ACCREDITATION CANADA

Driving Quality Health Services

Accreditation Report

Fraser Health Authority

Surrey, BC

Supplementary survey

On-site survey dates: April 19, 2015 - April 24, 2015

Report issued: July 16, 2015

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

Fraser 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 April 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.

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

Fraser 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

Fraser Health Authority's accreditation decision is:

Accredited

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

1.2 About the On-site Survey

- **On-site survey dates: April 19, 2015 to April 24, 2015**

This on-site survey is part of a series of sequential surveys for this organization. Collectively, these are used to assess the full scope of the organization's services and programs.

- **Locations**

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

1 Abbotsford Regional Hospital and Cancer Centre - Abbotsford
2 Burnaby Hospital
3 Central City Tower
4 Chilliwack General Hospital
5 Delta Hospital
6 Fraser Canyon Hospital
7 Oceanside Mental Health
8 Peace Arch Hospital
9 Queen's Park Care Centre - New Westminster
10 Ridge Meadows Hospital
11 Royal Columbian Hospital - New Westminster
12 Surrey Memorial Hospital - Surrey
13 Timber Creek - Rehabilitation

- **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 Medication Management Standards
3 Infection Prevention and Control Standards

Service Excellence Standards

4 Ambulatory Systemic Cancer Therapy Services
5 Mental Health Services
6 Emergency Department

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)	15	1	13	29
 Accessibility (Give me timely and equitable services)	34	0	1	35
 Safety (Keep me safe)	190	20	37	247
 Worklife (Take care of those who take care of me)	37	1	32	70
 Client-centred Services (Partner with me and my family in our care)	65	3	5	73
 Continuity of Services (Coordinate my care across the continuum)	26	1	0	27
 Appropriateness (Do the right thing to achieve the best results)	218	12	73	303
 Efficiency (Make the best use of resources)	9	1	8	18
Total	**594**	**39**	**169**	**802**

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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Leadership			46	4 (100.0%)	0 (0.0%)	81	4 (100.0%)	0 (0.0%)	127
Infection Prevention and Control Standards	37 (97.4%)	1 (2.6%)	19	26 (96.3%)	1 (3.7%)	7	63 (96.9%)	2 (3.1%)	26
Medication Management Standards	67 (93.1%)	5 (6.9%)	6	58 (93.5%)	4 (6.5%)	2	125 (93.3%)	9 (6.7%)	8
Ambulatory Systemic Cancer Therapy Services	46 (95.8%)	2 (4.2%)	2	89 (92.7%)	7 (7.3%)	3	135 (93.8%)	9 (6.3%)	5
Emergency Department	45 (95.7%)	2 (4.3%)	0	78 (97.5%)	2 (2.5%)	0	123 (96.9%)	4 (3.1%)	0
Mental Health Services	36 (100.0%)	0 (0.0%)	0	84 (95.5%)	4 (4.5%)	0	120 (96.8%)	4 (3.2%)	0
Total	**231 (95.9%)**	10 (4.1%)	73	339 (95.0%)	18 (5.0%)	93	570 (95.3%)	28 (4.7%)	166

* 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			
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)	Unmet	0 of 1	0 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 Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Mental Health Services)	Unmet	1 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Systemic Cancer Therapy Services)	Met	2 of 2	0 of 0
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Mental Health 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			
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Systemic Cancer Therapy Services)	Unmet	4 of 7	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	0 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Unmet	3 of 5	0 of 0
Two Client Identifiers (Ambulatory Systemic Cancer Therapy Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Unmet	0 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	3 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Unmet	4 of 5	3 of 3
Infusion Pumps Training (Ambulatory 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: Medication Use			
Infusion Pumps Training (Emergency Department)	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)	Unmet	6 of 7	1 of 1
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Systemic Cancer Therapy Services)	Unmet	3 of 3	1 of 2
Falls Prevention Strategy (Emergency Department)	Unmet	2 of 3	0 of 2

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

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 Fraser Health Authority is commended for their ongoing commitment towards the accreditation process. The vision, purpose and values of the organization remain foundational. Since the 2014 accreditation survey, the Fraser Health Authority has seen significant change and also achievements of some key milestones. In the fall of 2013, the Minister of Health commissioned that a strategic and operational review be undertaken of Fraser Health Authority. The findings and recommendations from the Ministry of Health review were received in May of 2014. As a result of the review 10 priority actions were developed including 4 overarching priorities and 6 enabling priorities. These include: 1) Capacity for care across all sectors, 2) Quality and Safety, 3) Staff and physicians, 4) Patient and Family Centeredness, 5) Public Health measures, 6) Accountability, 7) Governance, 8) Operational organization and management, 9) Lower Mainland collaboration, and 10) Budget accountability.

The progress and updates on the organization's strategic and operational plan is reported to the Ministry of Health on a quarterly basis. Targeted outcomes, detailed action plans, current results and milestones achieved are reported. The reporting is also done in the spirit of transparency and enhanced visibility by sharing the results openly and through the use of dashboards and the "Our Health Care Report Card". Reports are presented at the organizational and site level.
The organization is commended on their openness to report their results. This is a demonstration of their commitment in being a learning and improving organization. The organization recognizes the opportunities and challenges and is implementing sound processes to ensure that they can be addressed. The efforts of the Fraser Health Authority has also been recognized at the Ministry of Health level whereby the learnings are now being applied more generally by the Ministry and quality assurance monitoring is beginning for other health authorities as well.

The organization also welcomed the appointment of a new board chair, new board members and a new CEO. As well, changes to executive committee and vice president portfolios, current restructuring of clinical programs and services and the quality improvement and patient safety department and the establishment of a new portfolio of patient experience which has a dedicated vice president patient experience has taken place. The organization has also celebrated the opening of the new tower at the Surrey Memorial Hospital and the releasing of the "Our Health Care Report Card." Extensive planning was also undertaken with regards to Ebola preparations as Fraser Health Authority –Surrey Memorial Hospital was the designated Ebola site for the province of British Columbia. The staff and leadership are to be commended on the preparation of this unit and significant education for all staff. As the organization continues to mature into their new structure which will have site and program leadership, it will be essential for the organization to develop processes to sustain the standardization of policies, guidelines and clinical best practices.

