPS systems are in place for critical care systems for the operating rooms and intensive care areas, among others. Most sites have back-up of diesel fuel and larger sites also have propane back up. The client home where IH staff members provide services present a challenge for ensuring appropriate back-up systems are in place. The home services are further complicated by the fact that much of the equipment is provided by third parties. It is recommended that the organization investigate opportunities to increase the accountability relative to performance of equipment of third parties that provide in-home equipment.

There are many security processes in place to protect the well-being of patients, visitors and staff. One of the most significant electronic security systems is the use of card access. A recent IH audit has been completed on the status of access systems. The audit confirmed priority areas of mental health, emergency department, pharmacy and obstetrics. The organization is proceeding with priority investments in these areas. While the organization finalizes the planned upgrades it is recommended that additional education on the functionality and related use of the security access systems be provided, as some areas are not utilizing the system as planned.

Service and maintenance contracts to external companies reflect the obligation of contractors to the health authority including the obligation for safety. However, the organization has recognized that this needs to be strengthened. The team is encouraged to complete its work on the development of policies outlining the: "Owners General Requirements". This includes such areas as multiple safety elements regarding fire regulations, noise and vibration, hazardous materials, asbestos, hazardous spills and clean-up, and occupational first aid. Once this is completed it can become an integral part of all contracts.

The organization is commended for the development of its document: Environmental Sustainability Strategic Work plan 2015/16-2016/17. While only in a draft format, it continues to receive various forms of input, and it is noted several initiatives are already underway. In particular, many sites have commenced a variety of recycling and waste reduction strategies including battery recycling, while others are actively focused on sustainable transportation initiatives for employees. Of special note is comprehensiveness of the plan inclusive of strategies in the areas of improved recycling/waste reduction, paper use reduction, fleet fuel use reduction and sustainable transportation environmental stewardship.

3.1.9 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)

The organization has released a multi-year strategic plan for emergency preparedness in 2012. Roles and responsibilities have been clearly defined. A director trained in emergency management is on call for emergency response 24/7. Standardized documents, streamlined templates and on-call schedules are all housed on the intranet. Leadership training is available and it includes orientation for those taking call for their facilities and programs. Staff members are well informed. Relationships are strengthened with community partners including municipal governments and first responders. The organization is encouraged to formalize some of these relationships.

Unfortunately, the organization has had to activate its incident management response (IMR) to address many emergencies in recent years. This included wild fires, floods, mass casualties and suspected Ebola, and potential service interruptions such as drug shortage and job action. To its credit, activation criteria and processes are well described, staff members know what to do and additional skills and people are easily mobilized such as for communications.

Post event, the organization debriefs, often learns valuable lessons and improvements are made. Spiritual care and a social worker are available to staff members and volunteers for debrief and support.

The document entitled: "Health Emergency Response on Call – Quick Reference Guide (June 2015)" is an excellent four-page document with need-to-know contact numbers, a glossary, a response process checklist, the emergency operation centre (EOC) organizational structures, advanced planning tips for prolonged events, and other things.

Back-up systems for electricity are in place for most facilities except for some community-based programs, and there is oxygen and suction back-up in larger facilities.

The reporting on current fire safety training is inconsistent. The organization is encouraged to ensure that all staff members have the necessary training and report these numbers. Staff members working in high-risk environments such as laundry could benefit from fire extinguisher training.

The organization coordinates its planning for pandemics and outbreaks, with infection prevention and control, Public Health and Emergency Heath Management taking lead roles.

An area of risk identified by the organization with regards to emergency readiness concerns its residential sites. This area could benefit from additional training and support. Recognition is given for the innovative evacuation drills that include strategies such as "ice cream on the lawn".

The organization is commended for its progress in having the training, skills and infrastructure in place to respond to emergent events.

3.1.10 Priority Process: Patient Flow

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

Unmet Criteria	High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards	
6.8 The team has a process to identify and respond to clients whose condition deteriorates to an urgent situation or crisis while on the waiting list.	

Surveyor comments on the priority process(es)

The organization has placed access and flow as its first priority and pillar of excellence and has dedicated significant resources and senior leadership commitment to addressing this issue. There is significant evidence of efforts made at a local and regional level for acute care sites, as well as more widely with community stake holders.

There is excellent data distributed at set times daily and which provide a region-wide picture of bed utilization. Each of Interior Health's sites has set up a process to review the census and needs with a particular emphasis on ensuring flow of patients and reducing bottle necks especially in the ED. There are good over-capacity protocols which are utilized when other usual processes have been exhausted. During the survey visits the sites spoke about "congestion" versus "over-capacity" and have become accustomed to contingency planning for census levels between 100 and 115%.

There is evidence of a commitment by coordinators, managers and senior leadership to all work together to identify opportunities for admitting and discharging patients to the appropriate resource to ensure patients are receiving care in the right place by the right services. During one site visit a surveyor was able to follow a tracer that included multiple meetings, starting with community resources to determine what residential, assisted living, community mental heath and social supports were available for transfer of patients out of the acute care setting. Subsequently, the access manager met with coordinators and managers to get an understanding of patient load and priority issues in each of the departments. This meeting was appropriately chaired by a shift coordinator that was using technology such as texting to obtain live feedback for moving patients to plan for admissions within the abilities of the hospital. A detailed alternate level of care (ALC) patient review was subsequently completed, with special attention given to a patient that was non-compliant and requiring a creative approach to expedite diagnostics and care in order to facilitate discharge completion as quickly as possible.

Senior leadership at the site participates in a daily teleconference with the Patient Transportation Office and nearby facilities to discuss potential transfers or repatriation of patients. On the day observed, this facilitated an additional three transfers or discharges which cleared a bottleneck at one of the larger centres. The morning process ended with a wider provincial telephone call to gather information and feedback from larger centres such as Vancouver General Hospital to determine what patient repatriation could occur.

There were appropriate tools to track patient movement at all meetings observed and a daily commitment to ensuring that safe, effective and appropriate care was available for patients. The team, from coordinators to senior leadership are committed to checks several times a day to review and improve patient flow at a local and regional level.

Several improvement initiatives are underway. One is "early pulls" which encourages early admissions for patients that have been waiting in the ED overnight, and another is the clinical care improvements such as the A-B-C-D-E bundle implementation on ICU which has reduced ventilator days and length of stay (LOS).

The region and province recognize the importance of an upstream approach and have been adding supports including substantial capital expansion and increasing the number of residential beds. The resource, Pathway to Home, is an excellent resource for patients that have sub-acute or rehabilitation needs of 30 to 90 days. These supports along with hospice and increased community supports are all helping in keeping patients out of the ED.

Multiple strategies including the Access and Care transitions, Quick Response and Hospital to Home have all had significant impact on improving outcomes, decreasing LOS and reducing readmissions. The implementation of the Patient Transportation office and high-acuity response team (HART) has been transformational for the region. The HART team has improved access for high acuity patients needing rapid competent care during transport, and allows smaller centres to provide continuity of services in their communities where previously scarce resources were sometimes used to transport higher acuity patients. The additional benefit of outreach education and case reviews offered by HART has been accepted as a terrific success by staff members and leadership across the region.

The organization demonstrates excellence with its collaborative and accountable approach to ensuring the best access and flow-through of patients in the system. There remain some opportunities for improvement, including the need for better supports for patients with mental health and substance use issues. Some centres are keeping patients with acute mental health conditions in seclusion rooms in the ED in excess of 36 hours. There is a need to continue expanding services to this vulnerable community to ensure their needs are met. The region is now at the point where it needs to consider creative approaches to offering social support services beyond traditional working hours.

Additionally, it is noted that there remain long wait-lists for surgery in some areas. The province has adjusted the target wait-lists for procedures to 26 weeks. There are some mechanisms in place for following up with patients that deteriorate whilst waiting for surgery but these largely rely on self-identification to a primary care provider that follows up with perioperative services. The region would benefit from considering a standardized process to follow up on patients that have delays or extended wait times for procedures.

Some communities report an increase in the Canadian Triage Acuity Scale (CTAS 4) patient attendance at the ED due to lack of primary care providers. There are several physician recruitment strategies underway to address shortages but these trends need to be monitored and alternate care models such as nurse practitioner explored.

3.1.11 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: Perioperative Services and Invasive Procedures Standards		
11.5	The team verifies that surgical equipment or medical devices returned to the operating/procedure room following repair or replacement are clearly marked with the date of their return/arrival and a signed notice describing the maintenance or purchase.	!
22.6	The organization transports contaminated items separately from clean or sterilized items, and away from client service and high-traffic areas.	!
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
3.3	The medical device reprocessing department is designed to prevent cross-contamination of sterilized and contaminated devices or equipment, isolate incompatible activities, and clearly separate different work areas.	!
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.2	The medical device reprocessing department's hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.	!
10.1	The medical device reprocessing department has an appropriate area for the storage of sterilized medical devices.	
11.2	All endoscopic reprocessing areas are physically separate from client care areas.	!
13.9	The team designs and tests quality improvement activities to meet its objectives.	!

Surveyor comments on the priority process(es)

The medical devices and reprocessing (MDR) team is headed by a practice leader with regional responsibilities. The leader is supported by MDR coordinators that have site-specific responsibilities. The practice leader is responsible for providing recommendations for the goals, objectives and priorities. These are supported by the MDR coordinators.

The coordinators support the goals, objectives and priorities for the network by providing recommendations, education and support to all staff members that perform reprocessing activities. All information pertaining to MDR processing and standard operating procedures (SOPS) can be found on the internal intranet network . All staff members working in the reprocessing department must demonstrate completion of an accredited

course. All staff members must demonstrate continuous competence. Educational material is available for self-learning on the iLearn network. Vendors also provide education on how to process new equipment and also offer periodic refreshers. Educational activities for each of the employees can be documented and followed by the leaders. Staff members receive regular performance evaluations as per guidelines.

Inventory, trays and location of trays is documented and made available should problems arise. The Alex Gold management system has been implemented at most sites which make this process efficient and seamless. Staff members interviewed during the survey were enthusiastic and had a strong commitment to safety and quality of reprocessing. Safety was of prime concern and demonstrated at all steps of the reprocessing process.

Noted strengths are: seamless tracking and inventory management with implementation of the Alex Gold system; strong commitment to quality and safety; new equipment and physical environment in Kelowna and Vernon; centralized management and purchasing; centralized supply chain; engaged and well-educated staff; and multidisciplinary team participation, with finance, bio-medical, infection prevention and control and individual site representation.

The challenges relate to: costs for upgrading sites (Pleasant Valley Health Centre, Shuswap Lake Hospital) to current standards; keeping pace with expanded surgical services; working with limited resources; and high costs of maintenance and acquisition of equipment.

Areas for improvement are the need to review the location of hand-hygiene dispensers, as per accreditation standard at entrances to processing areas; and need to remove wooden cupboards and porous counters at Pleasant Valley Health Centre and Shuswap Lake Hospital.

Biomedical engineering services are available to all sites. The service is divided into three regions, and each region has centralized staff members at a regional location which provides services to facilities within that region. All equipment is tagged and identified. This allows the department to know the location of equipment and monitor the age of the asset and schedule routine maintenance. This allows planning for replacement and prioritization. All staff members that are hired are expected to have at least a Diploma in Biomedical Technology from one of the colleges.

All new staff members undergo an extensive and comprehensive three-month orientation. Some of the maintenance to the sterilization equipment has been contracted to Black and Macdonald. All staff members undergo regular performance evaluations as per policy. Additional education is encouraged and provided by vendors or through other methods.

The department is highly committed to safety and quality. Biomedical engineering plays a strong role in evaluating the equipment that is being considered for purchase. The YES equipment management system has been implemented.

Noted challenges are: budget constraints; increasing inventory with greater demands and increased service frequency; management of adequate staffing; integration of devices with internet capabilities and need for IT support; standardization of equipment, and requests for proposals (RFPs) being done too quickly by Health Shared Services BC (HSSBC) thereby, not allowing all stake holders to be adequately represented.

Noted strengths are: centralized inventory control and maintenance performance system; highly trained technicians; ability to audit the frequency and type of preventive maintenance, and a standardized process for capital acquisition.

3.2 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, innovation, and action.

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

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

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

The Kelowna Assertive Community Treatment Program (ACT) was implemented in January of this year and by nature of the program, the leaders are directed by the Ministry of Health to serve a specific group of individuals over the age of 18 with severe and persistent mental illness.

Information regarding demographics, burden of care, system capacity and mental health and substance use utilization are reviewed and analyzed in order to inform the service needs of the priority population.

The ACT team has successfully integrated a peer support worker into the program who provides the client perspective. This individual is very engaged in the team and actively participates in team huddles and the review of client care plans.

A number of performance targets are set by the Ministry of Health for the ACT team. In addition to these the ACT team has identified additional goals including the number of Emergency Department visits, admissions to hospital and length of stay in hospital experienced by the population being served. The ACT team has also done some early work on several quality improvement initiatives identified by team members. Leadership for the team is encouraged to document the progress made on these and other goals and post the results in areas where team members are able to see them.

In discussion with members of the ACT team, they indicated they felt well supported in terms of education and training. In addition to programs that they can participate in, team members support self-learning opportunities through case studies which are presented to peers. A number of safety features have been implemented to support staff safety while providing care.

The program is well resourced which is very beneficial to achieving the targets set by the Ministry of Health. Client information is readily shared between those within the circle of care through the Meditech system and the electronic health record.

As part of the visit with the Kelowna ACT team, the surveyor was able to meet with six representatives from partner agencies including the RCMP, the John Howard organization, Acute Care, Ministry of Justice and Forensics. The group were very complementary of the work done by the ACT team. All spoke to the significant impact the ACT team is having in supporting the hard to serve and reducing their own work. As well the partners recognized the efforts of the ACT leaders to ensure the staff on the team are highly competent and engaged in their work. The ACT team leadership plans to create a Community Advisory Committee in the near future to gather input into the planning and delivery of ACT team services in the Kelowna area.

The ACT team is commended for the great work and partnerships they have been able to accomplish in less than a year of operation.

3.2.2 Standards Set: Public Health Services - Horizontal Integration of Care

Unmet Criteria		High Priority Criteria
Priority Process: Population Health and Wellness		
16.5	The team designs and tests quality improvement activities to meet its objectives.	!
16.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

Public Health teams are energized and passionate in describing and implementing their work. There have been significant changes since the 2012 survey with staff at every level commenting on the improved connectedness and increased opportunity within the organization. The CEO is commended for taking action on a past recommendation to expand the Senior Leadership group to include the Chief Medical Health Officer. Public health activities now span the portfolios of three Vice Presidents, creating a considerable upstream population health influence on the organization.

The direction for Public Health programs comes from BC's Guiding Framework for Public Health and Priorities for the BC Health System. The teams have some flexibility to shift resources to meet emerging needs (Healthy Built Environments) and to ensure equitable access based on population need (e.g. Dental Services).