This is a supplementary survey (2015) as the organization prepares to move towards a 4 year survey cycle, this survey only focused on 9 Leadership related required organizational practices, tracers in emergency departments, acute adult mental health services, medication management, patient flow, infection prevention and control and ambulatory systemic cancer services. The survey also validated findings from the 2011 and 2012 survey visits. The organization also requested that the nurse sensitive adverse events initiative be reviewed as part of the survey visit.
Since the previous survey that reviewed infection prevention and control, the organization is commended on their response, implementation and ongoing efforts to manage and reduce hospital acquired infections and outbreaks. It was noted that the organization had implemented a number of strategies including the cohort of CPE patients with dedicated staff and equipment to reduce transmission. This initiative would be an excellent initiative to publish. The organization should also be commended on a comprehensive hand hygiene program

which has significantly improved hand hygiene for staff, volunteers and physicians. They are encouraged to continue with this program to ensure sustainability and ongoing compliance.

The organization has established an access and flow operations committee whose purpose and mandate is to identify, review and monitor strategies to support client flow throughout the Fraser Health Authority. They undertake several activities such as identification of access and flow education for staff, development and implementation of physician escalation processes and overcapacity protocols. The committee has access to real time capacity information in order to continually monitor access and flow within the organization. The committee has broad representation which ensures that key stakeholders are involved in planning and decision making processes. This committee also reviews and approves any proposals from program areas that could impact flow and capacity (e.g. closing surgical inpatient beds when operating rooms are closed). Through the efforts of the committee there is a heightened awareness and understanding of the importance of patient flow. The committee works under the principle of influence versus authority. In the spirit of being proactive, the committee undertook the development of a winter congestion strategy which served the organization well. The committee also supports sites and teams in implementing process improvements to support patient flow and capacity management. This committee is commended on their commitment and innovative strategies to support patient flow and to minimize overcrowding in the emergency departments. The committee is encouraged to explore strategies to improve the engagement of frontline physicians. The mental health program has implemented daily 11 am "congestion calls" which facilitates the movement of patients out of emergency departments to more appropriate inpatient units. The collaboration amongst all mental health facilities is clearly evident on these calls.

As a result of data related to nurse sensitive adverse events within the Fraser Health Authority the organization undertook a significant initiative to address nurse sensitive adverse events. Recently they have transitioned to care sensitive adverse events (CSAEs) as the opportunities to reduce these events are a responsibility of all health care providers. The goal is to reduce the number of care sensitive adverse events down to 10 events per 1,000 discharges for patients 55 years or older. This excludes mental health, obstetrics, neonatal, and pediatrics. The organization is commended on mobilizing the necessary resources and expertise to oversee this initiative and to give the team the time and space to do this work. There is no doubt that the planning, implementation and evaluation components of the initiative have had a tremendous impact on the results to date. Targets have been set and are monitored on an ongoing basis through the CSAE dashboard. Events monitored are pneumonia rates, urinary tract infections, pressure ulcers and in-hospital fractures from falls. The strategies that have been undertaken to address CSAEs and the organizational and local leadership is phenomenal. Ongoing audits to ensure compliance, unit data reports, site wide action plans, visible dashboards, posters, simplified algorithms, visual reminders, newsletters, inservices, care champions , the "Reducing Adverse Events – rover cart – care talks" and committed staff and leadership have all contributed to the success to date. The organization is commended on the success so far and encouraged to keep up the great work and ensure that it can be sustained – a special thanks to the Burnaby site for demonstrating the power of the CSAE initiative. It was evident throughout this tracer that there is a passion and desire from the staff to make care better for patients. This is truly a testament to patient-centred care. With the success of this model the organization is encouraged to formally publish this work. There may be an opportunity to align the activities of medication reconciliation and infection prevention control practices with CSAE since these efforts also contribute to the goal of reducing care sensitive adverse events.

The organization has the key elements and components in place to have an effective and responsive quality management and patient safety structure. As the organization solidifies the new structure for quality and patient safety, it will be important to ensure that there is a quality and safety framework with clear accountabilities, measureable deliverables and alignment at the leadership and board level.
Change can be expected to be an ongoing and dynamic occurrence in health care. The cohesiveness of governance and leadership, coupled with meaningful staff and community engagement and effective communication will assist Fraser Health Authority in realizing its vision - Better health. Best inHealth Care.

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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: Safety Culture	
Client Safety Quarterly Reports The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.	· Leadership 15.11
Patient Safety Goal Area: Communication	
Client And Family Role In Safety The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	· Mental Health Services 16.7
Two Client Identifiers The team uses at least two client identifiers before providing any service or procedure.	· Emergency Department 11.6
Medication reconciliation at care transitions 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).	· Mental Health Services 10.6 · Ambulatory Systemic Cancer Therapy Services 9.15 · Emergency Department 9.3
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

Unmet Required Organizational Practice	Standards Set
High-Alert Medications The organization implements a comprehensive strategy for the management of high-alert medications.	· Medication Management Standards 2.5
Patient Safety Goal Area: Worklife/Workforce	
Client Flow The organization's leaders work proactively with internal teams and teams from other sectors to improve client flow throughout the organization and mitigate overcrowding in the emergency department.NOTE: This ROP only applies to acute care organizations or health systems with an emergency department.	· Leadership 13.4
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 · Ambulatory Systemic Cancer Therapy Services 21.2

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: 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)
not applicable for this survey

3.1.2 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)
not applicable for this survey

3.1.3 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)

Workplace Violence
Fraser Health Authority is very fortunate to have a strong team overseeing all activity related to a comprehensive strategy to prevent workplace violence. There are sound processes and policies in place to support workplace violence prevention. Stakeholders including front line staff, managers and other key partners such as local police agencies are involved in the development and review of policies, procedures and processes. There is designated leadership responsible for the monitoring of workplace violence events. The team has developed risk assessment tools to facilitate the assessment of potential risk of workplace violence. There is also extensive training available to support staff. There are also processes in place to monitor training completion. The organization will have all staff who work in mental health and emergency trained in workplace violence by the end of June 2015.

The team also uses data to monitor incidences and to make improvements. They also use data to adjust staffing models. All data reports are provided to the sites quarterly. Currently, the executive leadership team receives this information on an annual basis. It is recommended that the executive also receives these reports quarterly and that this activity becomes aligned with the organization's quality and safety plan. This team should be very proud of the processes and resources that they have developed and implemented. They solicit feedback from stakeholders through the Gallup survey and make improvements accordingly.

To ensure that the organization is prepared to address simultaneous events involving aggression and violence (e.g., security personal are not available as they are already involved in an event). It is suggested that the team develop various scenario plans to ensure that the organization is prepared should such situations occur. For example they may wish to use a table top exercise format to facilitate this planning.

Client Safety Training and Education
The Fraser Health Authority provides a variety of client safety training and education programs for staff, physicians and volunteers. Training can be provided by various mediums such as online courses, classroom sessions, webinars, and bulletins and just in time learning. Education has focused in the areas of infection control, medication safety, care sensitive adverse events, releasing time to care, falls, hip fractures, VTE and surgical site infections. Sessions have also focused on building quality and safety capacity at events such as the new employee and medical staff orientation and leadership workshops.

The organization is encouraged to develop an annual client safety training and education plan which supports opportunities based on data, trends and quality reviews. Consideration of safety issues related to the organization, delivery of services and needs of clients and families can help in informing the plan.

3.1.4 Priority Process: Integrated Quality Management

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
15.11	The organization's leaders provide the governing body with quarterly reports on client safety, and include recommendations arising out of adverse incident investigation and follow-up, and improvements made.		ROP
	15.11.1	Quarterly client safety reports have been provided to the governing body.	**MAJOR**
	15.11.2	The reports outline specific organizational activities and accomplishments in support of client safety goals and objectives.	**MINOR**
	15.11.3	There is evidence of the governing body's involvement in supporting the activities and accomplishments, and acting on the recommendations in the quarterly reports.	**MINOR**

Surveyor comments on the priority process(es)

Client safety plan and reporting to the board
In the fall of 2013, the Minister of Health directed that a strategic and operational review be undertaken of Fraser Health Authority. The findings and recommendations from the Ministry of Health review have guided the current quality and safety plan and priorities for the organization. With the appointment of a new board chair, several new board members, a new CEO as well as reorganization within the management and leadership teams new structures and processes to support a solid foundation for quality and safety is also occurring. It will be important that the structures and processes that are put in place ensure that the board receives the necessary reports related to client safety including recommendations arising from adverse events. The board is ultimately accountable for the quality and safety of health services of Fraser Health Authority, so it is critical that quality and safety is high on the agenda and that the organization provides these reports to the board on a quarterly basis.

On an annual basis, a summary report has been provided to the board's quality performance committee on patient safety event management activities. Beginning in quarter one of 2015/16, the board's quality committee will be provided with a quarterly report on patient safety event management activities, including patient safety reviews. These reports will include an overview of recommendation categories and actions taken. Implementation of this action will ensure compliance with this standard.

Adverse event reporting
The organization has mechanisms in place to support the reporting of adverse events, sentinel events and near misses. Follow up and accountability is currently at the program/site level. A recommendations module is being implemented and was piloted in the mental health and maternal, infant, child and youth program. Plans are underway to implement in critical care, renal, older adult and rehabilitation. Implementation of the module will be used as a key source for reporting recommendations and actions for improvement. Currently, there is no overall process for the oversight of these events at the organizational level and there is

uncertainty as to whether events are addressed in a timely and satisfactory manner. Having an organizational lens to ensure that analysis and trending can be undertaken and a process to share findings occurs will facilitate improvements to reduce or prevent similar events from occurring.

Disclosure
The organization has a written policy and process for the disclosure of adverse events. Support is available for teams as they prepare for disclosure meetings. The organization may wish to evaluate their current quality assurance review process to ensure that it is effective.

Client Safety – Related Prospective Analysis
The organization provided evidence of two prospective analysis: 1) The Good to Go Initiative: managing care transitions for patients following hip fractures and 2) a human factors assessment for the labour and delivery system. The first one focused on ensuring that care transitions is optimized for those who have suffered a hip fracture. A compelling finding was that one in three individuals will fall again after a fractured hip and three quarters of acute care readmissions could have been prevented with sound transition planning. Based upon these drivers the Good to Go team is testing processes to support optimal care transitions in hospital and community using by using the "Fresh Start" toolkit as the guide. The organization may wish to explore whether this process could be replicated with other opportunities such as congestive heart failure and COPD (chronic obstructive pulmonary disease).

The second analysis was a human factors assessment for labour and delivery. Through the expertise of a human factors specialist the review was done to understand the factors that could lead to negative patient outcomes during a normal low-risk birth. Some of the improvements from this review included strategies to improve teamwork and communication, standardized education, implementation of Baby Pause to ensure completed and consistent handover at all transitions, improved accessibility of equipment and the standardization of maternal and fetal assessment and confirmation of findings between care providers. One cannot underestimate the value of having access to a human factors specialist to assist in supporting a strong and viable patient safety culture.

Medication Reconciliation
The medication reconciliation governance committee has broad representation from across the organization. They have a dedicated project manager. The committee has a clear project charter and work plan which included a change management and communication plan as well as a quality improvement and sustainability plan. The proposed timeline has full implementation by 2017-2018; however, the team has been asked to accelerate the implementation and therefore, will be revisiting their current work plan. They have utilized various strategies to support the implementation plan including train the trainer, various educational resources including a physician education package, shared learnings from sites that have implemented as well as providing ongoing consultative support. Audit tools and processes are in place but since health records is collecting this data it isn’t timely and therefore improvements can be delayed.