Since 2012, Public Health has assessed and reported on many population health issues of relevance to Interior Health and its partners. They are encouraged to share these more widely. Notably, several health assessment activities and reports have been completed including the Influenza Impact 2015 report. With the Board of Directors in support, health protection staff have partnered with others on a Large System Drinking Water Strategy. A Maternal Child Health Report including 19 indicators will be available in late 2015. These initiatives are significant in that they incorporate health equity and the social determinants of health as foundational to addressing health issues. The organization is commended for their community profiles which are available broadly and used for many purposes.

Innovative initiatives include STOP HIV which promotes stigma reduction, testing, engagement and treatment for HIV/AIDS. Food security work by the Promotion and Prevention team has resulted in an internationally acclaimed document on Best Practice in Urban Agriculture.

With the May 2015 release of the organization's robust Ethics Framework, there is now work in progress to add a chapter on public health ethics which will ensure the collective interests of a population for the common good will also be considered.

The health protection team works with others to protect the health of the population and minimize risk (acute care pertussis outbreak). They are involved in many partnerships including the Trail Childhood Lead

Survey, a partnership with industry, Interior Health and the community. The team is commended for their logic models and internal communication plan. Vaccine supply and distribution is managed safely in the public health environment. The organization is encouraged to continue to work with primary care to ensure safe cold chain management in those settings.

The organization is recognized for their Aboriginal Health and Wellness Plan which includes priorities to ensure cultural safety and meaningful participation, and to improve health equity and mental wellness. Street outreach nurses have embraced motivational communication with their clients. The organization is encouraged to offer this training to more front line providers.

Staff report having frequent touch points with their direct reports but the organization is encouraged to complete formal performance assessments on all staff as per policy. Volunteers and students feel welcome and valued in public health especially in child health clinics.

There are a multitude of health care staff and community partners interacting with families especially during the maternal child continuum of care. The team is encouraged to look for opportunities to combine and/or share the client record, plan together and ensure consistent messaging.

A Public Health Accreditation Working Group has evolved into a Public Health Cross Portfolio Collaborative with a purpose to facilitate planning, collaboration and quality improvement across public health portfolios. It is hoped this group will work with the IH Quality Consultants to ensure common, standardized, measurable objectives for their quality initiatives. The team is encouraged to consistently test the quality of its improvement activities, regularly evaluate its indicator data, and continue to review and evaluate quality improvements for feasibility.

Public Health is encouraged to continue their quality journey and ensure there are sufficient efforts to engage front line staff.

3.3 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:

Episode of Care - Ambulatory Systemic Cancer Therapy

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

Clinical Leadership

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

Competency

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

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

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

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

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

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

3.3.1 Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria

Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
4.9	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
8.6	The team uses standardized clinical measures to evaluate the client's pain.	
11.5	The team has a process to evaluate client requests to bring in or self-administer their own medication.	
12.3	The team transfers information effectively among service providers at transition points.	ROP
12.3.1	The team has established mechanisms for timely and accurate transfer of information at transition points.	**MAJOR**
12.3.2	The team uses the established mechanisms to transfer information.	**MAJOR**
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

For the purposes of this accreditation survey the renal services of Interior Health (IH) have been surveyed using ambulatory care standards which do not address all aspects of the renal services and continuum of care. An administrator and medical director work in collaboration to develop, sustain and enhance renal services across the IH, and lead the renal team. The Provincial Health Services Authority via the BC Renal Agency (BCRA) directs much of the program planning and requirements.

Funding for dialysis, pre-dialysis and home therapies are controlled by the BCRA. Indicators of performance required by the province include financial reporting and access and quality indicators. There is a provincial database called PROMIS where patient-specific and system-specific data are entered. The leadership can use this reliable data to review processes and implement quality improvement initiatives.

Challenges to program planning include the large geographical area, weather, transportation and lack of family physicians in some communities. As a result, the team has implemented telemedicine, which when required allows for consultations between visits to the community dialysis units. Until recently, it was only the nephrologists that travelled to the various sites across the region but now the whole inter-professional team attends. This process has greatly enhanced satisfaction among clients and their families.

Given the complexity of patients served the leadership has successfully increased pharmacy support across the region. Most of the nephrologists, clinical and administrative leaders participate on provincial renal committees that address issues such as evidence based practice, technical issues, vascular access, finances, equipment and facility renewal.

Priority Process: Competency

The renal team has a defined interdisciplinary team with specific roles and responsibilities related to the care and treatment of renal patients. All staff members and physicians working in the renal program have the necessary clinical qualifications. The team meets with patients and their families every three months to review the advanced care plan and the patient's current state. This improved frequency of meeting with the team has greatly increased satisfaction among patients and families.

By way of BCRA the team receives funds as value added from vendors for education. These funds are used to support projects/pilots focused on quality improvement, process redesign and improvement for patient care and outcomes. They also supplement funding for patient and staff education with the regional renal programs in BC.

New nursing staff members (both RN and LPN) attend an eight-week, full-time Dialysis Specialist Education Program (DSEP) provided by program nurse educators. Following successful completion, there is a four-week preceptor program for the new nurse.

With the exception of new hires requiring a probationary performance review, most of the staff members interviewed could not remember when they last received a formal performance review. They were quick to mention however, that they receive just-in-time feedback which helps them to improve practice or acknowledges exceptional effort.

Priority Process: Episode of Care

The surveyor team members conducted clinical tracers at five clinical settings. In-centre dialysis units visited included the Royal Inland Hospital in Kamloops, Kelowna General Hospital, and the Penticton Regional Hospital. The two Community Dialysis Centres visited were the Kamloops Community Dialysis Unit and the Rutland Dialysis Centre. The tracer activity included interviews with medical and administrative leaders, middle managers, patient care coordinators, front-line staff members and most importantly, patients and their families.

The Royal Inland Hospital (RIH) in-centre dialysis unit at Kamloops is located in a previous in-patient unit. The physical space is crowded and not optimally laid out but the team does its best with a difficult situation. The reverse osmosis room is small but clean and accessible. There is a chronic kidney disease (CKD) clinic, a peritoneal dialysis education centre and hemo-dialysis training centre. The team is rounded out with the vascular access nurse, educator, social work, dietician and pharmacy. There are two technicians on duty that set up and take down the machines, clean the patient environment and can do some basic trouble shooting with the dialysis machines. The patients and families interviewed are impressed with the care. One new renal patient stated: "the nurses have the patience to listen to patients - they are empathetic and treat us as a whole person". The space between dialysis machines is tight and it is difficult to have a private and

confidential conversation with the patient at the chair-side, or between two clinicians at the workstation regarding patient care issues.

The Kamloops Community Dialysis centre is a splendid space for patients that have to spend fours hours per day, three to four times per week. There is plenty of space between dialysis machines and so privacy and confidentiality are ensured. One family member mentioned the patient being given a consistent spot that is cosy and private and said: “I feel comfortable leaving my husband here while I do a few errands, knowing he is well cared for and comfortable”. Other patients described the care as compassionate and highly skilled.

The Rutland dialysis clinic is a cramped older space with little room for storage. Recently, the team had to make room for ordering their own supplies, rather than continuing to enjoy the advantage of the just-in-time stores service. It has been a great challenge to accommodate the larger volumes of supplies. As well, the utility room includes the medication cupboard and a small cluttered counter. The patient interviewed has been receiving dialysis care for 17 years. This patient was able to describe the emergency preparedness kit all dialysis patients are given to use in the event of a community emergency of any kind. The team at Rutland has used a detailed form for transfer of information at transition points for almost four years. It would be worthwhile for the other centres to trial this tool that meets the ROP requirements.

Kelowna General Hospital is the main site for the renal program of IH. The services at this site include the CKD clinic, transplant program, home modalities and hemodialysis. The physical space is new, bright and inviting. The clinic uses both beds and chairs for patients undergoing dialysis. The chairs look most uncomfortable and the patients would benefit from the more comfortable adjustable chairs found in other clinics across IH. The workspace supports the interdisciplinary team functioning. The team has experienced upheaval, with having three different managers in two years. As a result, performance appraisals have not been done other than the probationary ones for new hires.

The clinic at Penticton Regional Hospital is open and welcoming. Patients are supported and encouraged to be as independent as possible. As noted in the ratings, there is one client that performs independent haemodialysis. This client feels very much in charge of their treatment and their life.

The team is presenting at the BC Kidney Days on their Advanced Care Planning: Developing a Standard Approach project.

General observations across sites include the following:

Although staff members have received hand-hygiene education, they are not currently being audited so are likely less aware of compliance with the ROP. Hand-hygiene gels are readily available but there was little evidence of usage throughout the tracer visit at all sites.

The procedure across sites for the transfer of information on transition ROP does not meet the test for compliance in most of the sites. A verbal report is given face-to-face or via telephone, and so there is no opportunity to review the information later.

The bio-medical department renal biomedical engineer is responsible for managing and monitoring equipment performance including preventive maintenance and episodic repairs. The department is an active participant provincially in the selection of new renal equipment via the provincial facilities and equipment group.

Medication reconciliation is well done across all sites visited. The renal team has developed a policy that delineates when and under what circumstances the patient will have medication reconciliation conducted or reviewed.

Patient and family complaints have significantly decreased since the team increased the frequency of case management meetings between the interdisciplinary team and the patient and family. In preparation for this meeting, all blood work, medication, issues with pain, access and personal concerns are addressed.

The transplant program is well developed and operates via the CKD clinic. Patients that meet the criteria for a transplant are worked up by transplant staff members in collaboration with the Vancouver General Hospital and St. Paul's Hospital.

Priority Process: Decision Support

The teams have access to robust data via the PROMIS database. They are able to benchmark a variety of indicators against various renal sites in Interior Health as well as with like operations across the province.

Clinical practice guidelines are reviewed, selected and evaluated by provincial expert committees to help ensure consistency of practice across the province. A project management department helps support quality improvement initiatives by establishing project charters including scope of work. The department also assists with analysis of results and evaluation.

The teams could not provide the surveyor team with evidence of written specific, measurable, attainable and results-focussed and time bound (SMART) goals and objectives. Teams are actively involved in many quality improvement plans and projects but there does not seem to be one document that pulls it all together and makes it relevant to the physicians and front-line staff.

Priority Process: Impact on Outcomes

Due to the longevity of patient care relationships (one patient at the Rutland site has been a patient for 17 years), the staff members may use personal recognition along with the photo on the chart that is updated on a regular basis. Staff members that do not know the patient also ask for name and date of birth.

The staff members conduct a falls assessment at initial entry into the program using the key questions identified in the falls prevention guideline. Subsequently, at every treatment or visit, the patient is assessed for general condition and asked if they have had a fall or a near fall. If they have had a fall, the form is completed with interventions identified. Patients interviewed at all the centres visited validated this practice occurs.

The team has not experienced a sentinel event but is able to find the policy online and knows what process to follow in the event.

3.3.2 Standards Set: Ambulatory Systemic Cancer Therapy Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy			
9.15	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client 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 the how often medication reconciliation is repeated. *Ambulatory care clients are at risk of potential adverse drug events when their care is highly dependent on medication management OR the medications typically used are known to be associated with potential adverse drug events (based on available literature and internal data).		ROP
	9.15.1	The organization identifies and documents the type of ambulatory care visits where medication reconciliation is required.	**MAJOR**
	9.15.2	For ambulatory care visits where medication reconciliation is required, the organization identifies and documents how frequently medication reconciliation should occur.	**MAJOR**
	9.15.7	The team provides the client and the next care provider (e.g., primary care provider, community pharmacist, home care services) with a complete list of medications the client should be taking following the end of service.	**MAJOR**
Priority Process: Clinical Leadership			
2.5	The team has sufficient space to accommodate its clients and to provide safe and effective services.		
2.6	The team has sufficient staff to accommodate clients and meet workload demands.		
Priority Process: Competency			
3.5	Sufficient workspace is available to support team functioning and interaction.		
3.7	The team evaluates its functioning at least annually, identifies priorities for action based upon the evaluation, and makes improvements.		
Priority Process: Decision Support			

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
22.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
22.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
22.5	The team designs and tests quality improvement activities to meet its objectives.	!
22.6	The team collects new or uses existing data to establish a baseline for each indicator.	
22.7	The team follows a process to regularly collect indicator data to track its progress.	
22.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy

The team has recently taken on a quality project to provide standardized group teaching. This is a change from the previous one-to-one teaching sessions for new patients. The lead on this project has reorganized the patient teaching packages, created a checklist to review with the patients and also a power point presentation in collaboration with the educator resource. The revamped teaching packages are being used at all the Community Oncology Cancer Clinics and volunteers have taken on the role of assembling the packages.

The volunteers are a key member of the inter-professional team and support patients with refreshments and also maintain the wigs and head coverings which are available for patients to use until they obtain their own.

Priority Process: Clinical Leadership

The BC Cancer Agency (BCCA) has hired a Director of Community Oncology Network (CON) who liaises with the 44 Community Oncology Network Clinics across BC. This is a welcomed position and will facilitate communication between the 11 CON sites within IH which includes 3 satellite clinics, one inpatient unit and seven community chemotherapy clinics. The CON program has identified a number of priorities moving forward that will impact on IH cancer services including a review of provincial quality standards, a program needs assessment to determine HR needs and implementation of telehealth services.

In order to support quality a number of structures exist within both BCCA and IH including professional practice leader support related to standards for practice. The BCCA website hosts provincial cancer care standards that are accessible to IH staff. BCCA Provincial Chemotherapy Certification Program provides the initial training for all IH nurses and establish ongoing competency tools available to nurses. The IH Regional Cancer Care Services Working Group consists of leaders from all sites and facilitates communication and

collaboration on quality initiatives to promote care standardization across the region. The Family Practice Oncology Network exists for IH physician support.

The patient volume has increased 20% at the Penticton site in the last fiscal year and the current staffing levels are insufficient to meet the patient volumes. The family physician oncologists work Monday to Thursday, and some patient treatments have been moved to Fridays so that the team can safely manage the workload. Volunteers are active members of the team and support patients by offering beverages to organizing patient teaching materials.

The team is exploring opportunities to work with BCCA to purchase infusion devices with oncology-specific dose error reduction software.

Priority Process: Competency

These are high-functioning teams that are dedicated to providing excellent, compassionate patient care.

The Oncology Network is exploring opportunities to create a unit clerk-specific job profile which identifies the unique requirements of this role. There have been some challenges in recruiting qualified unit clerks that are able to work with the two separate computer systems of the BCCA and IH.

BCCA offers a standardized nursing certification program in oncology. The program includes required online pre-reading, a knowledge test and practicum at BCCA. All oncology nursing staff members complete the program including those working on the in-patient unit at Kelowna General Hospital.

BCCA provides evidence-based standardized protocols, pre-printed physician orders (PPOs) and information which is used at all the Community Oncology Cancer Centres. This facilitates provision of standardized, current and evidence-based care.

Although BCCA provides educational opportunities, the oncology leadership at IH feels that oncology nursing staff members could benefit from a specialized nursing educator resource to support ongoing staff learning.

Priority Process: Decision Support

The patient record is maintained according to the BCCA standardized chart. This requires IH staff members to access two different computer systems and creates some duplication in documentation which is a potential for error. For example, the laboratory results may be obtained from the IH laboratory or external laboratory. Thus, a hard copy of these results is printed off and placed in the paper chart until the 'faxed' copy is entered into BCCA's electronic record.