The team has recognized various opportunities and challenges to ensure medication reconciliation is successfully implemented across the organization. The power of the patient story can be a powerful tool to raise the importance of medication safety and medication reconciliation. The team may wish to consider having patient/family representation on the project team. The medication reconciliation team may wish to consider whether they can align medication reconciliation under the theme of medication safety and partner with the care sensitive adverse events initiative (CSAE) particularly with functions such as educations and auditing.

3.1.5 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)
not applicable for this survey

3.1.6 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)
not applicable

3.1.7 Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)
not applicable for this survey

3.1.8 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)
not applicable to this survey

3.1.9 Priority Process: Patient Flow

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
13.4	The organization's leaders work proactively with internal teams and teams from other sectors to improve client flow throughout the organization and mitigate overcrowding in the emergency department. NOTE: This ROP only applies to acute care organizations or health systems with an emergency department.		ROP
	13.4.1	The organization's leaders, including physicians, are held accountable for acting proactively to improve client flow and mitigate emergency department overcrowding.	**MAJOR**

Surveyor comments on the priority process(es)

The organization has established an access and flow operations committee whose purpose and mandate is to identify, review and monitor strategies to support client flow throughout the Fraser Health Authority. They undertake several activities such as identification of access and flow education for staff, development and implementation of physician escalation processes and overcapacity protocols. The committee has access to real time capacity information in order to continually monitor access and flow within the organization. The committee has broad representation which ensures that key stakeholders are involved in planning and decision making processes. The committee works under the principle of influence versus authority. This committee is commended on their commitment and innovative strategies to support patient flow and to minimize overcrowding in the emergency departments.

In general it was evident throughout the organization that patient flow is a priority for Fraser Health Authority and significant work has taken place to improve the flow of patients through the emergency departments. Targets have been established to measure the systems performance at discharging patients from emergency and admitting patients to hospital from emergency. Numerous process improvements in the emergencies have contributed to improving discharge times. There is a shared ownership both at the system and individual hospital level to improve the patient flow for those patients waiting for an inpatient bed.

Under the leadership of the access and flow operations committee the organization is to be commended for the systems approach to developing the winter surge plan, utilized in 2014/15. The staff in many facilities stated that the detailed plan made a difference to improving patient flow during times of high demand. Keeping areas open that would normally be shut over the holiday was identified as one of the primary successes of the plan.

For continued improvements to the emergency department wait times the organization is encouraged to review the patients utilizing the emergency departments for opportunities. For example, out of the emergency departments visited Hope and Burnaby provide a repeated IV therapy and dressing change service. Where appropriate, consideration may be to have these services provided elsewhere rather than utilizing emergency resources and improving the patient experience by having potentially long wait times for non urgent care.

Children's mental health was identified by the emergency teams as a particular challenge. While the number of patients is relatively small the patient wait time and overall experience was voiced as a concern. There is particular uneasiness about the emergency department's inability to provide adequate care for these patients. It is understood that work has recently begun to improve this situation and learnings from other health regions are being sought.

Inpatient flow improvements that have taken place should be commended and can be attributed to a team approach. Particularly the focus has been on utilizing over capacity spaces, long stay rounds, the access coordinator positions, reducing the transmission of infections, monitoring discharges before 11 am, repatriation and predicting discharges to improve planning. The recent implementation of measuring consultant times will assist with understanding the flow and may provide opportunities for improvement. To further the work Fraser Health Authority is encouraged to engage the physicians in discharge planning and seek opportunities to identify process improvements to facilitate discharge. Some of these may include setting an expected date of discharge early in the admission that is agreed upon by the entire care team including the physician, utilizing Canadian Institute for Health Information (CIHI) expected length of stay vs. actual length of stay data and measuring the rate of predicted vs. actual discharges. The organization will see improvements in patient flow when the physicians are engaged in the process.

Opportunities to cohort patients should be sought to further improve patient flow and overall care of the patients. Cohorting is considered a leading practice. Of particular note, the team reported that the Surrey hospitalist schedule currently has the physicians on different units several times during their rotation. This may contribute to a lack of continuity of care and longer length of stay.

Other impediments to patient flow observed were the access from several of the facilities for patients in need of a cardiac catheter or pacemaker. This appears to be causing significant bed blockage. The teams did report that when an urgent case is required that accommodations to send the patient to Royal Columbia are quickly made. Fraser Health Authority may want to review wait time data for these procedures to identify opportunities for improvement.

The journey to improving patient flow is a continuous one and requires a system approach. Fraser Health will continue to be challenged with flow as the population continues to age. The work with engaging primary care and the "GP for Me" campaign are important longer term strategies that should reduce the reliance on acute care.

3.1.10 Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)
not applicable for this survey

3.2 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

3.2.1 Standards Set: Ambulatory Systemic Cancer Therapy Services

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
9.15.5	The team works with the client to resolve medication discrepancies OR communicates medication discrepancies to the client's most responsible prescriber and documents actions taken to resolve medication discrepancies.	**MAJOR**
9.15.6	When medication discrepancies are resolved, the team updates the current medication list and retains it in the client record.	**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**
15.3	The team conducts independent double checks on infusion pumps prior to administration.	!
16.5	Following transition, the team has a process to regularly evaluate the effectiveness of the transition, and uses this information to improve its transition planning.	
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.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
21.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP

21.2.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
22.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
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		
11.5	The organization identifies, addresses, and limits environmental distractions for team members who are ordering, verifying, checking, preparing, dispensing, and administering systemic cancer therapies.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care - Ambulatory Systemic Cancer Therapy

The ambulatory oncology team at Fraser Health Authority has a plan for implementing a complete medication reconciliation process, starting with a trial at the Burnaby site once access to PharmaNet is available. Meanwhile, the pharmacist is instrumental in documenting the best possible medication history and reviewing it with each new patient.

Both teams develop an excellent professional relationship with clients to anticipate needs and acting on areas of need identified to the best of their ability. All team members have strong empathy and insight for their patients and their needs, and are able to deliver care in a capable professional manner; thus, instilling confidence.

Priority Process: Clinical Leadership

Royal Columbian Hospital (RCH) is in much desperate need for 'privacy' space for sensitive conversations and consultation. As well, the work area is an extremely busy traffic area with patients back and forth for physician consultations. The waiting room is also too small for the number of patients attending clinic.

The pharmacist at the RCH clinic is invaluable to this busy interprofessional team. The pharmacist is unable to be backfilled when required to cover shifts in the dispensary or other clinical commitments and funding is currently only for 0.5 FTE. The role of the pharmacy technician is clearly positively experienced in the Burnaby clinic.

Aditionally, the volume of chemo production for both ambulatory sites has escalated to a point that it is difficult to accommodate. Pharmacy has absorbed the workload into their daily work structure to date, but it is at a point of impacting other patient care services. The volume, patient acuity, and complexity of protocols has increased substantially.

Priority Process: Competency

The Fraser Health Authority oncology program is linked closely and actively with BC Cancer Agency and receives significant education support and resources including monthly newsletters to provide information on new drugs and/or new or revised protocols or regimens of Chemo. The oncology program meets regularly and has established a strong, productive relationship. The recent roll-out of the Alaris pumps appears to have been seamless and has provided a vital and welcome safety net for administration of chemotherapy infusions.

Priority Process: Decision Support

This team has a strong relationship with service providers and other teams, which creates a transparent experience for the patient.

Priority Process: Impact on Outcomes

The UFO (Unified Fraser Health Oncology) is a group of passionate, energized, and extremely competent care givers who have a strong commitment to their patients and their well being. They have developed several quality initiatives over the short time of their group's existence and can absolutely attest to the value of the teamwork they have created. Their response to the provincial patient satisfaction survey was evidence of their passion for their patients and for ensuring they were supporting their patients in every way possible. The team provides a vast amount of information, coaching and support to the patients and their families, and even connecting them with services that may be required or support where needed.

There is an opportunity for this team to better identify patients at risk of a fall to promote enhanced safety in this regard. As well, the team is working on measurable objectives coupled with indicators that they can measure and ensure the continuous improvement they all strive for.

Priority Process: Medication Management

This is an extremely cohesive program which respects and utilizes each interprofessional team member to their full scope of practice. Patient safety is the focus of all activity. Concerns expressed are relative to the significant impact the increased volume and complexity of chemotherapy has on production for the pharmacy department.

3.2.2 Standards Set: Emergency Department

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.3	The team has access to seclusion rooms and/or private and secure areas for clients.		!
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			
8.5	After triage, the team follows set criteria and gathers input from the client's other service providers to identify immediate and urgent needs and decide on priorities of service.		
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
	9.3.1	The team initiates medication reconciliation for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated and documented with the involvement of the client, family, or caregiver. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.	**MAJOR**
	9.3.2	The organization identifies criteria for a target group of non-admitted clients who are eligible for medication reconciliation and documents the rationale for choosing those criteria.	**MAJOR**
	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		
13.2	The team meets applicable legislation for protecting the privacy and confidentiality of client information.	!
Priority Process: Impact on Outcomes		
11.6	The team uses at least two client identifiers before providing any service or procedure.	ROP
11.6.1	The team uses at least two client identifiers before providing any service or procedure.	**MAJOR**
16.3	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	ROP
16.3.1	The team has implemented a falls prevention strategy.	**MAJOR**
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**
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 departments are working with provincially established wait time targets of 5 hours for discharged patients and 10 hours for admitted patients to be moved to the units. There is an obvious culture of process improvement as the teams work internally to improve patient flow and with stakeholders outside of the department to improve the flow of inpatients to the units. For example, evidence of good patient flow is rates of patients left without being seen ranging from 2.7% - 3.9% in the 2014/15 fiscal year. The organization is to be commended for the work they have accomplished to date.

As the process improvements and flow have been implemented there are a number of different terminologies that are utilized. It is difficult for the public and senior leadership to understand the purpose and function of the different areas. For example, rapid assessment zone and care assessment zone have similar purposes; similarly, fast tack and super track have a similar purpose. The organization may want to consider standardizing the terminology to improve the understanding and purpose of each of the areas.

Priority Process: Competency

There is a particular emphasis on training and supporting new staff through orientation, training and courses, and transitioning them through different areas of the department to become competent emergency nurses. Advanced courses are available for staff to increase their knowledge of emergency care. There is an obvious culture of development and training. For example, non-violence crisis training is provided and of particular note is a course entitled “Strangers in Crisis” that is required for staff to attend. Physician attendance is also encouraged in particular circumstances. Surrey Memorial Hospital has made a conscious effort to maintain a competent skill set by having emergency nurses work shifts in the mental health and paediatric emergencies. Infusion pumps are standardized throughout Fraser Health Authority and there is documented evidence of effective infusion pump training.

Priority Process: Episode of Care

Fraser Health Authority is to be commended for the work that has been undertaken to improve patient flow through the emergency departments. It was evident at all of the sites that were visited that there is an understanding from the entire site that patient flow was important and that the ownership for patient flow is a shared one between all departments.

In terms of a patient experience, all of the patients interviewed were happy with their care and commented that the emergency department was meeting their need. However, there is an opportunity to improve the overall patient experience when patients are presenting to the emergency departments. The current triage and registration process is cumbersome and requires the patient to move three times. The current methodology of a pre-registration with the registration clerk, a move to the triage nurse, and then return to the registration area is frustrating for patients. It is recognized that the organization wants to capture the true wait time from time of presentation to the emergency department until treatment and discharge; however, it is recommend that the patient flow be analyzed to improve the patient experience.

The current process that was observed for medication reconciliation for admitted patients is excellent and plans are underway to complete the rollout of this process in all of the emergency departments over 2015. To date, no process has been determined to conduct the best possible medication history for an at risk population who are being discharged from the emergency.

The transfer of information at transition points was observed and is an excellent process both within a facility and between facilities. The standardized process is well established and easy to use. All of the staff find value in both the patient transfer record and the 48/6 document.