Priority Process: Impact on Outcomes

The programs are measuring the number of clinic visits, number of chemotherapy treatments, number intravenous (IV) prescriptions and number of take-home prescriptions.

Patients are provided with information on medication safety, hand hygiene, falls prevention and chemotherapy safety.

Priority Process: Medication Management

The BCCA reviews current evidence and creates protocols and PPOs which are used at all of the satellite clinics.

Recently, the pharmacy staff from BCCA visited the pharmacy at Penticton Regional Hospital for five days, observed all the staffs' activities and provided recommendations on how to improve processes to improve staff and patient safety. These improvements have been implemented however, the organization is urged to consider building a separate negative pressure room to prepare the chemotherapy medications.

Medication reconciliation occurs for all new patients. The medications are reviewed by the oncology pharmacist that verifies the list against those on the BC PharmaNet system. These medications are checked for potential drug interactions against the chemotherapy regimens that are ordered for the patient. Any issue that is identified is discussed with the oncologist or family physician oncologist.

All chemotherapy regimen doses are double-checked by the pharmacist prior to preparation. These doses are subsequently double checked by the nurse prior to administration. All chemotherapy infusions are double-checked by a second nurse prior to infusion to the patient and the independent double checks are co-signed in the patient medication administration record (MAR).

As patient volumes continue to increase, encouragement is offered to ensure that adequate nursing and pharmacist resources are in place to safely prepare and administer these high-alert medications.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.4	The organization's goals and objectives are specific and measurable.		
Priority Process: Competency			
4.10	Team leaders regularly evaluate and document each staff member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
7.11	The team follows a process to identify, address, and record all ethics-related issues.		!
12.4	When medication management is a component of care (or deemed appropriate through clinician assessment), and with the involvement of the individual, family, or caregiver (as appropriate), the organization generates a Best Possible Medication History (BPMH) and uses it to reconcile individual's medications.		ROP
	12.4.1	The organization identifies and documents the types of individuals who require medication reconciliation.	**MAJOR**
	12.4.2	At the beginning of service the organization generates and documents a Best Possible Medication History (BPMH), with the involvement of the individual, family, health care providers, and caregivers (as appropriate).	**MAJOR**
	12.4.3	The organization works with the individual to resolve medication discrepancies OR communicates medication discrepancies to the individual's most responsible prescriber and documents actions taken to resolve medication discrepancies.	**MAJOR**
	12.4.4	When medication discrepancies are resolved, the organization updates the current medication list and provides this to the individual or family (or primary care provider, as appropriate) along with clear information about the changes.	**MINOR**
	12.4.5	The organization educates the individual and family to share the complete medication list when encountering health care providers within the individual's circle of care.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			

19.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
19.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
19.5	The team designs and tests quality improvement activities to meet its objectives.	!
19.6	The team collects new or uses existing data to establish a baseline for each indicator.	
19.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
19.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization is commended for the recent development of the Mental Health and Substance Use (MHSU) Network. The work of this group is to prioritize goals and take into consideration not only the Ministry of Health's directives but also the clinical priority areas for the populations served. The organizational imperatives are providing some early wins in bringing focus and consistency to MHSU goals and objectives as well as providing alignment with the overall strategic direction of Interior Health (IH). The co-leadership model (administrative and medical) at both the MHSU Network and the local area network level has strengthened medical leadership involvement in planning and service design.

A number of innovative projects such as "LINC" developed in the Kelowna area have been developed to bring various services such as clinical mental health, substance abuse, housing, vocational, income, and counselling together under one roof and to prevent individuals from falling through the cracks between the various systems.

In the Thompson Caribou area strong relationships exist between the community mental health services and other groups, programs and organizations including Aboriginal groups, the local school district, elderly services and victim services.

Although goals have been developed at the broad level of community mental health services for IH, there is little evidence that sites have developed specific and/or measurable objectives to support these goals. The various sites are encouraged to develop, with staff input, measurable objectives that are in keeping with the overall program goals and then implement and monitor their progress towards achieving these goals.

Priority Process: Competency

There is evidence of strong team functioning at all the four community mental health sites visited during the survey. The interdisciplinary teams include various professional groups with the necessary qualifications and ongoing education to support the mental health and substance use needs of their clients.

There is a strong presence of psychiatrists in the programs, many of whom also provide service in acute and tertiary care, which facilitates provision of a tight system of follow-up, from acute/tertiary to community. As well, the physician co-manager role provides the opportunity for medical leadership participation when planning and evaluating service delivery.

The orientation program for new hires is extensive and ongoing learning is supported by the iLearn website. In addition to iLearn information, staff members have access to the InsideNet as well as the MHSU education site which provides information and resources aimed at enhancing practice. Staff members expressed appreciation for the orientation they received and access to ongoing education.

A collaborative approach between manager and staff members was noted at all sites. Multiple examples were provided of staff recognition for their contributions.

The policy of IH is to complete performance appraisals for staff members every three years. Evidence of this having occurred is not consistent across all sites visited.

Recruitment and retention of qualified staff members in some areas was not seen to be as large a challenge as reported at the time of the organization's previous survey.

Priority Process: Episode of Care

The teams demonstrated client-focused and strength-based care across all sites surveyed. Clients are invited to be involved in their own care; however, some individuals choose not be active participants and do not have family involved and this right is acknowledged by the team. Informed client consents were noted at all sites visited.

The teams indicated that ethics-related issues frequently occur in the community mental health settings. Most teams are able to articulate the informal process they would undertake to address such issues. However, there is inconsistent understanding by front line staff members regarding the recently developed ethics framework. The organization is encouraged to provide greater education on the ethics framework and how to activate its use for the front-line staff.

The organization has a robust patient incident reporting and tracking system and staff members interviewed indicated that they receive feedback and follow-up surrounding incidents.

All sites visited have a triage system that refers clients to other resources if their needs cannot be met by that community mental health team. Wait-lists are short and where these exist, clients that are waiting are reviewed frequently to ensure access should their needs have changed. The majority of the sites visited are able to receive direct client referrals for a good portion of business hours Monday to Friday. Clients with immediate needs outside of these hours are directed to a crisis line and potentially referred to the closest emergency department should their needs warrant immediate care.

The use of a common suicide risk assessment tool was noted at all sites. Patient safety plans were also noted in cases where the client has been assessed as at risk.

The community mental health programs are commended for the extensive partnerships they have developed to help support individuals and families meet their basic needs. In all areas, relationships have been built with local community groups/agencies to help support the client and family beyond their health needs, recognizing that other determinants of health have a significant impact on the client and their family's physical and psycho-social health.

At all sites surveyed the orientation program for new hires included education on crisis intervention techniques. Regular review of this material is also undertaken via online learning.

The program is commended for the significant relationship that has been developed with the local RCMP force. One of the features of this relationship is the "Car 40" program. This program involves a community mental health worker and an RCMP officer that are available to respond to any crisis which may arise in the community mental health programs and which has the potential to endanger the safety of the client or other clients and staff.

The teams have recognized the significant importance of ensuring the necessary information is transferred with the client. Common documentation has been developed and is utilized in the community mental health program at transition points.

Priority Process: Decision Support

The community mental health sites surveyed are documenting the majority of care electronically. Continuity of information is aided by the ability for all IH providers to access pertinent client information via the Meditech system. Data collection is distributed electronically, contributing to the organization's ability to generate statistics and monitor performance.

Video-conferencing is used extensively across the program sites for meetings as well as for client consultation. Information used to guide practice is initiated using several sources including the central quality committee at IH, and clinical educators in the various program sites as well web sites.

No formal research projects were reported as currently being conducted at the sites surveyed.

Priority Process: Impact on Outcomes

The teams indicated that the recent quality improvement activities focused on the ROPs and information regarding the ROPs was posted in a number of the centres.

Little evidence was seen of specific objectives developed by the teams, or indicators to measure the outcomes of such objectives. Leaders are encouraged to develop specific objectives/quality initiatives and indicators to monitor progress surrounding these indicators.

There is a robust incident reporting system and trends are communicated to the staff members to improve safety.

3.3.4 Standards Set: Critical 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	
4.6 Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Critical care services are provided across the region and include two tertiary centres; four regional centres and two rural centre (high acuity beds). There are 67 designated intensive care (ICU) beds. The program has operational accountability via the acute care services portfolio. Critical care works in partnership and collaboration with the Critical Care Regional (CCR) Network which has accountability to: establish the strategic priorities aligned with the Ministry of Health and Interior Health; develop clinical practice standards and guidelines across the region and in alignment with provincial guidelines and standards; and for quality and risk management. The CCR Network has implemented a Critical Care Coordinating Committee with representation from all sites. Each of the sites has a designated manager and medical director; and each of the units has access to an intensivist or internist with ICU experience. The majority of the units are closed, with only designated ICU physicians able to admit to the unit. The Penticton site is an example of an open unit where any physician can admit to the unit and the medical director is an internal medicine specialist.

The program has experienced many successes in the past three years including: development of the multidisciplinary Critical Care Coordinating Committee; establishment of the critical care database in six of the eight ICUs; development of a critical care webpage on "InsideNet" to ensure easy access to information

for all staff; implementation of the A-B-C-D-E bundle and the development of standardized order sets; clinical practice standards, guidelines and documentation.

The program and CCR Network have identified a number of challenges facing the program. These include: transport of patients related to geography and distance; capacity at the smaller sites and basic cardiac life support (BCLS) versus advanced cardiac life support (ACLS) capacity in the BC Ambulance Service; challenges including having face-to-face network meetings to continue to build collaboration and program capacity; and ongoing development of the collaboration between acute care services and the network.

The implementation of the nursing informatics RN position to support the implementation and maintenance of the BC ICU database has proven a positive development. These staff members are responsible for gathering and putting information into the database at the unit level and in some cases are also involved in the education for staff members on specific practice issues such as the 48/6 initiative. The first annual report for the critical care program will be available in the next few weeks, and will then be produced on quarterly basis. The teams are encouraged to use the information from the reports to address practice issues and improve clinical outcomes and practice.

The CCR Network has established network goals that are aligned with the strategic directions of the ministry and the health authority; site ICUs are responsible to translate those goals into goals and objectives for their unit. The units are at varying stages of development of unit-specific goals but all units are working on specific priority initiatives such as “48/6” and the “A-B-C-D-E Bundle”.

The critical care program is commended for the accomplishments that have been achieved in the development and maturing of the work of the program and the CCR Network.

Priority Process: Competency

The ICUs are supported by an interdisciplinary team. Members include: critical care RNs many of whom have critical care certification, allied health professionals including physiotherapy, occupational therapy, respiratory therapy, social work, pharmacy, internist and intensivists and others as required.

There is a comprehensive orientation program for all nursing staff. There is ongoing education for new equipment and changes in practice. All staff members have access to the online iLearn system to complete mandatory education as well as other education programs.

The team's major focus has been on the required organization practices (ROPs) required for accreditation, and the many new clinical practice guidelines and initiative that have been introduced.

At the Vernon Jubilee Hospital ICU the patient care coordinator has set up a resource room for staff members to access resources such as “just in time”; and by way of example one of the new intravenous (IV) pumps is available with step by step directions as to how to operate the pump. The staff members find this most helpful.

The teams are actively engaged in a number of quality improvement initiatives across the network; the network is seen as a positive vehicle for sharing information and best practice and working collaboratively to ensure best practice for all patients. The Nursing Informatics team from the Royal Inland Hospital recently presented at the Fall 2015 Critical Care Dynamics Conference. The team presented on the use of data to examine and improve practice with a focus on the Richmond Agitation Sedation Scale (RASS) assessment process in the ICU. Informatics RNs are part of the critical care team. The team is commended for this initiative in the unit and the opportunity to share best practice nationally.

Verbal feedback is provided to staff members on a regular basis and they are recognized for their work and their success and contributions. However, formal and documented performance reviews are not conducted on a regular basis. The organization is encouraged to further study the barriers to completing performance reviews and to implement strategies that would support managers in being successful with performance reviews.

Priority Process: Episode of Care

Rapid Response Teams (RRTs) and/or High Acuity Transport Teams (HART) are available at each of the sites to provide rapid response to patients on the in-patient units. Where there is not a formal RRT in place such as at the Vernon site, the ICU team offers that outreach service. There are standard guidelines and protocols to guide the rapid response team. The rapid response calls are reviewed and tracked. The HART teams are available to assist with the transfer of high-acuity patients from small facilities to the regional and tertiary centres.

The ICU teams are patient and family centred. A number of initiatives have been implemented to ensure families and patients are engaged in care and decision making for care. The organization has recently implemented the "MOST" approach to help engage patients and families in decisions around scope of medical treatments. Staff indicated that this process has significantly improved the ability for family and the team to discuss patient options and choices. Family members are supported in remaining at the bedside during emergency procedures if they chose to do so.

The CCR Network and teams have implemented a number of clinical practice guidelines. These include: ICU admission pre-printed orders; ICU adult analgesic/sedation pre-printed orders and transfer to ward pre-printed orders. The clinical practice standards include: spontaneous awakening trials; spontaneous breathing trials; early progressive mobility for critical care patients; A-B-C-D-E bundle; intensive care practice RN guidelines and the standardized critical care record for tertiary, regional and rural use, as well as the 48/6 plan of care. The team is encouraged to measure and evaluate the effectiveness of the changes and their impact on patient outcomes.

The team is commended for the collaborative work that is done between sites and organizations to address and improve patient care. An example of this is the collaborative work done at Kootenay Boundary Regional Hospital (KBRH) between the ICU and paediatrics to care for high acuity paediatric patients. As a result of this collaboration, the critical care unit at KBRH is a pilot site for tele-ICU with BC Women’s and Children’s Hospital which will launch December 2015.

The teams are encouraged to continue their commitment to quality improvement. Overall, commendation is given for the work that has been done across the region to standardize clinical practice and documentation.

Priority Process: Decision Support

The ICU database is a rich resource for the critical care program and the implementation of nursing informatics RNs to support data collection is a positive for the team.

The ICU has a comprehensive set of ICU documentation tools. Tools include: admission assessment; critical care record; ICU transfer record; best possible medication history (BPMH) record; clinical protocols and pathways such as venous thrombo embolism (VTE) prophylaxis; and ICU admission orders which are now standardized across the region.

The teams 'huddle' on a daily basis as well as conduct regular interdisciplinary rounds on a weekly or more often basis. The units are beginning to utilize their quality “huddle” boards as a mechanism to promote regular and frequent discussion on quality and safety issues. All staff members have opportunity to raise issues that need to be addressed.

Priority Process: Impact on Outcomes

The CCR Network and teams have implemented a number of quality initiatives across the region including: the A-B-C-D-E Bundle; the RIH Safety Cross initiative related to pressure ulcer prevention; and the face-to-face hand over initiative at Kelowna General Hospital. The team is encouraged to continue its work to improve the quality of care across the region, including the use of data and indicators to improve practice.

Priority Process: Organ and Tissue Donation

The organization is aligned with the BC Transplant Program for organ donation and retrieval and has access to all provincial organ donation policies and protocols online, including identification of potential donors; approaching families regarding donation; declaration of neurological brain death; management of the donor once brain death is declared and support for families.