The emergency departments have also invested time to develop a process to transmit information from one visit to the next. In particular, care plans for patients who frequently visit the emergencies (referred to as "friendly faces") are available. The current electronic emergency information system allows the team to flag on the patient record that a plan of care is available. This ensures consistency of care both within the same emergency or if another emergency department in Fraser Health Authority is visited. More importantly, it was observed that the emergency department team seeks to find appropriate services for a patient in need so that they do not need to seek services at the emergency department, and this plan is communicated via the above method.

Priority Process: Decision Support

The emergency department program has standardized many approaches to care in the departments by utilizing evidence based guidelines and nurse initiated protocols.

Priority Process: Impact on Outcomes

The program management model has provided an opportunity for Fraser Health Authority to standardize best practice and share learnings amongst each of the emergency departments. In fact one of the staff commented during the episode of care “how great it was to be part of a region because of the opportunities and standardization that it provided to ensure better patient care”. As the new structure is established opportunities to continue the collaboration amongst the emergencys will be important.

All of the emergency departments that were visited stated that safety briefings were carried out on a regular basis. Of particular note were the 'I care rounds' at Surrey and ER rounds at Burnaby that were conducted daily to review the patients currently in emergency in an effort to avoid admissions and/or begin the discharge planning process. This is an excellent method to improve communication amongst all stakeholders.

In addition to the regularly measured indicates such as wait time targets, rate of patients left without being seen and hand washing targets, other quality indicators that are measured include cardiac and stroke time to care indicators. All of the teams were conscious of the need to monitor these indicators to contribute to improved patient outcomes. Of particular note is Chilliwack's ability to translate the excellent care provided to stroke patients who present to the emergency departments to provide the same level of service to patients who are admitted to hospital who later stroke. Normally flow from the Emergency department should only be "one way"; however, Chilliwack has identified a need and put in place a process for inpatients to return to the emergency department to receive a telestroke consult and treatment as required.

Through patient feedback surveys the emergency program has identified the need to improve pain management for patients and have committed to identify opportunities to improve.

The organization has provided education to the emergency staff regarding the use of at least two client identifiers. When questioned, the staff were aware of the need; however, during observations the use of the identifiers was not consistent. The organization is encouraged to conduct regular audits to ensure the two client identifiers becomes routine practice.

The organization does have a falls prevention strategy; however, it is primarily focused on the inpatient population. The organization is encouraged to review the falls prevention strategy for applicability to the emergency setting. Adjustments are encouraged for improved assessment and notification methods which can be easily utilized in the emergency department.

Priority Process: Organ and Tissue Donation

All of the emergency departments work with BC transplant services to promote organ donation. The organs primarily donated are eyes and regular reports are provided to the teams from BC transplant. All of the departments commented that access for help to identify appropriate candidates and to work with the families are readily available and the quality is extremely high.

3.2.3 Standards Set: Infection Prevention and Control Standards

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
6.1	The organization provides clients, families, and visitors with information about routine practices and additional precautions as appropriate, and in a format that is easy to understand.	!
8.4	The organization's staff, service providers, and volunteers have access to dedicated hand-washing sinks.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

A critical component in patient safety is the prevention of infections. There are clearly outlined goals for improvement that have been detailed by the infection prevention and control team at Fraser Health Authority in a two-year service plan for 2014-2016. While the implementation of the service plan is only half way through implementation, clear improvements are being realized through the teams focused work. Of particular note is the management of hospital acquired infections and reduction of transmission of C. difficile and carbapenamase producing enterobactieriaceae (CPE). The team has achieved this reduction though focused efforts in terms of outbreak management, increasing hand washing compliance through audits and transparency of audit data to the clinical departments and leaders. The team is to be commended for the work they have achieved identifying patients with CPE and reducing the transmissions rates significantly. The unique approach to reducing transmissions by several improvement actions is noteworthy; in particular, the cohorting of patients, dedicating equipment and staff, twice daily cleaning and the detailed surveillance and reporting of cases.

In terms of the hand washing Required Organizational Practice – improvements in rates of hand washing have been achieved through regular audits and focusing on those groups (particularly physicians) whose rates of compliance with hand washing are not meeting the standard. Audits are conducted primarily by leadership at the unit level; however, a pilot utilizing co-op students has proven very effective to increase the rates of compliance and in particular with more challenging teams. Fraser Health Authority has identified “master auditors” to assist with the training of unit auditors to improve the quality of the audit results. Also of note is the increased hand washing audits when a unit is on an alert and/or outbreak from monthly, to weekly, to daily audits. This has no doubt impacted the spread of infections.

The infection control practitioner (ICP) staff support the care teams by providing advice and coaching on a 7 day a week basis, including days and evenings. Of note in the last survey was the challenge with retention and recruitment of ICPs – new changes were made to rotations, weekend coverage and provision of relief that have improved this situation. The organization reports that ICP staffing have stabilized and in talking with several ICP employees they feel supported by the organization to perform their job.

There is a definite culture across the sites visited of team work to combat the spread of infections, it is everyone’s responsibility. The ICP staff are seen as key members of the team and they seek many different opportunities to increase knowledge as evidenced by newsletters, Coffee Time for staff and education sessions. The organization is encouraged to spread these opportunities for dialog and learning throughout the organization.

Fraser Health Authority had Surrey Memorial Hospital chosen as the Ebola site for the province. As a result there has been a great deal of planning under way to establish protocols and processes if and when an event occurs. The IPC team is well aware of the need to keep the relevant teams trained for future outbreak possibilities whether it is Ebola or another organism.

The older sites are challenged by aging infrastructure and space challenges as well as capacity issues leading to hallway patients. However, the team has done an excellent job of mitigating and managing these risks.

Environmental services ensures that the cleaning staff is well educated on IPC practices. Regular audits are conducted on the units as well as spot checks by IPC and housekeeping. Ongoing educational opportunities reviews are provided to the housekeeping staff in order to ensure that they are kept apprised of current practices.

Those units who are on the vulnerable list are requested to complete an action plan to reduce the risk of further infection transmissions. There is pride on the units when they have been removed from IPC “watch” list. Regular audits are conducted on the units my both ICP and management to sustain the environment at the level required to reduce infection risks.

At the Royal Columbia Hospital (RCH) it was observed that they have a “star” volunteer who orientates families to infection prevention control practices. This volunteer is extremely knowledgeable about IPC practices. The RCH site may wish to consider using volunteers in the medical and surgical units as IPC ambassadors.

Fraser Health Authority is to be commended for the strong leadership in infection prevention and control and for helping to create a culture though out the organization that everyone has a role in preventing infections. It was very evident that the IPControl teams at each of the sites are committed and compassionate about ensuring that the site is supported in all aspects of infection prevention and control. The IPC practitioners have assigned units and it was evident throughout the tracer that the teams are well respected and appreciated by the various units and areas. It was noted that the IPC practitioners are very knowledgeable and take extreme pride in their role. It was also noted that there is excellent communication between sites and units when patients need to be transferred.

3.2.4 Standards Set: Medication Management Standards

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
1.3	The interdisciplinary committee regularly evaluates its roles and responsibilities and makes improvements as needed.		
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
	2.3.2	The program includes lines of accountability for implementation.	**MAJOR**
	2.3.5	The organization establishes mechanisms to evaluate the program on an ongoing basis, and shares results with stakeholders in the organization.	**MINOR**
2.5	The organization implements a comprehensive strategy for the management of high-alert medications.		ROP
	2.5.1	The organization has a policy for the management of high-alert medications.	**MAJOR**
8.2	The organization has a policy for when and how to override alerts by the pharmacy computer system.		!
12.7	The organization stores expired, damaged and contaminated medications, as well as those discontinued or recalled by the manufacturer away from medications in current use in the pharmacy and client service areas, pending removal.		!
13.3	The organization stores chemotherapy medications in a separate negative pressure room with adequate ventilation segregated from other supplies.		!
15.1	The pharmacist reviews prescription and medication orders within the organization prior to administration of the first dose.		!
16.1	The organization regularly cleans and organizes its medication preparation areas.		
21.1	Service providers provide clients and families with information on their medications prior to the initial dose, and when the dose is adjusted, and document this information.		!
25.4	The interdisciplinary committee provides staff and service providers with regular feedback about medication errors and near misses, and risk reduction strategies that are being implemented.		

27.8 The interdisciplinary committee shares evaluation results with staff and service providers.

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The governance structure supporting medication management at Fraser Health Authority requires a thorough review. It appears there are many committees such as a provincial pharmacy and therapeutics (P&T) committee, an organizational Fraser Health Authority P&T committee, a Fraser Health medication quality and safety committee and various Lower Mainland pharmacy services committees and workgroups. These committees appear to have little inter-face, and in fact appear to be somewhat functioning in silos. There is no evident accountability of responsibility.

Unfortunately the interprofessional nature of the committee membership does not appear to translate into interprofessional ownership of medication management responsibilities, and there appears to be a reluctance to encourage and entrench the shared ownership at the committee level. This appears to have resulted in several committees working in parallel. There are very few medication management standards and requirements that do not touch the interprofessional team - especially nursing, medicine and pharmacy. These disciplines must clearly understand the issues and scope of impact for each other and to enable objective and patient focused decision making.

The Fraser Health Authority P&T committee has a number of extremely high level goals on their plate for the next few years (e.g. establishing an electronic medication administration record, computerized physician order entry and implementing bar coded medication administration by developing a standardized pharmacy information system). These will require a clear vision and strong interprofessional relationship in order to be successful. There are also many projects that have just begun (e.g. targeted drugs identified for utilization initiatives – IV-PO, non-formulary and restricted drugs, antimicrobial stewardship program (ASP), and implementation of order writing standards). A clear accountability of reporting relationships and accountability will serve to enhance the success and growth of these programs through monitoring and learning from quality indicators, such as those already begun to be collected through the ASP.

Notwithstanding, the pharmacists at Fraser Health Authority are firmly entrenched into the interprofessional team within the region and supporting significant areas such as emergency departments, oncology, home intravenous (IV) programs, deep vein thrombosis (DVT) clinics, and of course areas of care such as medicine, critical care, surgery, etc. Pharmacists continue to evolve in their ability to contribute to patient care with their expanded scope and the ability to transfer some of the more distributive tasks to pharmacy technicians. The patient care team identifies with the roles of each other and strongly depend on the skill sets each brings to their delivery of patient care.

There has been tremendous work done on many of the areas noted to be deficient in the 2012 accreditation review. The team is congratulated on successfully pursuing these endeavours. Nurses are routinely taking medication to the bedside intact, and are having important informational conversations with their patients. There has been a concentrated effort to encourage prescribes to acknowledge the “do not use” abbreviations. The organizational Health Authority Medical Advisory Committee (HAMAC) has supported this effort through policy. The ASP has been implemented, and shown marked financial impact through reduction of use of targeted antibiotics. It will be exciting to see the results as they reflect on the c. Diff rates, length of stay and other indicators. Lastly, there has been significant work on the revised required organizational practices (i.e. high-alert medications, heparin safety, narcotics safety, and concentrated electrolytes), which has been no easy feat. As this progresses, the organization is encouraged to develop a scientific methodology for the adjudication process of potential risk, and therefore create an objective framework for approval of "exception request" submissions for approval. It would be advised to incorporate a human factors element to this assessment. Furthermore, as a component of the required audit and review process, it would be advisable to incorporate an evaluation of the decisions made regarding the exceptions requests by using patient safety and learning system (PSLS) reports as a source of outcomes related to safety.

3.2.5 Standards Set: Mental Health Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
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			
7.3	The assessment process identifies the client's strengths, needs, and expectations, and family and caregiver involvement.		
10.6	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
	10.6.2	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**
	10.6.4	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			
15.2	The organization's process for selecting guidelines includes seeking input from clients, families, staff, and service providers about the applicability of the guidelines to client recovery.		
Priority Process: Impact on Outcomes			
16.7	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.		ROP
	16.7.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**
17.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.		
Surveyor comments on the priority process(es)			

Priority Process: Clinical Leadership

There is a strong leadership team within the mental health program that appears to work collaboratively across all mental health sites. Front line clinical staff commented on how approachable and visible their leaders are across the various sites. All levels of the leadership team have a sincere commitment for the safety of their staff and quality of patient care. In 2014, the Mental Health and Substance Use (MHSU) Strategic and Operational Priorities 2015-2020 document was released which provides a clear direction for the program. The leadership team is currently identify the goals and measurable performance targets for the next five years and is strongly encouraged to involve patients and families during this process. The video produced " Moments to Milestones-First Responder Engaging People Who Use Substances" is one of several examples of this program providing leadership to reduce mental health stigma across the Health Authority and the Province of BC.