Organ donation can occur at all ICU sites. The Kelowna site has recently implemented protocols for organ donation after cardiac death; this is the only site in the region implementing this protocol at this time. The team has received education and training in terms of the associated protocols.

The teams have 24/7 access to the provincial transplant coordinators that will come to the site if organ donation is to happen. Staff members reported that they are extremely well supported by the transplant coordinators throughout the entire process. There is also good support for families from the ICU team.

The teams review their organ donation data to determine where there may have been missed opportunities for donation and to examine what could be done to improve organ donation rates.

Organ donation can be an extremely difficult conversation, particularly in the small rural communities and these communities may not have access to medical staff to complete the assessment of neurological brain death. For this reason as well as geographic challenges with access due bad weather, patients may be transferred to regional or tertiary centre for the assessment.

3.3.5 Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.6	The team establishes 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.		
2.2	The team has the workspace it needs to deliver effective services in the emergency department.		
Priority Process: Competency			
5.13	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and constructive way.		
Priority Process: Episode of Care			
8.7	The team has ongoing communication with clients who are waiting for services.		
8.8	The team monitors possible deterioration of condition for clients waiting in the emergency department and reassesses clients as appropriate.		
9.3	With the involvement of the client, family, or caregivers (as appropriate), the team initiates medication reconciliation for clients with a decision to admit and a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).		ROP
	9.3.3	When medications are adjusted for non-admitted clients in the target group, the team generates and documents the BPMH with the involvement of the client, family, or caregiver.	**MAJOR**
	9.3.4	For non-admitted clients in the target group, the team communicates medication changes to the primary health care provider.	**MAJOR**
	9.3.5	For non-admitted clients identified as requiring medication reconciliation, the team provides the client and the next care provider (e.g., primary care provider, community pharmacist, home care services) with a complete list of medications the client is taking.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			

16.3	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	ROP
16.3.4	The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	**MINOR**
16.3.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
17.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
17.5	The team designs and tests quality improvement activities to meet its objectives.	!
17.6	The team collects new or uses existing data to establish a baseline for each indicator.	
17.7	The team follows a process to regularly collect indicator data to track its progress.	
17.8	The team measures ambulance offload response times, and uses it to set target times for clients brought to the emergency department by EMS.	
17.10	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.11	The team implements effective quality improvement activities broadly.	!
17.12	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
17.13	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

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 emergency department (ED) and trauma network play a vital role in ensuring that strategy is developed and aligns the needs and execution of ED services with the vision and mission for the region. Due to the increase in population in the region and pressures on the ED much effort has been expended to work at targeting a plan for expansion in emergency departments as well as improving access and flow across the continuum. Commendation is given for efforts in increasing accountability at a physician level which has improved engagement and ensured greater success in moving patients appropriately within the health care system.

A number of EDs have experienced significant surges as well as having to respond to code orange, including bus accidents with multiple casualties. This has helped to shape the emergency and disaster response plan and the ED teams and trauma network have an important role in feeding into needed development or revision of emergency response plans.

There are good relationships with community partners and a true willingness to support important upstream programs to reduce admissions to the ED. There is a sense of both local and region teams from the front lines to senior leadership, and being aware of complex cases and trying multiple approaches to facilitate patients to the best place to receive care. The Patient Transport Office (PTO) ensures transport is available to repatriate patients so they can receive care closer to home.

Some EDs are facing significant issues with work space and layout. The team at Castlegar site has identified the need to redesign the ED work space as there is crowding with limited space to deliver services. There is cluttering of the work space with equipment and supplies. There is no separate work space for medication preparation. The medication and charting and consultation are all completed in a small room. The triage area is separated from the emergency room beds by a curtain, limiting privacy and confidentiality. There is a small waiting area for clients.

The Kootenay Boundary Regional Hospital has identified the need to redesign the ED work space. There is crowding with limited space to deliver services. The team has done a good job of working within the space challenges. The space is limited which results in crowding at the main desk. There is small alcove which is used for medication preparation and includes a 'pyxis' machine and refrigerator. Charting, monitoring and consultation are all completed at the main ED desk. There is cluttering of the work space with equipment and supplies. The team and team leadership has done a great job in redesigning and de-cluttering the main trauma room. The team has also looked at ways to multi-purpose the rooms. There is limited space for private family consultation.

At the Royal Inland Hospital site the entrance for patients self-referring to the ED is small and becomes congested with even a small line up. The Emergency Medical Services (EMS) entrance is directly adjacent and contributes to this congestion. There are a number of wheel chairs that were located just inside the entrance way, which additionally present a risk to safety and a trip hazard. The main doors are constantly opening and closing which is disruptive, and the staff members and patients are subjected to an uncomfortable environment due to windy or cold weather conditions. There is an awkward physical process of lining up for triage and then lining up again for registration. The waiting room is out of eyesight of the triage nurse, and unobserved incidents occur.

From a strategic and leadership perspective continued efforts to develop mental health and substance use supports and programs will ease pressure on the system.

Priority Process: Competency

There is a good orientation program in place and this was observed at each of the sites visited. The educators and coordinators play an active role in ensuring both regional and local pieces of orientation are completed for all new employees, transferring employees and employees returning to work after time away. The educators and managers take the opportunity at orientation and at regular touch points to develop personal learning plans and competency development for staff. The ED and Trauma network also provide regular education updates via outreach initiatives. A great deal of positive feedback was received on the support given by the high acuity response team (HART) team and the rural SIM team for their outreach work, especially at the smaller sites.

There is good support and plans in place for responding to code white/violent incidents and sites also reported access to supportive RCMP, EMS and security when additional supports were needed.

There is a strategic approach to managing congestion and surges in the ED as well as capacity on the in-patient units. Excellence in working locally, regionally and with partners was demonstrated to improve flow of patients in the organization and discharge back to the community. Despite these efforts however, there are often extended stays in the ED especially in populations with mental health or substance use issues. Encouragement is offered for the organization to work with partners to develop better social supports especially outside of normal working hours to better serve this vulnerable population. It was noted that patients in secured rooms in the ED are there between 36 and 48 hours on a regular basis, and this was noted across a number of sites. Additionally, staff members would benefit from additional training on managing mental health and addiction issues in the ED.

Infusion pump training has been completed at a number of sites but there are gaps which need to be addressed to ensure that all staff members receive the necessary training on the new equipment.

Performance appraisals are done well at some sites and require considerable improvement in others. Encouragement is offered the organization to determine if changes are needed to make the process of performance review easier and more achievable, and also to track completion rates of performance evaluation of ED staff.

The Regional Medical Director is in the process of implementing a physician performance review process which includes team and peer review.

Priority Process: Episode of Care

Staff members that are working in the Interior Health (IH) EDs have a good understanding of the need for prompt triage and nursing assessments of patients attending the emergency department. The Canadian Triage Acuity Scale (CTAS) is well-understood and used, and the triage nurses are usually more senior nurses. There have been some reports of triaging incidents at some sites, and these are reviewed with managers. Updates and training in CTAS is available and in certain sites there have been blitzes to update this training.

Each of the sites has a different process for easily identifying CTAS levels of the patients which encourages quick response or reassessment as needed. At the time of the survey some of the busier sites were experiencing delays in times from nursing assessment to first assessment by the physician. Additionally, there were some sites where a formal reassessment and observation of clients in the waiting room was not occurring in a formal way.

IH is encouraged to consider reviewing signage and communication for patients in the waiting room to help them understand expected wait times and how to appropriately identify their own deteriorating health condition so that they can play an active roll in their safe care.

Medication reconciliation is accepted as an important practice however, there are variations in process and success across the region. Completion of med reconciliation in targeted non-admitted patients is in the early stages.

Priority Process: Decision Support

The ED and trauma network have done an excellent job at developing best practice guidelines, clinical pathways and pre-printed orders (PPOs) which have been implemented widely across the region. All sites reported that they found the PPOs and guidelines helpful and were able to modify them as required if resources were unavailable on site. Technology supports the capability to place needed guidelines in PPOs in an easy-to-access way and there were no reports of confusion with older guidelines, indicating that archiving is effectively done.

Royal Inland Hospital is moving to an electronic health record as the first site for trial, which will further assist in easing the sharing of information as necessary between sites. Currently, there is an ability to flag files for "familiar faces" which then prompts a review of the patient record and care plan. This has been reported as a successful initiative for dealing with patients that may frequent more than one ED in the region.

Policies and procedures are recent and easy to find. Staff members know how to access resources electronically and the region has worked well to link resources such as the most recent clinical protocols for management of potential organ donors. The PPOs/order sets are additionally well-formatted and consistent which ensures ease of readability and use.

Every time there in an introduction or revision of a protocol there is associated training at the site level. The interaction and involvement of clinical educators is appreciated by the staff at the sites.

Priority Process: Impact on Outcomes

Excellent work has been done by the Emergency and Trauma Network to identify best practice and clinical pathways. There are a number of PPOs which have been widely implemented. All sites agree these PPOs are helpful in day to day work and in some sites, it was easy to modify if services and resources were more limited.

There is information readily available on CTAS scoring and wait times in the ED at all sites. Targets have been set provincially for no more than a 10-hour wait from ED to admission on the in-patient unit. Managers receive this information regularly and there is a commitment at a senior leadership level to be regularly reviewing this information.

Internal and external stakeholders have an active and accountable role in improving access and patient flow. This ensures bottlenecks are addressed and patients are not left for long periods in the ED. Despite these efforts, there is a general trend that patients with mental health related issues may stay in seclusion rooms in the ED for periods in excess of 36-48 hours.

The teams at the regional level use the information to make improvements in a number of areas however, awareness or development of improvements at the front line were not always observed. It did not appear that at the local level there were objectives and time lines for QI projects/initiatives, or an understanding of how to translate objectives from a higher regional level to the local level.

There are opportunities for front-line staff members to be more involved and receive information on quality data such as incidents and near misses, falls rates, medication adverse events, delays in off-loading, incidence of patients that left without being seen and performance relative to CTAS criteria for assessment. There were some quality initiatives seen at sites however, formal communication regarding these activities is unclear, and there remain opportunities for more active engagement at the front-line level as well as efforts to better evaluate the effectiveness of quality initiatives.

There has been excellent regional progress on falls prevention. Prevention of falls is considered by staff. All staff members questioned had a good grasp of care that needed to be taken to reduce the likelihood of patient falls such as the use of non-slip socks, lowering stretchers, advising patients of the availability and use of call bells. In a number of sites visited no formal risk assessment was observed, nor was there documentation regarding risk level or actions taken on patients that may be 'falls risks'. Most staff members questioned were unaware of fall rates in the emergency department, although some said they believed rates to be low.

Falls rate data was seen only on some of the units however, most managers were aware of where to find the information. There has been a region-wide approach taken to falls evaluation, but this is not well understood at the local level. This initial evaluation has led to the purchase of items such as slip-free socks, hip protectors and risk reduction activities such as lowering stretchers, using bed alarms and placing higher risk patients closer to the nursing station.

Staff members did know they had received instruction or equipment relative to falls and they knew how to use the materials distributed however, they may not understand the relevance at their site. As mentioned earlier, some staff members questioned were unaware of fall rates in their ED and some said they believed these to be low. A notable exception to this is the Vernon ED where falls rates and other quality indicators as well as patient safety learning system data are clearly posted.

There have been regional strategic reviews and actions taken regarding falls but not with the specific ED population. The organization would benefit from developing a more formal falls prevention process, catered to the needs of the emergency department service users.

The use of two client identifiers was observed inclusive of the process for labelling unknown patients until their identity can be confirmed such as for the unconscious trauma patients.

There are some big-dot indicators however, understanding of progress towards these big dots was not seen at the site level nor was there clear information about how sites were tracking towards success as part of the larger regional objectives set.

Priority Process: Organ and Tissue Donation

There is a well-established organ donation program with a designated OPO person based in Kelowna. The OPO person is directly involved in supporting the program and takes an active role in all aspects from policy to discussions with family regarding donation. Staff members across sites are aware of where policies are, and how to call for support if needed. All staff members that were interviewed were aware of the importance of organ donations. Most staff members acknowledge more of this process is done in the ICUs but where appropriate, especially during traumas, all sites were able to identify times where they had worked through the organ donation process.

3.3.6 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		
4.10	The organization regularly evaluates and documents each staff member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
10.6	The organization responds to requests for medication information after hours.	
12.1	The organization maintains an accurate and up-to-date record for each client.	
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

Home care services throughout the region provide excellent, compassionate care to their clients. Based on the needs of each unique community, appropriate services are available as resources permit. Ongoing review of resources occurs and lobbying for additional resources has taken place as warranted. The good, collaborative partnerships in the communities ensure that the clients receive the care that they require if home care cannot provide all of the services needed. Communities are well-aware of the home care program and referrals are accepted from a variety of sources.

Staff members are engaged in their work environment and consequently have the ability to influence the work that they do. Efforts are made to ensure that staff members are supported and able to interact with one another on a regular basis. Staff members connect in a variety of ways: face-to-face, and telephone or video-conference depending on the area where they work.

Although not all staff members participate in the initiative, there is a "Safety Line" for added security for those staff members that work alone. In Kelowna the program has also developed a relationship with RCMP to assist with staff and client safety as appropriate.

Priority Process: Competency

Home care staff members are well supported in their education, with dedicated educators (knowledge translation team), other staff, equipment vendors, and the iLearn computer learning system, which is another example of the superb way that Interior Health uses technology. Staff members are adequately prepared for the roles that they have to carry out in the areas where they work.

There is annual intravenous (IV) pump training provided. However, owing to the infrequent use by some nurses, they are quickly able to refresh their skills with the educational system available to them when needed.

There is a robust orientation program. All staff members have the necessary orientation period before they are required to work independently. The learning materials provided throughout the orientation time are extensive.

Staff members are recognized for their contributions in many ways, both formal and informal. All staff members encountered during the survey genuinely appreciated working here and liked working in the home care area. Nevertheless, it is important for managers to continuously assess the impact of the increasing workloads and be cognizant of the possibility of staff burnout.

Priority Process: Episode of Care

Interior Health is congratulated for an excellent home care program that is available to both rural and urban locales. The care provided is client centred and holistic in nature. It is provided in a safe and effective manner. Falls prevention and safety risk assessments are undertaken to ensure both clients and staff members are safe while providing care to the individual. Staff members are well-prepared and clients are extremely happy with the care they are receiving. An interdisciplinary team approach was witnessed in all areas visited.

Many successful programs have been initiated to help people go home, or keep people at home. These include: Back to Home; Pathways to Home, and Home First. This is a testament to the exceptional home care program in the region. Effectiveness and efficiency are always being considered as well. This led to clustering of care provided by staff members at residential settings in Kelowna to better utilize the time community health workers (CHWs) spent in the facility.

Clients are presenting with increasingly complex, chronic conditions which is ever more taxing on the system to provide the necessary care. Frail elderly, dementia, brain injury, palliative care clients, and others also need increasing levels of care. Another related issue identified in Kelowna was the cost of housing that is facing many of the clients. This requires the help of additional team members like social workers.

Rural areas have challenges that surround the issue of isolation and lack of specific, specialized resources more readily found in the urban communities. Travel distances are great to service the rural client population. Staff scheduling can be a problem based on client volume fluctuations and acuity.

Well-developed clinical care management guidelines/protocols assist with the standardization of care provided to clients across the region. This helps staff members with the education needed for care to be provided and the assurance that the most current, evidence-based care protocol is in place. This is definitely shown in the excellent wound care program that is provided to all clients requiring this type of intervention.

Home care is fortunate to have the level of rehab staff support, which is apparent across the region. This includes such professionals as occupational therapists, respiratory therapists, physiotherapists and the aides attached to each program area.

At this time, medication reconciliation is occurring for those clients for whom medication delivery is a part of the care plan. The full roll out of the program will occur in January, but the charts and information that were reviewed showed that this was occurring now.

Priority Process: Decision Support

Client information is protected by keeping it in secure locations. In some instances though, this means that the charts are openly available during the regular work hours of the staff. It would be advantageous to have the cupboards that are housing charts kept locked at all times whether or not staff members are in the building.

Technology is well-utilized across the region and occurs for charting, transfer of client information amongst service providers, photos for wound care, cell phones, and other things. The one additional piece would be the move to have nurses able to chart on the electronic chart as other professionals currently do. Laptops for point of care charting would also be advantageous when the budget allows.

Research is not typically initiated by this group, but policies and processes are in place to ensure that appropriate research and ethics protocols are adhered to if this should happen.

Priority Process: Impact on Outcomes

Home care regularly evaluates the services and makes revisions as needed. Much of the benchmarking and goal setting is based on ministry and regional driven initiatives, and evaluated with informal and formal mechanisms. However, some individual areas also set their own goals and objectives. This process could be strengthened with additional expertise provided to assist with setting specific, quantifiable goals in some settings.

It would be valuable to engage in client satisfaction surveys to determine the level of approval the clients have for the services they are receiving. This is another way of determining the quality and effectiveness of the programs and services.

Team meetings "huddles" occur routinely daily and weekly and as required. These are used to update client information, discuss staffing issues, review safety concerns, and other topics. This is also an excellent way of connecting with staff members and showing support for the work that they are undertaking.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
8.4	The organization's staff, service providers, and volunteers have access to dedicated hand-washing sinks.	
14.1	The organization has a quality improvement plan for the IPC program.	!
14.3	The organization seeks input from staff, services providers, volunteers, and clients and families on components of the IPC program.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The on-site review of the infection prevention and control (IPAC) program of Interior Health (IH) included visits to Kelowna General Hospital, Vernon Jubilee Hospital, East Kootenay Regional Hospital, Royal Inland Hospital, Lillooet Hospital and Health Centre, Shuswap Lake General Hospital, Kootenay Boundary Regional Hospital, Castlegar and District Community Health Centre, Cariboo Memorial Hospital, and Queen Victoria Hospital.

The IPAC program is managed by the leadership of an enthusiastic, knowledgeable and dedicated team, which includes a director, twenty infection control practitioners (ICPs), an epidemiologist, program manager, two administrative support staff, and two co-op students. A microbiologist devotes 1.5 days per week to the program, provides medical scientific oversight, and shares emergency after hours' on-call services with two other microbiologists. One of the changes as a result of the most recent strategic exercise was to cross train the ICPs in all sectors in order to maximize the use of the resource within IH. .

The regional director and eight of the ICPs, hold certification in infection control. The remainder are working towards certification. Eighteen of the ICPs are situated across Interior Health, and the remaining two serve as the regional education and hand-hygiene leads. Coverage of all sites and services can be challenging, both in terms of geography and scope of services. The ICP weekend and statuary holiday on-call service is from 0800 hour until 1600 hours. Other emergent situations are 'escalated' using the administrative on-call system. Management and staff members report that they receive timely and excellent support from the infection control service, and this feedback was consistent at all the sites visited during this survey.

Internal and external partnerships are well established and include: collaborative working relationships with the clinical areas; housekeeping; physical environmental services; medical reprocessing; food services and microbiology. The occupational health program is managed off site and it participates in investigations as required. The team works closely with the public health department on a regular basis and actively participates in regional initiatives.

There is a well-developed hand-hygiene program in place across the region. The program is led by the ICPs with the support of two co-op students that perform audits. The IH Hand-Hygiene committee is a

multidisciplinary committee, which oversees the development and evaluation of the program. Audit results are reported to the managers and staff electronically and posted beside the elevators and in some other areas within the units. When compliance falls below 69% threshold, ICP meets with the manager and looks at ways to increase compliance. Although overall the compliance appears to be improving, surveyors' general observations indicate that hand-hygiene practices were not clearly evident at the clinical areas visited. This is an area in need of continuous improvement. The ICP responsible for hand hygiene and members of the quality office at the Kelowna site have received education on the concepts of positive deviance. There is an opportunity to explore these concepts further as a way for staff members to engage in infection prevention and control, as well as to reinforce manager accountability and building unit commitment.

Comprehensive surveillance is carried out using a well-integrated computer-based system which links to microbiology and admission data. Standardized definitions and internal benchmarks are in place. Ongoing surveillance includes antibiotic resistant organisms (ARO), Clostridium difficile (CDI) surgical site infections (SSI), central line associated infections (CLI), and ventilator-associated pneumonia (VAP). Respiratory tract infections and urinary catheter associated infections are tracked in residential care. General trends show an improvement in overall infection rates. CDI rates show some fluctuation across the region, especially in some of the smaller centers. The organization needs to ensure sufficient resources are available, including advanced laboratory analysis to fully investigate these, especially in situations where the rates remain consistently above benchmarks.

The education program is well developed. All staff members receive IPAC education at orientation and hand-hygiene training. Prevention control educational materials are available for patients and their families on all the clinical areas and are posted on the IPAC website. Patient education is either done on the unit, or by the ICP upon request. The organization does not have an overall outbreak policy. Policies and procedures for staff screening and immunization are in place. Three regional occupational health nurses provide service. Maintaining current immunization status and tuberculosis (TB) skin testing has been a recent challenge. The organization should ensure that immunization status and TB testing is up to date for all staff.

There is a food services safety plan is in place. The Hazard Analysis Critical Control Points (HACCP) food safety approach is used consistently, which includes daily audits and quality control at critical control points. All food services workers must have the Food Safety training. The regional auditor conducts regular audits. There was evidence of well-managed, safe practices in the food production process in all the sites visited. Staff members are knowledgeable and proud of the work they do.

The housekeeping department follows the provincial best practices for environmental cleaning for prevention and control of infections. Cleaning frequency and methods are categorized according to risk of infection. Again, staff members are knowledgeable about their responsibilities. There is a comprehensive housekeeping training program in place, which has been co-developed in partnership with infection prevention and control. Quarterly cleaning audits are done, reviewed with the staff and submitted to the province. A company carries out a yearly audit of the building and the results are posted on the public website and used internally to provide feedback to staff.

The facilities across the region include older areas which are cluttered and present potential risks of infection transmission. For example, clean supplies are stored in an open area in the nursing station on the surgical unit at the Kelowna Hospital. Clean and soiled materials are intermingled at the East Kootenay site. A system of tagging cleaned equipment with green tape has been implemented. However, the taping system is inconsistently followed and there is insufficient space to segregate the clean equipment therefore, it is frequently stored beside dirty items in the corridors. This practice requires review.

The laundry service for the region has established a committee and working groups to standardize laundry practices in compliance with Canadian Standards. There is no physical separation of the clean and soiled

linen handling areas at the Kelowna, Vernon and Kamloops sites. The temperature is also a challenge. Windows were open at the Vernon site, and fans were in use at Kamloops to control temperature. An audit needs to be done to fully assess the safety and integrity of this function at all IH sites.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.5	The organization provides appropriate work areas to support interdisciplinary team functioning and interaction.	
3.7	The team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
4.15	Each team member's performance is regularly evaluated and documented in an objective, interactive, and constructive way.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
16.2	The team meets applicable legislation for protecting the privacy, security, and confidentiality of resident information.	!
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 organization and the residential care team has access to various tools and resources that provide information about its residents and community; one of which is the annual detailed services, operational planning and budget report. This is a comprehensive and information-rich report.

The organization has a well-established bed planning process. Using population projections, the team modifies bed allocations throughout the health authority regions and identifies service needs to accommodate and align with resident needs. Recently for example, requests for proposals (RFPs) were initiated for an increase in beds in the Kelowna and Vernon areas.

The team acknowledges consistent support from the organization in the timely response to and provision of equipment needed to support resident care. The availability of ceiling lifts and sit/stand support poles were observed throughout as a support to safe lifting and transfers.

Systems are in place to ensure security, particularly after hours, and for those residents at risk of elopement. All homes had a warm, welcoming feel; a great environment for residents and families. Personal and recreational spaces for residents are generally appointed and home-like. For some homes the presence of cats, birds and fish tanks are an added bonus, contributing to the home-like environment.

The organization supports student placements for various members of the interdisciplinary team including most recently, nurse practitioners.

Residential services team members are commended in their ongoing effort and commitment to standardizing resident care processes across the region. Also commendable is the systems response to supporting continuum-based care needs with the introduction of Pathways to Home, strategically allocated respite beds, and the provision of day programs at some sites.

The greatest asset this team has is its people; the residents/families, leaders and staff. Each of the homes toured during the survey is filled with caring, committed and compassionate team members that value residents and their families and one another. With this great foundation the team can and undoubtedly will build great things.

Priority Process: Competency

Although all the appropriate members of the interdisciplinary team are available to support resident care, some homes are challenged with the current physician services model. In many cases, residents are supported by their personal community-based physicians and understandably, they have competing demands on their time. While some gains have been made in regards to consistencies in practice provision via the provincial General Practices Services Committee, the residential services program is encouraged to continue their efforts locally and provincially to secure improvements in physician services. Orchard Haven is unique, in that all services are co-located with the hospital, making it easier to co-operate and collaborate with other services. The physicians are steps away and readily available to check on the residents as needed.

The organization is commended for providing clinical educators and the iLearn system which is used to support staff throughout orientation and with ongoing staff development. It is important to ensure ready access to computers for staff members to avail of this resource in a timely manner. However, this was expressed as a challenge at one site.

Some variation was noted with regard to infusion pump training. Some homes report a more generic training approach, whereas others indicate it is being provided as "just in time" (JIT). Given that the need is variable and that the admission process to the facilities can often be delayed, it may be more practical to consider standardizing the process as a JIT training opportunity.

Comprehensive workplace violence training sessions are available to all staff via iLearn modules. It was acknowledged that training for violence is provided for direct care providers. There may be an opportunity to consider this training for all staff members.

The organization has committed and invested significantly to staff training and education regarding responsive behaviours. There is training in the physical intellectual emotional capabilities environment social self (PIECES) and the Gentle Persuasive Approach (GPA) programs. Snoozelen therapy rooms are provided at select sites, the appropriate staff members have received training to facilitate this therapy. Additionally, aggressive alert toolkits are available on each of the units.

As noted throughout the on-site survey visits there is inconsistency in performance reviews. This is an opportunity for improvement.

Priority Process: Episode of Care

The organization has a comprehensive, clearly articulated Residential Care handbook and Family Council resource guide which are provided on admission. Additionally, some homes provide a site-specific handbook. In an effort to streamline this information for residents and their families, it may be worthwhile to consider consolidating these handbooks/guides into one manual.

In addition to core admission assessments such as the falls risk and skin assessment, there is also an assessment of aggressive responsive behaviours including verbal abuse, aggressive behaviour, and disruptive behaviour. The admission process also includes a "Pain Assessment Tool" developed in 2009 and adopted from the Calgary Regional Health Authority (CRHA).

The tool: "My Day" is used in many of the homes. This communication tool is posted in the resident room and is used by all members of the team. Included in this document are: safety issues; communication approach; personal care; bathroom routines; nutrition; sleep/rest and special needs. This tool is updated based on results of the resident assessment instrument (RAI) assessments.

Laboratory services are offered weekly on site, and given by the local hospital lab. Other diagnostics and consultations are facilitated as required. Point-of-Care Testing (POCT) processes for glucose monitoring is standardized across the region, using the Accuchek Inform ll. This tool ensures that every test is automatically recorded per each specific team member. It then stores all information, allowing central management of all meters and data. Maintenance and/or replacement issues are managed by a centralized resource.

Currently, pharmacy services are provided by various vendors. The residential services leadership team is in the process of developing a RFP to provide greater consistency and capacity of pharmacy services.

A comprehensive array of activity interventions are provided from recreation services and made available to all residents. The diversity and resident-centred focus of programming was noted throughout the sites visited.

Kudos are given to the food services team in each of the Interior Health homes for their commitment and effort in meeting the unique and increasingly diverse dining needs of residents.

Most homes have capacity enabling private spaces, pastoral care and recreation activities. Beautiful secure garden areas were observed throughout; some of which are maintained voluntarily by community landscaping companies.

The family members that were interviewed consistently report being well-informed regarding their loved one's care. They also report feeling respected and valued as a member of the health care team. All homes have residents' councils. Family members described this as a helpful forum to contribute to service planning. Though teams have advance care directives in place, they are currently in the process of implementing Medical Orders for Scope of Treatment (MOST) which is a provincial initiative/requirement.

With regard to ethical decision-making, many staff members were not aware of the recent ethics framework launched in May 2015. This is likely attributable to the timing of the region-wide roll out.

Priority Process: Decision Support

Although there are elements of automation in residential services, on the "wish list" of some homes is a fully integrated and electronic health record as well as the electronic medication administration record (e-MAR). These would certainly provide for increased effectiveness and efficiency for teams.

Priority Process: Impact on Outcomes

Teams within Interior Health support the right of residents to live at risk. The Managed Risk Agreement is used to affirm this process. Safety-related brochures are readily available in the homes. Residents and family members interviewed during the survey were able to validate having received verbal reinforcement of safety issues.

All adverse events and near misses are reported using the Provincial Patient Safety Learning System (PSLS) and externally as indicated for specific reporting. Additionally, pharmacies are notified of pharmacy-related errors. There is an opportunity though to close the loop with the front line. Staff members report not always being made aware of the outcomes or actions after they report events.

Informal feedback from families and residents is received on an ongoing basis. Formally, the satisfaction process is managed provincially; this is scheduled for residential services in 2016. Again, family members interviewed report that their feedback is welcomed, respected and followed up on.

There are committed resources and processes for supporting quality improvement (QI) at each of the homes. A number of pertinent provincial outcome indicators have been identified. These are managed and supported at each home via regular quality reviews, and reported quarterly. Results are made available per home, at the IH level and as well provincially. This enables benchmarking. The team is encouraged to consolidate/standardize process measures associated with these outcomes as a further support to the quality improvement strategy. Some pockets of process measure monitoring are noted, but it is inconsistent in approach. Additionally, it was noted that specific targets are not identified for these indicators. In an effort to support teams in their QI journey, the establishment of targets may prove helpful.

It is also noted that progress towards QI goals is not widely promoted. The QI information is posted on communications boards in some homes whereas other homes indicated: "information coming soon". There is consensus though that quarterly promotion of the information is occurring, and that timelier reporting of progress would support effective change management.

3.3.9 Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.3	The organization has a program for antimicrobial stewardship to optimize antimicrobial use. Note: Beginning in January 2013, this ROP will only apply to organizations that provide inpatient acute care services. For organizations that provide inpatient cancer, inpatient rehab, and complex continuing care services, evaluation of this ROP will begin in January 2014.	ROP
2.3.5	The organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.	**MINOR**
11.2	The organization has a policy for when and how to override smart infusion pump alerts.	!
12.3	The organization maintains appropriate conditions in the medication storage areas to protect the stability of medications.	
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.	!
16.3	The organization has a separate negative pressure area with a 100 percent externally-vented biohazard hood for preparing chemotherapy medications.	!
16.4	The organization has a separate area with a certified laminar air flow hood for preparing sterile products and intravenous admixtures.	!
22.1	The organization has a process for determining which medications can be self-administered by clients.	
22.2	The organization has criteria for determining which clients can self-administer medications.	
22.3	The organization has a process for storing medications that are self-administered by clients.	
22.4	The organization provides information and supervises clients who self-administer medications.	
22.5	The process for self-administering medications includes documenting in the client record that the client took the medication and when it was taken.	

26.1	The organization informs staff and service providers on the value of reporting adverse drug reactions to Health Canada specifically unexpected or serious reactions to recently marketed medications, and their role in reporting this information.	
26.2	The organization provides staff and service providers with information on how to detect and report adverse drug reactions to Health Canada Vigilance Program.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The pharmacy department has a strong, progressive leadership team in place. There is a robust medication distribution system providing unit dose and centralized intravenous medications to all the hospitals, including the six-bed acute site in Princeton.

The deployment of Automated Dispensing Cabinets (Pyxis) across Interior Health supports many safety initiatives including identification of high-alert medications and separation of look-alike and sound-alike medications. The development of an internal software system to support scanning of physician orders accessible to pharmacy across all locations is impressive and facilitates standardization of processes across the region.

The BC Pharmacy and Therapeutics committee is responsible for formulary decisions which all five Regional Health Authorities implement. This has changed the role of the Interior Health (IH) Pharmacy and Therapeutics committee to focus on the development of pre-printed physician orders (PPOs) and other medication safety initiatives.

There is strong inter-professional collaboration between physicians, pharmacists, nursing, informatics and quality leads for the medication safety initiatives across IH.

The incorporation of the independent double check (IDC) into nursing practice for high-alert medications is clearly evident across the region. At South Okanagan General Hospital, the team has developed an electronic double signature for medications requiring the IDC using the electronic medication administration record (eMAR)/BMV system. This will be implemented in October 2015 and the team is commended for its energy and enthusiasm to improve patient safety.

The pharmacy clinical services have expanded significantly since the previous accreditation survey and pharmacists are a key member of the patient care teams. The pharmacy clinical leadership team has determined which clinical activities and patient groups should be prioritized to receive clinical services. Several comprehensive learning packages have been developed to provide pharmacist education on targeted therapeutic areas and guide the focus of their clinical work. A Drug Tracker Program (DTP) has been developed to track resolved drug therapy problems and is used to monitor clinical quality outcomes. The pharmacists are also supported by clinical pharmacist leads.

At the Vernon Jubilee Hospital, the pharmacy department recently moved into a new space that provides for improved work flow for the processing and dispensing of medications for the hospital and outpatient ambulatory care areas, including the Cancer Clinic. Staff members here are excited to be in the new space. At the Kelowna General Hospital (KGH) the pharmacy department is undergoing extensive phased-in renovations due for completion in February 2016. This has resulted in an enhanced intravenous (IV) and

chemotherapy preparation area for improved work flow. The organization is encouraged to address some of the space challenges with the IV preparation areas at the other sites.

The pharmacy team is challenged with the increased demand from higher chemotherapy volumes, higher home infusion patients and increasing complexity of medications with the existing staffing complement. At KGH, the surgical unit moved into a new space adjacent to the main building. Automated dispensing cabinets and anaesthesia cart exchange trays were implemented to enhance patient safety however, pharmacy staffing to support the work was not increased.

IH recently implemented an Antimicrobial Stewardship program. Some of the initial focus has been a refresh of the IV to PO step-down program and review of all PPOs with antibiotics to ensure appropriateness. The region is encouraged to continue the excellent work, create the data warehouse to monitor impact, and develop an evaluation framework.

Further opportunities for improvement identified during the tracers include: full optimization of the smart pump technology; development of a formal process for the reporting of adverse drug events and finalizing and implementing the self-medication policy and procedure.

The department is encouraged to implement a monitoring system for the medication refrigerators on the in-patient units at the Vernon site, and also to consider conducting a survey to determine the level of satisfaction of the pharmacy services at the various sites.

3.3.10 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		
4.8	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	
Priority Process: Episode of Care		
7.8	The team uses standardized clinical measures to evaluate the client's pain.	
10.5	The team has a process to evaluate client requests to bring in or self-administer their own medication.	
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

Since the organization's previous accreditation survey, it is evident that Interior Health (IH) has continued with its good work and improved upon it. For example, it was noted in a previous survey that medicine services in various parts of the region were working independently. On this current survey, it was good to see that the teams are engaging in various activities like the cross-portfolio day, medicine services' working groups employing a hub and spoke model that allow for not only inter-medicine collaboration, but also inter-program synergy. An example of this is the: "Hospital to Home" committees that include representation not just from medicine services but also residential services and home health.

The leadership members appear to work well together and have taken a unifying stance to delivering medicine services. This is embodied in their: "planning regionally, delivering locally" mantra. Further, the leadership is commended for listening to their staff. A good example is taking the pragmatic approach of prioritizing initiatives in the organization that are essential, optional and unnecessary. The organization is encouraged to further its pruning and prioritization of its initiatives. It is noted that unlike other service areas, there is no network for sharing across the region for medicine, and the organization may want to consider this platform for the future.

It is evident from both the macro-level and micro-level that IH is quite aware of its aging population, and the surveyor team also observed this on the units and in conversation with staff. Patients are more complex, requiring more services and are often hospitalized or alternate level of care (ALC). Interior Health has certainly made strides in embracing several strategies for example, the 48/6 to improve the situation, and this will certainly need to be enhanced and added to as this older demographic increases in numbers and continues to age.

Priority Process: Competency

All the teams observed during the on-site survey in medicine reported a high degree of satisfaction for working in their interdisciplinary service area. There were numerous examples of where physicians and management and staff members support each other to provide excellent care. Patients expressed pleasure with the care from the teams. One beaming patient care coordinator said: "I'm so proud of my team".

In several instances charting for various disciplines was noted to be separate in the patient record. IH might consider a common approach to charting to further remove "silos" within the team.

IH has a robust orientation for new staff. There is ongoing orientation for existing staff. The organization is congratulated on the support that it gives front-line staff members, managers and physicians for professional development, both at the regional and local levels.

It is clearly evident that infusion pump training is a priority and the managers receive information about staff members that have engaged in this training. It is recommended that managers also receive lists of those staff members that have not engaged in this training. All staff members that the surveyor team encountered reported taking infusion pump training.

Many teams in the medicine service have recognized that a large percentage of nurses entering the workforce are newly graduated. Some teams have taken steps to further orientate them to medicine services. The team in Kamloops has even gone so far as to develop an informal mentorship program. Given that there is a large cohort of new hires to the profession of nursing, the organization may consider specific strategies to support them in addition to those in existence like the new graduate program.

An area that continues to be a challenge for IH is performance appraisal for every staff. Seldom did they report having this type of documented and formal feedback, even within the organization's three-year target. IH is strongly encouraged to prioritize performance appraisals by supporting supervisors to complete them, and/or redesigning the process to make it easier to do.

The organization does a great job of recognizing the staff members both formally and informally. Formally, there are awards for quality and safety. There are also e-cards for managers to send to their staff. The administrators in Vernon send hand-written thank-you notes for exceptional work. Staff members also report informal recognition in meetings and casual e-mail from supervisors. This is an area of noted strength for the organization.

Priority Process: Episode of Care

Standardization is an organization-wide priority, and has certainly been embraced by medicine services. This is most embodied in the 48/6 approach to patients admitted to medicine. IH was mandated to do this by its funders and instead of limiting it to narrow parameters it actually broadened its use to almost any adult admitted to their care.

The organization has collaborated with the First Nations Health Authority to improve access and cultural competency in caring for First Nations and Metis people. Further, non-English speaking patients working in the fruit industry are often met with services in their language of choice. Another strategy related to poverty appears to be underway and the organization is applauded for this and encouraged to continue to reach out to marginalized communities.

The ethics framework has been used in medicine services and there is good evidence noted and even more impressive and observed during the on-site visit was seeing a team talking at rounds about an ethics issue and engaging the ethics framework.

At the local level, it is evident that teams in medicine work with their partners to reduce barriers for patients to be placed or discharged safely. Many complex patients are reviewed at huddles, team meetings and sometimes, at higher management levels to determine a best course of action.

Many of the teams observed have been challenged with being over-capacity. There were instances of several patients being cared for in hallways. This is not ideal, but it is noted the organization is working on strategies to address this, both from an operational with the 48/6 approach and also from an infrastructure point of view.

It was clear that a best possible medication history (BPMH) is generated for all patients. This was observed consistently for all admitted patients to medicine. Interior Health can be proud of this achievement. Many physicians have embraced medication reconciliation, which is another great achievement for this organization.

Exceptional work has also been done and was observed for confirming two patient identifiers and the provision of information about safety to patients and their families. Patients reported a high level of satisfaction with their care. They also had a good understanding of their diagnosis, investigations, treatment and future plans. Patients felt empowered to speak up if there was a concern. IH also has solicited feedback from patients after their admission and made improvements based on this feedback. The organization is currently looking at another approach to this, one that is not so onerous for patients. This is because patients are receiving feedback surveys from any and all services where they received care/service.

IH has also fully implemented interventions to prevent pressure ulcers and venous thrombo embolism. These initiatives have significant organizational support and are part of a large quality improvement strategy. There are front-line teams that have a good awareness of these metrics and use them for quality improvement initiatives. However, some front-line teams were not having this information shared with them regularly and were not engaging in quality improvement activities. Therefore, it would be important to ensure this information is cascaded to these groups. Team-based, engaging and excellent quality improvement initiatives were observed at Kelowna General Hospital. Indeed, this approach should be spread across the organization.

A standard approach to transitions is being used and employed by staff. This is for both internal and external transfers. However, there is variability in using a paper tool versus a verbal-alone approach. Furthermore, tracer activity in long-term care reported a lack of information transfer. Moving to an electronic health record, while a significant capital cost and organizational change, would likely improve this and many other communications. For now, it might help to standardize this process and ensure that long-term care is receiving information at transfer.

An area for improvement would be to adopt standardized pain scales across IH, as it appears there are several non-standardized approaches to this being used.

Priority Process: Decision Support

It was clear on numerous occasions during the survey that the medicine teams were working with other services in the organization and community partners to co-ordinate care.

While the charts are mainly paper-based and were easily located, IH, if is has not done so already, should consider moving to an electronic system at some point in the future. Understandably this will be expensive and a significant change for the organization.

IH selects evidence-based guidelines at the authority level. This process involves an interdisciplinary team and guidelines are reviewed regularly. This was evidenced in algorithms, tools and order sets.

Patient privacy is respected and there were no concerns identified.

New technology is often selected by the Provincial Health Services Authority. However, staff members were seen to be piloting new equipment for vital signs at the Vernon Jubilee Hospital and reported training.

There did not appear to be much research occurring on the medicine services. However, if there was, it is approved by a research ethics board. One leader stated that much more attention has been paid to quality improvement, and is a good example of the organization prioritizing.

Priority Process: Impact on Outcomes

As already mentioned, use of the two-identifier process has been successfully implemented in the medicine services at IH. This was evidenced by observation and from patients reporting that this is the process.

A falls prevention strategy is also fully implemented. It is particularly impressive to have board commitment to such initiatives.

There is a culture of quality at IH and is pervasive amongst senior leaders and managers. The organization has invested in both infrastructure and personnel to improve its care and spread its successes. Staff members at some sites, especially Kelowna General Hospital's medicine and in-patient oncology services, are immersed in quality improvement activities and metrics that the organization collects and distributes them to the unit level. However, some sites did not have this awareness and quality improvement activity occurring. The organization is encouraged to continue to cascade and spread its quality improvement culture to the front line, and to also balance competing initiatives, which it is already doing.

3.3.11 Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.2	The team's objectives for mental health services are specific and measurable.	
Priority Process: Competency		
4.12	Team leaders regularly evaluate and document each team member's performance in an objective, interactive, and constructive manner.	
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		
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
17.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
17.6	The team collects new or uses existing data to establish a baseline for each indicator.	
17.7	The team follows a process to regularly collect indicator data to track its progress.	
17.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The organization is commended for the recent development of the Mental Health and Substance Use (MHSU) Network to support program planning across the continuum of care including acute, tertiary and community. The work of this group to prioritize goals and take into consideration not only the Ministry of Health's directives but also the clinical priority areas for the populations served. The organizational imperatives are

providing some early wins in bringing focus and consistency to MHSU goals and objectives as well as providing alignment with the overall strategic direction of Interior Health.

The co-leadership model (administrative and medical) at both the Network and the local area network level has strengthened medical leadership involvement in planning and service design.

The teams across the sites surveyed have not consistently developed goals and objectives that are measurable and specific. Much of the recent work has been focused on the Required Organizational Practices (ROPs). Leaders are encouraged to develop specific goals and objectives in keeping with the overall organizational goals and identify the measurements of success for these goals.

Leadership for the acute areas has indicated a concern regarding the shortage of in-patient beds to meet the needs of the population served. There is a sense that this area is 'under-bedded' in terms of acute resources. Occupancy rates are high at the Kelowna General Hospital and the in-patient area is frequently over census.

A central utilization committee coordinates admissions from across the province to both the Hillside and South Hills centres. Both of these centres are valuable resources for tertiary and psycho-social rehabilitation, respectively, for the entire province.

Priority Process: Competency

Strong, cohesive interdisciplinary teamwork was evident at all the sites surveyed. The teams meet regularly for staff meetings and planning sessions. Goals to improve team functioning are identified and acted on. There is a strong presence of medical leadership (psychiatrists) at all sites. Many of these physicians also work in the community and facilitate continuity of care between acute, tertiary and community sectors.

Orientation programs are robust and include education regarding safety measures. Staff members indicated they felt safe while delivering care.

There is limited use of infusion pumps and when there is a need, staff members are given just-in-time education and are supported by 'super users' from other areas in the organization.

A number of managers met during the on-site survey are new or interim in their roles. The organization is encouraged to develop strategies to stabilize management/leadership positions.

Seclusion is infrequently used at most sites. A reduction in the use of seclusion has been a quality improvement initiative and success in reducing the frequency with which this approach is needed is being achieved. The teams are commended for this work and encouraged to continue to strive for standardization across the region.

Priority Process: Episode of Care

The teams are commended for the coordination that occurs between acute, tertiary and community-based services. Transitions are well coordinated and there is follow-up to ensure the client needs are being met. There is evidence of suicide risk assessments and the development of patient safety plans when indicated. Patients are informed about their rights and how to raise concerns they may have.

Care plans are utilized across the sites and are up-to-date. Planning for discharge begins early in the patient's stay and involves the patient and family as appropriate and desired by the patient. The teams are also commended for their work in implementing medication reconciliation across all the acute and tertiary sites.

Although this is not a current expectation of the organization, these teams felt it was important for the well-being of their patients and have successfully implemented the required processes.

The clients interviewed during the survey were complimentary towards staff. They indicated they felt safe and respected. The physical design of the centres supports the psycho-social needs of clients and provide opportunities for physical exercise.

Priority Process: Decision Support

The majority of the sites surveyed have both electronic and paper documentation. Given that most organizations in Interior Health are using Meditech, there is good flow of client/patient information amongst Interior Health providers. The use of video conferencing is used widely to support meetings as well as patient consultations.

Client care plans are completed and up-to-date. Daily huddles and team meetings are used as effective tools to support discharge planning and staff communication. Staff members are supported with several resources, including educators, to ensure best practice guidelines and evidence-based protocols are in place.

Priority Process: Impact on Outcomes

There is a strong focus on safety both for patients and staff members across the sites visited. Emphasis has been placed on preventing incidents of workplace violence and staff members receive regular training in this area.

The teams are commended for the work they have done in building relationships with the RCMP. The joint program of "Car 40" offers the support of a mental health worker as well as an RCMP officer to sites such as South Hills Centre and which do not have a Code White procedure.

Recent quality improvement processes have focused on the ROPs. Leaders are encouraged to develop specific objectives for their areas that are in keeping with the overall organization's strategic direction. As well, there is opportunity to increase staff members' awareness of the current objectives and progress made with the use of display boards or quality boards.

3.3.12 Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.2	The team's goals and objectives for obstetrics services are measurable and specific.		
Priority Process: Competency			
3.7	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.		
4.9	Team leaders evaluate and document each team member's performance in an objective, interactive, and positive way.		
Priority Process: Episode of Care			
3.4	The team uses structured communication tools to communicate clearly and effectively.		!
9.6	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	9.6.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	9.6.2	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.	**MAJOR**
	9.6.3	A current medication list is retained in the client record.	**MAJOR**
	9.6.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	9.6.5	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.	**MAJOR**
9.9	The team uses a safe surgery checklist to confirm safety steps are completed for a surgical procedure.		ROP
	9.9.2	The team uses the checklist for every surgical procedure.	**MAJOR**

10.11	The team follows the organization's established policies on handling, storing, labelling, and disposing of medications and breast milk safely and securely.	!
12.4	The team transfers information effectively among service providers at transition points.	ROP
12.4.1	The team has established mechanisms for timely and accurate transfer of information at transition points.	**MAJOR**
12.4.2	The team uses the established mechanisms to transfer information.	**MAJOR**
13.11	The team stores clean and sterile obstetrics equipment, medical devices, and supplies according to manufacturers' instructions, and separate from soiled equipment and waste.	!

Priority Process: Decision Support

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes

17.5	The team shares benchmark and best practice information with its partners and other organizations.	
18.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
18.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
18.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
19.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The perinatal group sets the goals and objectives for all sites delivering perinatal care based on site feedback, benchmarking and outcomes and advocates for corporate endorsement of their directions. An example is the corporate focus on caesarean section rates has been realigned to a focus on vaginal birth rates without adverse outcomes. The group is also working on time to breast.

Capital equipment is prioritized at the unit, site and then health authority level. There is a concern that with increasing budget pressures there will be less capital equipment resource allocation. The unit requires a new fetal monitor to replace an outdated one, as well as several updated hospital beds and an automated drug dispensing unit.

Priority Process: Competency

There is a full interdisciplinary team in place complete with designated credentials. RNs in labour and delivery and post partum have completed postgraduate perinatal specialist certification, neonatal resuscitation and fetal surveillance. This was obtained from the BC Institute of Technology or equivalent if trained out of province. The team's education and training needs are supported by a manager and a patient care coordinator, and this may be shared at the smaller volume sites, and also an educator may be shared at smaller volume sites.

The managing obstetrical risk efficiently (MORE ob) program is viewed positively by the team and team leaders. There are safety huddles, a communication book to share ideas and concerns, and a quality board in place. The obstetrics team works closely with Public Health and the Ministry of Children and Family Development. There is coordination of services between the perioperative and surgical programs and pharmacy. The site MORE ob core team meet monthly to review incidents, review Take 5 team debriefings and develop actions plans related to MORE ob and education and team functioning

At all the obstetrics sites, the team members have input to their work and job design. They stated they felt supported by their manager and the organization. This included support for an extra RN position to reflect increased workload.

The Perinatal Maternal Child Committee meets monthly to conduct quality improvement reviews, and reviews of policies and procedures. The committee also conducts chart reviews of any adverse outcomes

The Regional Perinatal Shared Care Initiative includes, patient care advocate, midwifes and doulas, lactation consultant, prenatal educators, obstetricians and general practitioners, nursing and educators and provides support for priorities related to gaps in patient care. They have developed guidelines for such things as high body mass index (BMI) risk and advocacy for transfer out, locally developed postpartum depression workshops, and Slurps and Burps which is a breastfeeding support program.

Staff recognition occurs in the "In the Loop" which is an Interior Health monthly publication, and by service awards and less formal recognitions on the unit, with appreciation walls and the personal connection of managers with their staff

One of the challenges identified is the turnover of staff. This is particularly noted at the smaller volume sites. There are no full-time positions available and staff members take casual positions to consolidate their clinical practice. However, when a full-time position becomes available on another unit, these staff members are quite likely to move to that unit despite the training and education they have received. The leadership team is encouraged to look seriously at retention measures, including regular performance feedback and opportunities to engage in improvement initiatives, or informal leadership roles on projects.

Staff members indicate that they are overwhelmed with the number of changes being initiated. This was particularly noted at Kelowna General Hospital where there are new processes around emergency caesarean sections and planning for a move to a new unit in another building. It will be important to apply a change management strategy and framework to help staff members and managers adapt to the magnitude of the change that will be necessary.

There has been significant leadership turnover at all the sites visited and still some more changes to come in the next few months. It is important that staff members have stability in the leadership so that they can develop a professional relationship with their leader. Consistent leadership will also ensure that initiatives that are started can progress to completion and that performance issues are addressed consistently.

Priority Process: Episode of Care

The teams are congratulated for their efforts to drive best practice around skin to skin care for babies This commitment to excellent care is visible and consistent across sites. The teams are encouraged to consider how they might continue to evolve this practice in instances when mothers cannot be present for example, with surrogate cuddlers. Teams are also encouraged to continue to explore further opportunities to keep mother and baby together such as in post-anaesthesia care unit (PACU) and during transfer from labour and delivery to the post partum unit.

All documentation tools are standardized across the province. Charts are complete. Assessments and care planning are well done. The Maternal and Fetal Levels of Service Classification is used to assign the appropriate level of care and proactively manage risks of anticipated adverse events.

Fetal health surveillance is a component of a module in the MORE ob program. However, every two-year certification, which is quite common elsewhere in the country, is not a mandatory requirement for staff.

At the sites with smaller volumes, the administration is aware of the pressures of a small staff complement and unpredictable volumes of activity. Administration regularly meets with staff members to discuss strategies to address fatigue and stress including back-up on call, calling in extra staffing and being available to help and to troubleshoot.

The use of green tape to signal that a piece of equipment is clean has not been consistently implemented. There were numerous times where a piece of equipment was not labelled, yet staff members indicated that one should assume that if its in the hall it is clean. Potentially clean equipment is however, adjacent to equipment that is clearly soiled. It is recommended that managers and infection prevention and control practitioners develop a process to regularly do rounds on units and remind staff members to label clean equipment, or remove it for cleaning.

Priority Process: Decision Support

The team is familiar with the organizational privacy policies. Review and adoption of evidence-based guidelines is done primarily via Perinatal Services BC working groups which currently are working on neonatal withdrawal and neonatal skin care. The MORE ob also supports adoption of best practices.

Priority Process: Impact on Outcomes

The Interior Health Perinatal and Child Network sets the goals and objectives which direct site-specific goals and objectives. The Provincial Neonatal Patient Transfer Group manages the accommodation for newborn care in the province. Regular regional meetings take place to evaluate and review new initiatives/best practices and sentinel events at the regional level.

Reduction of caesarean sections and the MORE ob program are major objectives. The team has completed the third phase of MORE ob, with 98% participation in workshops and skills drills, including physicians and midwives. The teams report that the program has proven highly beneficial.

Staff members are able to articulate a number of process outcomes, which are primarily ministry or network driven, but are challenged to relate these process outcomes to outcome measures. There are multiple indicators at the provincial and regional level. However, there is little evidence of robust improvement work at the unit level. The teams are encouraged to build a front-line team of staff members that are interested in carrying out small tests of change. This will enable the development of a culture of quality improvement.

3.3.13 Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.2	The team's goals and objectives for rehabilitation services are measurable and specific.		
Priority Process: Competency			
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.		
Priority Process: Episode of Care			
7.5	With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.		ROP
	7.5.1	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).	**MAJOR**
	7.5.4	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
The organization has met all criteria for this priority process.			

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Allied Health team has experienced significant changes during the past two and one half years. Most significant is the organizational structure change which focused on ensuring a patient-centred approach to care service and delivery, at the same time as making it one regional service. This restructuring has allowed the team to look at the region as a whole.

The team has a strong knowledge of the population it serves and uses several methods to acquire this expertise. The areas of mental health, frail elderly and respiratory therapy, such as for congestive obstructive pulmonary disease (COPD) are targeted populations by the Ministry of Health whereby there is significant focus on collecting information on the characteristics of that client population. This information is then used to assist in planning service delivery and resource allocation.

The client populations served are in acute care, residential, community, and mental health. The Allied Health team members are careful to point out that the population groupings they serve are the accountability of each of these services and not the Allied Health team. Allied Health's role is to provide rehabilitation services to each of the patients within each of the defined service areas. Examples are the stroke unit, orthopaedics, the Breathe Well program, and frail elderly.

There are 12 service groupings in Allied Health and are provided across the continuum of acute, community and residential care. They are: rehabilitation nursing; physiotherapy; occupational therapy; speech language pathology; social work; dietetics and respiratory therapy. At the tertiary sites in Kelowna (Kelowna General Hospital) and Kamloops (Royal Inland Hospital) there is also orthotics and prosthetics, neuro psychology and physiatrist.

There has been a major review of Allied Health and its role in providing rehabilitation services. Allied Health has developed three goals linked to Interior Health's strategic framework which covers the period 2014 to 2017. The team has also broken down the priorities for these three goals for each year. There are six priorities for 2015 - 2016. These goals and objectives mainly focus on foundational elements and building capacity within the team. The goals and objectives describe what the team wants to achieve for rehabilitation services and definitely link to the strategic plan. However, these are not focused on desired clinical outcomes. The team members are encouraged to advance their planning so that there are clearly defined goals and objectives that are measurable and time-specific. One of the current goals is to establish a Rehabilitation Council for Interior Health. This will be the ideal forum for the development of measurable goals and objectives which are regional in nature and apply to each Allied Health focus area in the region.

Leadership provides significant support to the team members so that they are able to deliver quality rehabilitation services. The structure alone demonstrates this for example, there is a clinical practice lead in each of the disciplines. There is a Professional Practice Council which focuses some of its efforts on the development of professionals served by the council. There is also the leadership development model fostered by the region, as well as succession planning.

The team has several successes of which it is proud, and one of these is the effort to reduce the number of hospital admissions from the emergency (ED) department. This collaborative effort placed rehabilitation professionals in the ED to work with these patients. The analysis of the results of this initiative demonstrated that patients could be diverted home or to other services without being admitted. The analysis of the results of this initiative also showed that the program was successful in its goal to divert patients to a more appropriate setting to address their needs.

There is a significant focus on using volunteers and students in all the allied health disciplines in the region.

Priority Process: Competency

The organization has developed significantly in its use of the interdisciplinary process to deliver care and services to the target population. This includes encouraging all team members to develop skills to improve the interdisciplinary approach for example, training from the College of Health Disciplines, and the significant work done on the collaborative practice model. A specific example of the interdisciplinary process at work is the application of the 48/6 process. Individual Allied Health professionals are required to ensure that patients are assessed in six functional areas within 48 hours of the decision to admit. This process has also played a part in enhancing the interdisciplinary process.

Interdisciplinary teams across the region communicate regularly to coordinate services roles and responsibilities. This communication occurs at the unit level in individual case planning and delivery of care services. It is also occurring at a regional level in the overall planning, organization and coordination of allied health services.

There are some elements which demonstrate that local teams are able to evaluate their functioning, identify priorities for action and make improvements. For example, the quality boards on units document progress in certain targeted areas such as compliance to required organization practices (ROPs). As the team further develops within the new structure and when the Rehabilitation Council is formed and operational, it is suggested that the team take a more formal process to regularly evaluate its functioning on an annual basis or more often than annually. While the team may choose to develop its own methodology to do this, there are methodologies and tools available.

There is significant organizational support for team members' ongoing education. The uptake of the multiple opportunities available for Allied Health staff members is quite good. Every professional practice lead was able to cite multiple examples of how they use these educational opportunities. There is also a focus on training for the next generation leaders. A new learning strategy is being developed and when fully implemented, it will include having every employee develop a learning plan.

Team members are recognized for their contributions in several ways including: service awards dinner; publication of “Every Person Matters” newsletter; and quarterly staff recognition events such as the barbecue and the Golden Apple awards, which is a provincial program.

Priority Process: Episode of Care

The team has realized great achievements in the area of standardization across the region. Examples are implementing the Stroke protocol, the 48/6 program, the Breathe Well program, Home First program, and there are others. All of these have been implemented across the region in a consistent way. There is also consistency in all operational aspects of the Allied Health groups. This is facilitated by having one leader for Allied Health for the entire region, with supports by professional practice leads in each of the disciplines. Another example is the implementation of priority intervention guidelines which ensures that patients are prioritized based on need. This allows the team to be responsive to requests for services and assists in keeping wait times for services to at a minimum.

Clients are quite appreciative of the quality of care and services provided by the team. They feel part of the care planning process. There is good communication with patients and patients are aware of their diagnosis and treatment plan as well as their role in safety.

There are standardized methods for the assessment of pain, risk of falls and pressure ulcers. There is implied consent for treatment which is unwritten. There is written consent for individual procedures such as for blood transfusion and surgery.

Medication reconciliation is not fully implemented on the rehabilitation units at this time. The team are encouraged to review the practice of medication reconciliation at transition points.

The team takes a truly patient-centred approach in the delivery of care. The team works to assist the patient in developing clinical goals and there is regular monitoring with the patient to assess whether these are being achieved. Barriers to that are preventing patients from achieving positive results are identified and barriers are addressed. Every patient is assessed to determine the risk of developing pressure ulcers and interventions are put in place as required. The process is comprehensive and is measured to establish the effectiveness of pressure ulcer prevention strategies.

The regional team and Allied health professionals are commended for the quality of care that they provide to their target population. The new structure integrates all allied health professionals in all appropriate programs and services and more than ever, they are an incorporated part of the interdisciplinary team process where rehabilitation services are required.

Priority Process: Decision Support

Improvements have been made in ensuring smooth and effective patient flow. One of the best examples of this is the implementation of the 48/6 program, which has been significant in improving the communication amongst Allied Health and other disciplines. This has facilitated improvements in patient flow.

The team uses evidence-based guidelines in multiple ways, and the Stroke Collaborative, implementation and use of 48/6, and use of Accreditation Standards are examples. Each of the Allied Health disciplines select evidence-based guidelines to influence enhancements to practice. In addition, the teams are about to implement the IH Inter-Portfolio Rehabilitation Council and this will serve many purposes including placing a major focus on integrating best practice into clinical care.

The organization has multiple research projects within some of the Allied Health disciplines. These projects meet applicable research and ethics protocols and standards.

Priority Process: Impact on Outcomes

The introduction of quality improvement (QI) specialists to the team has served the Allied Health group well. These positions are able to support in several ways including the collection and analysis of data to evaluate quality initiatives. Several examples were cited where the QI specialist's support is invaluable, including the work on the falls prevention strategy.

The involvement of patients is having a positive impact on the organization's ability to implement and evaluate quality improvement initiatives. The patient safety learning system (PSLS) and the engagement of patients on quality improvement committees are just two examples of how patients are engaged.

Several examples were cited that demonstrate that the team is completing all aspects of quality improvement activities including the creation of measurable objectives within new, and some existing, programs, monitoring of indicators, and the regular collection and analysis of indicator data. Examples of established quality improvement initiatives where this is occurring include: "Repositioning Health Care for Older Adults", "Stroke Protocol" and the "Falls Initiative".

3.3.14 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards		
10.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	
10.3	The area where invasive procedures are performed has three levels of increasingly restricted access: unrestricted areas, semi-restricted areas, and restricted areas.	!
10.10	The operating/procedure room has a restricted-access area for the sterile storage of supplies.	!
12.1	The team ensures that supplies are available and equipment is functional before the client enters the operating/procedure room.	!
13.3	The team uses a safe surgery checklist to confirm that the safety steps are completed for a surgical procedure.	ROP
13.3.2	The team uses the checklist for every surgical procedure.	**MAJOR**
14.6	Immediately prior to the procedure, the team conducts a preoperative pause to confirm the client's identity and nature, site, and side of the procedure, and documents the pause.	!
15.4	The team minimizes the use of multi-dose vials when possible.	
16.3	The team ensures that every medication and solution on the sterile field is labeled.	!
16.7	The team retains all medication containers used on the sterile field until the end of the procedure.	!
29.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
29.5	The team designs and tests quality improvement activities to meet its objectives.	!

Surveyor comments on the priority process(es)

The surgical program is headed by a vice president of acute care services. There is also an Interior Health (IH) council in place with physician representatives and administrators to help guide surgical care across the health authority. An IH surgical executive has been formed, and this is an expertise-specific committee that is available to provide expertise to the leaders. At the individual hospital sites there are perioperative committees in place, under the lead of a medical director. With the development of this leadership model there is strong physician presence to aid in developing the future direction of the surgical program.

The objective of the IH surgical program is to ensure timely and appropriate and equitable care for all IH residents. Standardization of steps in navigating the surgical experience are in place. Those identified include booking and scheduling, pre-surgical screening, operating room (OR), post-anaesthetic recovery (PAR) day surgery, and surgical unit documentation. Standardized order sets and care maps are in use at some of the hospitals, but not all. Surgical audits are now quarterly with wait-list audits available via "Insight."

The IH surgical services and ambulatory care clinical practice standards manual is available to all service providers. In this manual the staff members can find practice standards and policies applicable to surgical and ambulatory care services. Several metrics are reported to the ministry. These include wait-lists for joints and cataracts, and surgical site infection rates. The individual hospitals track the first case start times and surgical checklist compliance.

During the site visits staff members were observed as energetic, well-trained and demonstrated a strong commitment to quality and patient care. Some sites have been designated as tertiary care centres while others provide services in line with surgical requirements of the area served. Recently, new modern suites have opened in the Kelowna and Vernon sites. Overcrowding of the surgical areas particularly at the Vernon site was noted.

Noted strengths are: strong physician engagement in aiding the direction of the surgical program; seamless patient flow throughout the surgical experience; strong commitment to patient safety and quality; and standardized documentation.

This program's challenges are numerous, and include the ability to attain wait time targets for joints in a climate of reduced funding. Also, defining the role of the surgical program, especially for where does the rural programs fit in, and what their role should be is a challenge. The financial challenges include trying to meet the objectives of the surgical program; staff recruitment and retention. The shortage of nurses and anaesthesiologists is noted. Identifying strategies for improvement of surgical services and recovery is an ongoing challenge.

There are challenges with physical plants, especially for providing a safe environment for storage of surgical supplies, patient flow, and reprocessing areas. This was clearly evident at both Pleasant Valley Health Centre and Shuswap Lake General Hospital. At Vernon Jubilee Hospital extreme overcrowding was observed on the surgical unit. As noted earlier, Kamloops the operating rooms at the Kamloops site were observed to be crowded and flow-through out of the area is compromised due to inadequate storage areas. There is need for expansion and modernization of medical devices and reprocessing (MDR) areas at the smaller sites. There is need for expansion of MDR at the Vernon site to allow the opening of a new OR and increased equipment sterilization and a decrease in surgical wait times.

Section 4 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.

4.1 Governance Functioning Tool

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: January 19, 2015 to January 20, 2015**
- **Number of responses: 8**

Governance Functioning Tool Results

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	0	0	100	93
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	0	0	100	95
3	We have sub-committees that have clearly-defined roles and responsibilities.	0	0	100	97
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	0	0	100	95
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	0	0	100	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6 Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	13	88	95
7 Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	0	100	98
8 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	0	0	100	96
9 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	0	0	100	94
10 Our governance processes make sure that everyone participates in decision-making.	0	0	100	94
11 Individual members are actively involved in policy-making and strategic planning.	0	0	100	89
12 The composition of our governing body contributes to high governance and leadership performance.	0	0	100	93
13 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	0	0	100	96
14 Our ongoing education and professional development is encouraged.	0	0	100	88
15 Working relationships among individual members and committees are positive.	0	0	100	97
16 We have a process to set bylaws and corporate policies.	0	0	100	95
17 Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
18 We formally evaluate our own performance on a regular basis.	0	0	100	82
19 We benchmark our performance against other similar organizations and/or national standards.	0	0	100	72
20 Contributions of individual members are reviewed regularly.	0	0	100	64

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21 As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	81
22 There is a process for improving individual effectiveness when non-performance is an issue.	0	0	100	64
23 We regularly identify areas for improvement and engage in our own quality improvement activities.	0	0	100	80
24 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	0	13	88	84
25 As individual members, we receive adequate feedback about our contribution to the governing body.	0	0	100	69
26 Our chair has clear roles and responsibilities and runs the governing body effectively.	0	0	100	96
27 We receive ongoing education on how to interpret information on quality and patient safety performance.	0	0	100	84
28 As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
29 As a governing body, we hear stories about clients that experienced harm during care.	0	0	100	85
30 The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	92
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	0	0	100	87
32 We have explicit criteria to recruit and select new members.	0	0	100	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	0	100	0	90

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
34	The composition of our governing body allows us to meet stakeholder and community needs.	0	0	100	94
35	Clear written policies define term lengths and limits for individual members, as well as compensation.	0	0	100	94
36	We review our own structure, including size and subcommittee structure.	0	0	100	89
37	We have a process to elect or appoint our chair.	0	0	100	95

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

4.2 Canadian Patient Safety Culture Survey Tool: Community Based Version

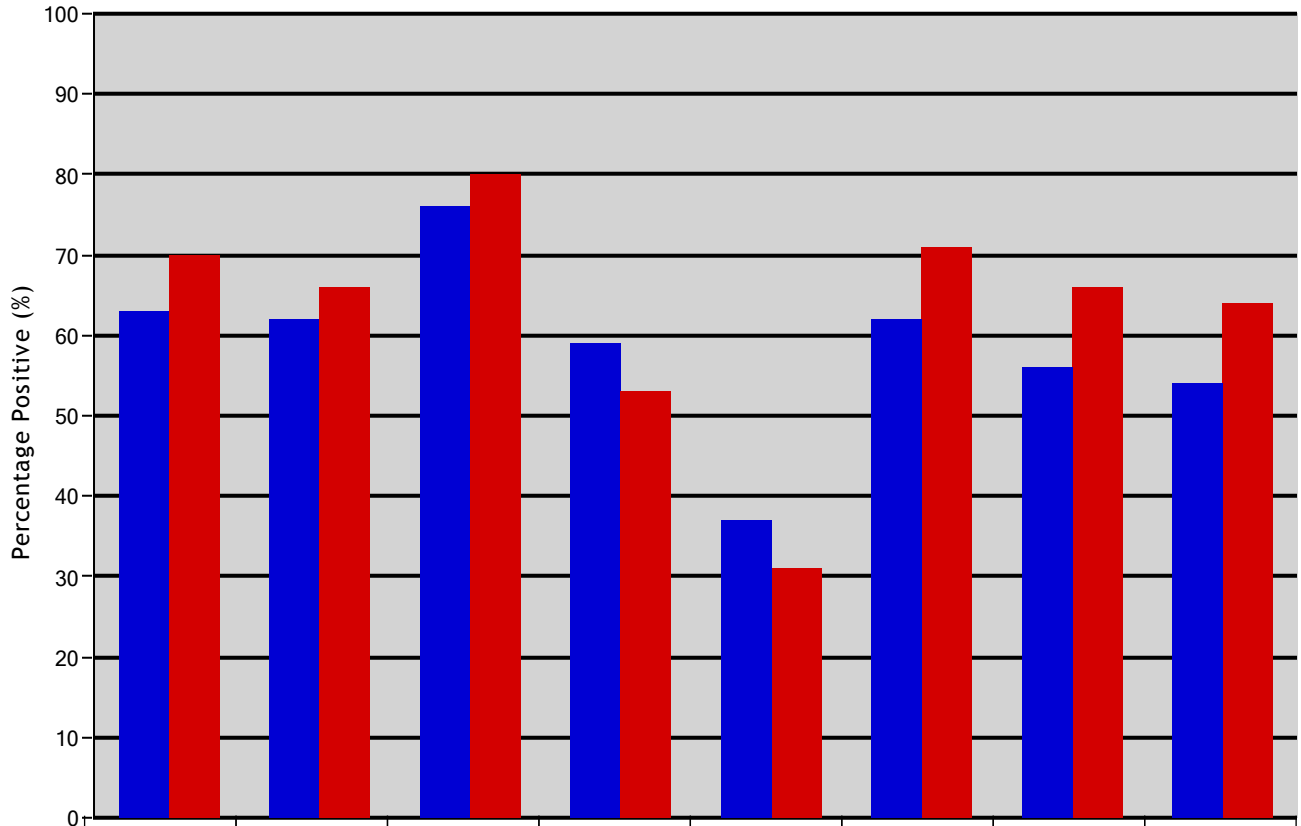
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

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

- **Data collection period: October 15, 2014 to November 30, 2014**
- **Minimum responses rate (based on the number of eligible employees): 366**
- **Number of responses: 737**

Canadian Patient Safety Culture Survey Tool: Community Based Version: 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
	63%	62%	76%	59%	37%	62%	56%	54%
	70%	66%	80%	53%	31%	71%	66%	64%

Legend

Interior Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2015 and agreed with the instrument items.

4.3 Worklife Pulse

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

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

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

4.4 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

Section 5 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.

This commentary provides some reflections on the preliminary report received from Accreditation Canada following the onsite visit by surveyors on October 2, 2015. Overall, Interior Health is pleased to learn that we have progressed considerably since our 2012 onsite visit, and that we continue to be a high performing organization that provides exceptional health care services.

The 2015 survey and accreditation process has been an excellent experience for Interior Health. As a health organization committed to continuous quality improvement in addressing the population health needs of the approximately 731,000 residents of the Central and Southern Interior of British Columbia, we value the opportunity to participate in a national program that helps us focus our improvement efforts, employ leading practices, and continue our ongoing efforts to advance quality, safety, and excellence.

Interior Health recognizes that it is a challenge to fully address all of the 2,113 standards used to assess our services across the 39 sampled sites (which cover a geographic area the size of the state of Oregon). We are further challenged as each provincial health system is different, and each health authority is different—making alignment with some of the standards difficult as they need to be generally applicable to all organizations who participate in Accreditation Canada's QMentum program.

After a review of some of the standards that are listed as unmet in the onsite report, we note several considerations that should be taken into account when interpreting the preliminary report. As examples, our reviewers believe that many standards are actually being met in the following service areas:

Å Infusion pump training is mandatory and staff in Emergency Services are updating their competency annually.

Å Interior Health has a policy, clinical practice standard, and standardized surgical safety check lists that are monitored through case records and insight reports.

Å Obstetrics services participates in quality improvement programs that are mandated by the Ministry of Health, which ensures effective communication/information transfer, mobilization of resources for urgent/emergent cases, and safe management of equipment.

Å The Medical Device Reprocessing Department ensures that devices and/or equipment is handled safely according to strict standards and designs and tests quality improvement initiatives regularly.

Å Our Ambulatory Systemic Cancer Therapy services implements and evaluates its falls prevention strategy and uses evaluation information to make ongoing improvements.

Å The Mental Health team is actively engaged in quality improvement and has regional/local working groups that meet regularly to review indicator data and evaluations of initiatives to determine the effectiveness of quality improvement activities.

From these and many other examples, it is clear that Interior Health is dedicated to evaluating our programs and continuously improving the quality of our services. Surveyors even commended Interior Health for having a very progressive Quality, Risk, and Accreditation Department. Where programs are not yet fully evaluated, it is because they are relatively new or under development, such as the Antimicrobial Stewardship Program.

It is noteworthy to point out that Accreditation Canada's standards are constantly being updated based on the latest research and national consultations. Since our last onsite visit in 2012, the decision award criteria have also changed. While that might mean our current award level may change, what won't change is our health authority's commitment to continuous quality improvement and high performance.

In the final analysis, we have a lot to be proud of as we met over 95 per cent of standards according to the preliminary report – significantly higher than the almost 90 per cent of standards we met during the last survey in 2012. Interior Health also performed very well on the Required Organizational Practices that apply to several service areas. These results are a testament to the great work that our staff and medical staff undertake on a daily basis.

Each of the Interior Health Accreditation Leads for the nineteen Standard Sets is looking forward to the final report from Accreditation Canada in order to recognize and celebrate our achievements with their respective teams. They will also review the unmet standards; examine each one in detail, and work to address any standards that are truly unmet. This is all part of our continuous quality improvement journey, and part of our dedication to meeting all standards for the next onsite visit in 2019.

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
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
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

Priority Process	Description
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