Priority Process: Competency

There has been significant improvements on the completion of the leadership teams' performance appraisals since the 2011 accreditation survey. Some areas still require significant improvement including a focused effort on clinical units. As the mental health program begins to implement their 'strategic plan' the leadership team must not overlook the importance of performance appraisals for their staff.

New staff stated the orientation to the mental health program was helpful and appropriate; however, on the various units, staff expressed a need for 'face to face' education. Over the next five years, the strategic plan will include more standardization and best practice guidelines and. The program will need to develop a more robust education program to support and implement these changes.

The mental health program has completed significant work on the 'seclusion and restraint policies' as well as the 'suicide risk assessments and documentation' since their last accreditation. The team is to be congratulated on this work and the document : Suicide Risk Management –Clinical Practice Guidelines.

Priority Process: Episode of Care

The mental health program is to be congratulated on working closely with the First Nations Communities and is encouraged to continue to work with other visible minorities. This program has fully functioning interdisciplinary teams throughout their sites. All staff work together to provide quality care for extremely ill mental health patients and work diligently to maintain safe work environments. Staff is very appreciative of the leadership team's focus on their safety including de-escalation techniques and panic buttons for all staff. If an incident occurs the staff member feels supported and is actively involved in the debrief and 'learnings.'

The "11 AM Congestion Calls" are another example of how this program is working as a team to provide faster access and improve flow from emergency departments into more appropriate clinical units. Since the last accreditation visit, the teams have developed 'appropriate' safe physical activities for their patients. Some units would benefit from additional physiotherapy to help with mobility and prevent falls.

Although medical coverage is available at all sites, collaborative relationships and processes between the mental health & substance use program, emergency departments and medical services need to be strengthened. Currently this coverage is variable and at one site psychiatrists do experience significant 'push back' when patients become medically ill.

All the staff associated with the mental health program, are to be congratulated on incredible team work and providing such quality and compassionate care for patients and their families.

Priority Process: Decision Support

All units have a clear process to ensure documentation and appropriate legislative requirements are met. Several units noted that patients transferred from other organizations or within sites did not always have accurate transfer documents including information regarding patients' positive C. diff or MRSA status. Development of a standard document and policy for its completion would be helpful. The program recognizes the importance of family and patient input and needs to more actively engage them as the mental health and substance abuse program moves forward on the strategic plan.

Priority Process: Impact on Outcomes

The program is now beginning to implement their five year strategic plan. The team is encouraged to develop clear, measurable goals for each of the five years and with one director accountable for each deliverable. Involving staff, patients and families throughout the process will ensure engagement within Fraser Health Authority and surrounding communities.

Section 4 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.

Fraser Health values the survey visit, recommendations and opinions of the Accreditation Canada Surveyors. This supplementary visit is timely as the organization is restructuring with a dedicated focus on Quality and Patient Safety from the 'Board Room to the bedside'. The level of detail provided and independent validation of our care and service against national standards of quality and safety will guide our improvement plans.

The survey visit occurred in the midst of organizational restructuring and we are proud of the continued focus our care teams have on quality and patient safety. The findings accurately capture the successes and challenges of the organization and prepare Fraser Health to deliver on its Patient Safety and Quality Strategy - to deliver the highest quality health care services to people in Fraser Health, and appropriately and safely transition people to higher-level services outside the geography when necessary.

We acknowledge we are settling into a new structure, new leadership both at the Board and Executive level and welcome the opportunities to better embed the standards into our processes and daily work. The Ministry of Health Review reinforced that Fraser Health had room for improvement in terms of quality and optimizing the use of resources; this accreditation visit showed we are making positive progress.

We are working in a mix of state of the art facilities and aging capacity; all communities are showing increasing population growth and demand for services. We are working to align our structures and strategies with the Ministry of Health recently released policy papers that include Surgical Services, a shift to Primary and Community Care so acute hospitals are appropriately utilized and a Patient and Family Centred Care focus becomes pervasive.

We recognize and celebrate the strengths that the Surveyors highlighted, including:

- Committed and caring care teams in Mental Health Substance Use, Ambulatory Systemic Cancer Therapy and Emergency Departments
- Demonstrated improvements in access and flow
- Demonstrated improvements in Infection Prevention and Control and Managing Medications
- Commendations for the results and methodology for Nursing Sensitive Adverse Events

Fraser Health continues to support the Accreditation Canada process as a key method to embed quality improvement and patient safety into our day-to-day work, to improve the patient, client, resident and family experience. We want to achieve this in a way that is recognizable and meaningful to everyone. This is ambitious, but it is achievable, necessary and we are well placed to deliver. The aim is set at a high level, but the means to achieving it will be built from the ground up. What will make Fraser Health successful is the combined effect of millions of individual care encounters that are consistently person-centered, clinically effective and safe, for every individual, all the time.

We want the implementation of the new Patient Safety and Quality Strategy to strengthen confidence and pride in the patients, residents, clients and families we serve. We want confidence for patients that their care in Fraser Health is the best it can be. We want confidence for people working in and with Fraser Health that they are doing what they came into our health authority to do, are valued and are key to delivering the ambition. Accreditation Canada's recommendations, observations and feedback will help to position us to deliver on this strategy.

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 decision making regarding ethical dilemmas and problems.
Resource Management	Monitoring, administration, and integration of activities involved with the appropriate 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, innovation, and action.

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 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
Decision Support	Using information, research, data, and technology to support management and clinical decision making
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	Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
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
Organ and Tissue Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
Organ Donation (Living)	Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge