ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

NL Health Services Labrador-Grenfell Zone

Happy Valley-Goose Bay, NL

On-site survey dates: June 9, 2024 - June 14, 2024

Report issued: November 19, 2024

About the Accreditation Report

NL Health Services Labrador-Grenfell Zone (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 June 2024. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

In the interests of transparency and accountability, Accreditation Canada encourages the organization to disseminate its Accreditation Report to staff, board members, clients, the community, and other stakeholders.

Any alteration of this Accreditation Report compromises the integrity of the accreditation process and is strictly prohibited.

A Message from Accreditation Canada

On behalf of Accreditation Canada's board and staff, I extend my sincerest congratulations to your board, your leadership team, and everyone at your organization on your participation in the Qmentum accreditation program. Qmentum is designed to integrate with your quality improvement program. By using Qmentum to support and enable your quality improvement activities, its full value is realized.

This Accreditation Report includes your accreditation decision, the final results from your recent on-site survey, and the instrument data that your organization has submitted. Please use the information in this report and in your online Quality Performance Roadmap to guide your quality improvement activities.

Your Program Manager or Client Services Coordinator is available if you have questions or need guidance.

Thank you for your leadership and for demonstrating your ongoing commitment to quality by integrating accreditation into your improvement program. We welcome your feedback about how we can continue to strengthen the program to ensure it remains relevant to you and your services.

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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

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

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

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

Accreditation Decision

NL Health Services Labrador-Grenfell Zone's accreditation decision is:

Accredited (Report)

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

About the On-site Survey

- **On-site survey dates: June 9, 2024 to June 14, 2024**

- **Locations**

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

  1. Charles S. Curtis Memorial Hospital
  2. Churchill Falls Community Clinic
  3. John M. Gray Centre
  4. Labrador Health Centre
  5. Labrador South Health Centre
  6. Labrador West Health Centre
  7. Labrador-Grenfell Health Administration Building
  8. Long Term Care Goose Bay
  9. Mani Ashini Health Centre
  10. Mary's Harbour Community Clinic
  11. Port Hope Simpson Community Clinic
  12. Strait of Belle Isle Health Centre

- **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. Infection Prevention and Control Standards
  2. Leadership

  Population-specific Standards

  3. Aboriginal Integrated Primary Care

  Service Excellence Standards

  4. Community-Based Mental Health Services and Supports - Service Excellence Standards
  5. Critical Care Services - Service Excellence Standards
  6. Diagnostic Imaging Services - Service Excellence Standards

7. Emergency Department - Service Excellence Standards
8. EMS and Interfacility Transport - Service Excellence Standards
9. Home Care Services - Service Excellence Standards
10. Inpatient Services - Service Excellence Standards
11. Long-Term Care Services - Service Excellence Standards
12. Medication Management (For Surveys in 2021) - Service Excellence Standards
13. Obstetrics Services - Service Excellence Standards
14. Perioperative Services and Invasive Procedures - Service Excellence Standards
15. Point-of-Care Testing - Service Excellence Standards
16. Public Health Services - Service Excellence Standards
17. Reprocessing of Reusable Medical Devices - Service Excellence Standards
18. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	71	12	2	85
 Accessibility (Give me timely and equitable services)	94	10	2	106
 Safety (Keep me safe)	706	42	40	788
 Worklife (Take care of those who take care of me)	126	28	4	158
 Client-centred Services (Partner with me and my family in our care)	379	42	18	439
 Continuity (Coordinate my care across the continuum)	87	7	4	98
 Appropriateness (Do the right thing to achieve the best results)	779	161	77	1017
 Efficiency (Make the best use of resources)	50	9	6	65
Total	**2292**	**311**	**153**	**2756**

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	43 (86.0%)	7 (14.0%)	0	85 (88.5%)	11 (11.5%)	0	128 (87.7%)	18 (12.3%)	0
Infection Prevention and Control Standards	38 (95.0%)	2 (5.0%)	0	27 (93.1%)	2 (6.9%)	2	65 (94.2%)	4 (5.8%)	2
Aboriginal Integrated Primary Care	54 (85.7%)	9 (14.3%)	0	90 (84.9%)	16 (15.1%)	1	144 (85.2%)	25 (14.8%)	1
Medication Management (For Surveys in 2021)	90 (93.8%)	6 (6.3%)	4	46 (97.9%)	1 (2.1%)	3	136 (95.1%)	7 (4.9%)	7
Community-Based Mental Health Services and Supports	38 (84.4%)	7 (15.6%)	0	81 (87.1%)	12 (12.9%)	1	119 (86.2%)	19 (13.8%)	1
Critical Care Services	43 (71.7%)	17 (28.3%)	0	87 (82.9%)	18 (17.1%)	0	130 (78.8%)	35 (21.2%)	0
Diagnostic Imaging Services	35 (94.6%)	2 (5.4%)	31	8 (100.0%)	0 (0.0%)	61	43 (95.6%)	2 (4.4%)	92
Emergency Department	55 (76.4%)	17 (23.6%)	0	77 (72.0%)	30 (28.0%)	0	132 (73.7%)	47 (26.3%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
EMS and Interfacility Transport	105 (92.9%)	8 (7.1%)	1	105 (87.5%)	15 (12.5%)	0	210 (90.1%)	23 (9.9%)	1
Home Care Services	40 (83.3%)	8 (16.7%)	0	64 (87.7%)	9 (12.3%)	2	104 (86.0%)	17 (14.0%)	2
Inpatient Services	39 (65.0%)	21 (35.0%)	0	72 (84.7%)	13 (15.3%)	0	111 (76.6%)	34 (23.4%)	0
Long-Term Care Services	54 (96.4%)	2 (3.6%)	0	93 (93.9%)	6 (6.1%)	0	147 (94.8%)	8 (5.2%)	0
Obstetrics Services	65 (89.0%)	8 (11.0%)	0	77 (87.5%)	11 (12.5%)	0	142 (88.2%)	19 (11.8%)	0
Perioperative Services and Invasive Procedures	102 (89.5%)	12 (10.5%)	1	98 (89.9%)	11 (10.1%)	0	200 (89.7%)	23 (10.3%)	1
Point-of-Care Testing **	33 (100.0%)	0 (0.0%)	5	33 (94.3%)	2 (5.7%)	13	66 (97.1%)	2 (2.9%)	18
Public Health Services	47 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	116 (100.0%)	0 (0.0%)	0
Reprocessing of Reusable Medical Devices	71 (83.5%)	14 (16.5%)	3	28 (70.0%)	12 (30.0%)	0	99 (79.2%)	26 (20.8%)	3
Transfusion Services **	66 (100.0%)	0 (0.0%)	10	56 (100.0%)	0 (0.0%)	13	122 (100.0%)	0 (0.0%)	23
Total	**1018 (87.9%)**	140 (12.1%)	55	1196 (87.6%)	169 (12.4%)	96	2214 (87.8%)	309 (12.2%)	151

* Does not includes ROP (Required Organizational Practices)
** Some criteria within the standard sets were pre-rated based on your organization's accreditation through the Quality Management Program – Laboratory Services (QMP-LS) program managed by Accreditation Canada Diagnostics

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			
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient Safety Goal Area: Communication			
Client Identification (Aboriginal Integrated Primary Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care Services)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Aboriginal Integrated Primary Care)	Unmet	2 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (EMS and Interfacility Transport)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Aboriginal Integrated Primary Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	1 of 1	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (EMS and Interfacility Transport)	Met	5 of 5	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
High-Alert Medications (Medication Management (For Surveys in 2021))	Met	5 of 5	3 of 3
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (EMS and Interfacility Transport)	Met	4 of 4	2 of 2
Infusion Pumps Training (Home Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (EMS and Interfacility Transport)	Met	3 of 3	0 of 0
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Unmet	2 of 7	0 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (EMS and Interfacility Transport)	Met	1 of 1	2 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
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
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Aboriginal Integrated Primary Care)	Met	5 of 5	0 of 0

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

Summary of Surveyor Team Observations

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

On April 1, 2023, the province of Newfoundland and Labrador established the NLHS (Newfoundland and Labrador Health Services). The former Labrador-Grenfell Health Region retained its boundaries and has become part of the unified health authority as a "zone." The LGZ (Labrador-Grenfell Zone) covers a vast geographic area (294,300 square kilometres) with a population of 37,000. The population includes three indigenous groups, many transient workers and agency staff. The LGZ has approximately 1,600 staff working in 22 facilities. Labrador-Grenfell partners with the Nunatsiavut Department of Health and Social Development, two Innu band Councils, NunatuKavut, Health Canada and private practitioners to deliver community health programs in Aboriginal communities.

Six (6) years have passed since the last survey, which has had to be postponed twice due to system-wide issues. Since the last survey, a great deal of progress has been made. At the time of the last survey, the CEO (Chief Executive Officer) and the CFO (Chief Financial Officer) positions were vacant and senior managers supported the region. Fortunately, the region has successfully filled its senior positions and established some stability. The NLHS - Labrador-Grenfell Zone is advancing some of the strategic priorities (e.g., the development of Family Care Teams is improving access to primary care, and patient and family experience advisors are helping to advance people-centred care).

Since the last survey, the NLHS - Labrador-Grenfell Zone has experienced a global pandemic, a province-wide cyber-attack, and two major weather events (Snowmageddon and Hurricane Fiona). Only a little over a year ago, the province announced it would move to merge all the health authorities into a single provincial health authority. The local Labrador-Grenfell Board has been dissolved, and a provincial Board of Directors has been established. Governance standards were not part of this review.

The LGZ values its many partners, including those noted above. During the survey visit, we had the opportunity to meet with some of your partners. Feedback from our Indigenous partners highlighted the need for more involvement in the co-design of services, rather than providing input on an almost finished proposal. LGZ's community partners expressed their appreciation for being consulted. We recognize that there is room for improvement, particularly in the form of regular and ongoing meetings with the NLHS - Labrador-Grenfell Zone for community partners, with actionable outcomes and deliverables.

Like front-line staff positions, the NLHS - Labrador-Grenfell Zone is challenged to fill its leadership positions. There are many new supervisors and managers in the organization. While these new supervisors and managers bring new energy and enthusiasm to the organization, they also need good onboarding, mentoring, and coaching. The NLHS - Labrador-Grenfell Zone is stretched thin, and the turnover rate in these positions is high. One of the unintended consequences of this high turnover is an unmanageable span of control and a lack of performance development and planning at the individual staff level, leading to dissatisfaction and staff feeling disengaged and under-appreciated.

Recruitment and retention is a significant issue for the organization. The zone as a whole is rural, with a number of remote sites, some of which are 'fly in' only, making it challenging to recruit to these areas. For those who have chosen to make their life here, they are now witnessing staff (who are part of the same provincial health authority) come as 'locums' to provide relief. This situation has led to some staff feeling disgruntled and possibly disincentivized.

For the most part, patients, residents, and families report satisfaction with a lot of the services offered at Labrador-Grenfell Health. The most challenging area that arose during the survey visit was the emergency department visits. Some of the patients, families, and community groups report that some of the staff and physicians in the emergency departments lack kindness and empathy. They also experienced racism, and some staff and physicians lacked cultural sensitivity. They recognize that some of these staff may be fatigued, lack work-life balance, and be burned out. The patient experience in these areas is certainly an area that requires some additional focus.

“Nothing about me without me”. Overall, Labrador-Grenfell should celebrate the progress made in embedding people-centred care within the organization, and the journey continues with an opportunity to build capacity and sustainability across the NLHS - Labrador-Grenfell Zone in all service areas and levels through the lens of co-design, co-build, co-deliver, co-evaluation, and collaboration. Two key areas include recruitment and education of Person and Family Experience Advisors and providing similar education to all staff and community members. This can be done formally and informally with existing relationships already established and with a campaign with posters, infographics, and the public-facing webpage of the organization. Indigenous communities also need access to care that is culturally responsive and trauma-informed. Quality improvement initiatives are an important step in maturing the people-centred approach.

The structures and mechanisms to support engagement are foundational to embedding people-centred care, as evidenced in the Rights and Responsibilities of Clients. There is also a need to evaluate the patient experience and outcomes by measuring what will impact and interface with the care journey experience. Examples include storytelling, one-on-one interviews, and focus groups/talking circles. The cultural shift to equity, diversity, and inclusion to support creating a safe space for all stakeholders, both internal and external to the organization, is how we create value and visibility for the provider of care and the recipient of care to create a belonging community with trusting relationships, kindness, and compassion.

Detailed Required Organizational Practices

Each ROP is associated with one of the following patient safety goal areas: safety culture, communication, medication use, worklife/workforce, infection control, or risk assessment.

This table shows each unmet ROP, the associated patient safety goal, and the set of standards where it appears.

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Aboriginal Integrated Primary Care 9.14
Patient Safety Goal Area: Worklife/Workforce	
Client Flow Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	· Leadership 13.4

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

Some priority processes in this section also apply to the service excellence standards. Results of unmet criteria that also relate to services should be shared with the relevant team.

Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.5	Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families.	
6.1	Annual operational plans are developed to support the achievement of the strategic plan, goals, and objectives, and to guide day-to-day operations.	!
6.3	The operational plans identify the resources, systems, and infrastructure needed to deliver services and achieve the strategic plan, goals and objectives.	
6.6	Management systems and tools are used to monitor and report on the implementation of operational plans.	!
Surveyor comments on the priority process(es)		

The vision for the legacy Labrador-Grenfell Health Region is “Healthy people living in healthy communities”. The values, with the exception of “innovation”, have been updated sine the last survey, with input from patients, families and the community. They are care, culture, innovation, quality, safety and teamwork. During the onboarding process the vision and values are communicated to new employees and leaders. They are posted throughout the Health Authority and on the website. The former Labrador-Grenfell Health Authority did not have a mission statement, but now that they are a provincial entity there is a mission statement that was developed with input from team members, clients, families and community partners.

Currently the Health Authority is in process of a transition. They are operating on a one-year provincial strategic plan. Once the new strategic plan is launched the team will develop operational plans. As the operational plans are developed it will be important to identify the resources needed, infrastructure needed to deliver services goals and objectives, realistic targets and how you will measure/monitor success. As well, you will need to communicate this progress to staff, patients, families, and community partners.

Since the last survey the Health Authority developed a strategic plan (2020-2023). They identified person centred care as the number one priority and have worked very hard to advance this work. In the current development of the provincial strategic plan, the team is also consulting the Health Accord NL, which is a 10-year transformational document, in addition to engaging with their stakeholders. The Health Indicators List is used as well as a Community Health Needs Assessment. Reporting to leadership on strategic goals was on a quarterly basis with two priorities/indicators chosen to report on each cycle. The regional board has been dissolved and a provincial board put in place. Across the zone, there is less engagement of front-line staff. There were pockets of staff who report they did not know there was a strategic plan or what would be encompassed in it. It is very important moving forward that front-line staff, patients, families and partners hear their voice in the strategic plan and goals/objectives.

As part of the information used to develop strategic plans and initiatives the team has used an environmental scan. This document needs to be refreshed as it is from 2017 and the country has experienced a global pandemic, severe weather issues, the local demographics have changed as examples.

Information for planning is also obtained from a variety of other sources: Community Needs Assessment (2022), Client Relations Office, reviewing emergency department visits, client experience surveys, client compliments/complaints, leadership walkarounds, exit/stay interviews, employee engagement surveys, Patient Advisory Council, Innu Round Tables with Indigenous Groups, post discharge calls, as examples. The new organization is developing a Client Experience Office. One of the challenges is that staff, patients, families and communities are experiencing survey fatigue. Other options could be focus groups and partner groups.

In meetings with a number of partners, they reported a lack of consistency in engagement. They would appreciate having regular meetings that are scheduled well in advance. They wish to be involved in the design of proposals that are relevant to them rather than asked for feedback near the end.

Another improvement the team has made since the last survey is related to risk identification and mitigation. The team has identified a number of risks, examined them and prioritized them. They have considered the risk appetite of the zone as well as potential and actual impacts. Staff recruitment and retention have been identified as one of the priority risks. From what the surveyor team heard and observed, recruitment and retention of staff would be the most critical issue heard from front-line staff, patients, families and community partners.

Priority Process: Resource Management

Monitoring, administering, and integrating activities related to the allocation and use of resources.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Traditionally in the Labrador-Grenfell Zone there has been a very small but hard-working team working on the finance portfolio. The team is now in the midst of transitioning to a provincial team that will certainly be better resourced. The province is still using 3-4 legacy budgeting systems but will transfer that to one over the next 1-2 years.

The team has a number of financial policies and procedures such as Approval of Travel, Delegation of Authority and Executive Limitations. Improving the financial literacy of supervisors and managers has been a focus since the last survey. Also, development of cost codes and processes to track pandemic supplies/costs has been a major focus since the last survey.

Some of the things the team are most proud of include the teamwork in their department. They are learning from one another and taking the best from all the zones to build a strong team/system. Other accomplishments include bringing together a document for a 2-year capital plan within just two months! They are resilient, committed and have built trust in one another. The team has renegotiated their contracts with agency nurses and were able to negotiate better rates. The province has a curtailment plan to reduce these costs by 15% by end of 2026.

Concerns for the team include the development of operational and capital budgets in a time of fiscal restraints but escalating costs of supplies and human resources. There is aging infrastructure and not enough capital dollars to address all the needs. In addition, some equipment is being used beyond its expected life expectancy. The equipment is well maintained, and risks mitigated. The team notes that they are having to be reactive versus proactive meaning there is never enough budget to fix some things before they break down.

Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
10.10	Reporting relationships and leaders' span of control is regularly evaluated.	
10.11	Policies and procedures for monitoring team member performance align with the organization's mission, vision, and values.	!
10.15	Human resource records are stored in a manner that protects individual privacy and meets applicable regulations.	!

Surveyor comments on the priority process(es)

Since the last survey, the Human Resources (HR) team has developed a robust Human Resources Strategy (2023) that aligned with the Zonal strategic plan. The four areas of focus included recruitment and retention, employee engagement, employee health and wellness and leadership development. While the province has struggled to recruit and retain staff, this area of the province is even more challenging. In 2020, the turnover rate of the province was 8.2% with a turnover rate of 14.0% in Labrador-Grenfell Zone. Some of the strategic initiatives to recruit and retain staff include “Grow your own”, recruit the “right fit”, implement business intelligence, and complete a marketing and branding strategy. Under employee engagement, some of the initiatives include ensuring open communication, surveying staff to better understand their needs, look for opportunities for growth, employee recognition, measuring and monitoring the “right things” and management support. For employee health and wellness, the team developed a wellness plan, is promoting employee development, improving cultural awareness, improving safety, enjoyment and working on information sharing. For leadership development and succession planning, the team has developed and implemented a corporate onboarding process for managers, promoted a leadership program that includes Modules from LEADS 360.

Despite focused work on recruitment and retention, this remains a significant issue. The initial efforts to recruit staff may have had some success but there have been some unintended consequences. One of those is that employee retention efforts are seen as inadequate. The organization is paying staff from other zones (who are now provincial employees) to do locums in Labrador-Grenfell Zone. They are paid higher wages (significantly higher), their accommodations and flights are covered while the existing permanent staff feel under-appreciated. Staff are tired, some report feeling burned out and this is corroborated by patients, families and community partners. Staff who are fatigued and burned out may be at a higher risk of making errors, have decreased civility and report decreased satisfaction. The province is investing heavily in retention of staff with a Retention Task Force. Some of the things they are looking at are long-term service incentives and incentives to convert from casual to full time. Again, monitoring for the unintended consequences will be important in planning.

Civility and respect in the workplace are important issues that have arisen since the last survey. The team has put some focused efforts into improving the issues. They are working with both physicians and staff. One of the tools has been to offer training on cultural sensitivity. An opportunity may be to bring in patient stories to learn about the impacts to patients and families from those who directly experience racism and other negative behaviors.

Since the last survey, the team has seen more reports of workplace violence. The team attributes this to the increasing complexity of healthcare, actual increases of violence, increased reporting as well as lower threshold for tolerance. There is a Workplace Violence Policy and efforts to reduce the risk and harm to staff. Occupational Health & Safety provide safety talks to all staff on Tuesday mornings; security has been added since the last survey and ongoing training and support provided to staff.

While there are policies and procedures about monitoring team members performance, the policies are not being followed. There were a number of staff and physician personnel files reviewed and only two had performance reviews completed and not in the last 3 years. It is recommended that the organization look at a quality improvement in this area. The span of control of some supervisors/managers may be contributing to this issue. As well, the staff report that there is such high turnover in supervisors/managers that they are not there long enough to get through a cycle of performance development plans.

The storage of human resource records is inconsistent. Many are stored at Human Resources; however, some are stored onsite in the managers office. This is not a best practice, and the organization is encouraged to do a quality improvement on this to rectify the issue.

Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
12.7	As part of the integrated risk management approach, the quality of contracted services and contracted service providers is regularly evaluated.	
15.3	A strategy to prevent the abuse of clients is developed and implemented.	!

Surveyor comments on the priority process(es)

Since the last survey the Labrador-Grenfell Zone has developed an Integrated Patient Safety Action Plan (2020-2023). The plan has patient safety goals, strategies, identifies resources needed, has timelines identified and measures. Patient safety issues are assessed by Leadership Walkarounds, incidents in the CSRS, Vanessa's Law, audits, risk assessment checklists, strategic planning, environmental scanning, looking at Hospital Harms Reports, etc. Goals include embedding patient centred care, improving access, improving medication safety, enhancing the patient safety culture as well as identifying and modifying organizational risks. Progress has been measured and reported on the goals and objectives. The Patient Safety Act (2017) sets out guiding principles for organizations to follow.

Labrador-Grenfell Zone uses the provincial Clinical Safety Reporting System (CSRS), procured by the Department of Health in the early 2000's. Incidents are reported in this system, reviewed and reports are rolled up and provided to senior leadership and the board. The province has An Act Respecting Apologies Legislation (2009) to protect those who apologize from litigation. The organization has a Disclosure Policy (PSQ-5-040, May 2024) that has been recently updated. Training (HIROC) is provided to managers on disclosure during their onboarding. While not a formalized process, those providing disclosure do follow up with some patients/families to ensure the disclosure process was effective and to see if there are gaps. Patient/family advisors provided input on the updated policy. The main change they requested was to change the wording from "next of kin" to "substitute decision maker" as it may not be a relative that they would choose to speak for them if they were incapacitated.

A number of policies exist relating to contracted services. Examples include: Contractor and Vendor Safety Policy (2011), Contractor and Vendor Safety Handbook (2011), Public Procurement Policy (2023), Purchasing Authorization Prior to Sourcing and Procurement (2021), Quotes Required – non-contract Goods and Services (2021). No evidence was provided regarding the evaluation of the quality of the contracted services and assurance that vendors were meeting the Service Level Agreements in the contracts. It is recommended that the organization formalize this process and update the Contractor and Vendor Safety Policy.

Medication reconciliation at Labrador-Grenfell Zone is initiated by the registered nurse. Many admissions occur through the emergency department. The nurse reviews the medications with the patient. The HEALTHe NL is also reviewed as a secondary source. The organization has worked with communications on a campaign to encourage patients to bring all medications (or at least a list) to the emergency department when they visit. Once the best possible medication history is completed, the physician reviews and orders the medication. One of the initiatives the team is most proud of is the development of the BPDMH or best possible discharge medication history. This list includes discontinued or changed medications to ensure clarity for patients/families. One of the quality initiatives related to medication reconciliation is that medications at transitions must be written again – writing "continue medications" is not an acceptable order. Compliance of medication reconciliation is monitored and reported to senior leadership and the board quarterly. Current rates of compliance are 80-95% in acute care and almost 100% in long term care.

The team has completed several safety-related prospective analyses. One focused on medical supplies (laboratory) and another on patient transfers. The former involved a review of inventory for the laboratory. The listed inventory was not in alignment with actual inventory. A review was done, issues identified, strategies developed, quality improvements made with an excellent outcomes.

There is a duty to report abuse in Newfoundland and Labrador and there is a risk assessment checklist. The team needs to develop a provincial strategy to prevent the abuse of clients – there are pieces of the strategy already in place, but the actual strategy itself is missing.
The organization has completed a Canadian Patient Safety Culture Survey Tool. The results are not what the organization hoped for with many scores lower than the last survey. An action plan has been developed to work diligently on development of a just culture.

One of the quality improvements initiatives completed recently is NOD (Name, Occupation, Duty). In feedback (Client Relations, Client Experience Surveys, post discharge calls) patients were reporting they did not know who people coming into their room were. In this initiative, anyone coming into a patient/resident room needs to introduce themselves, what they do and what they plan to do with the patient. The team is planning to measure the response and are already receiving feedback that this is improving care.

The team has pockets where they are doing quality improvement activities; however, there are areas where quality improvement is not well understood and patients, families and front-line staff are not engaged. Engaging (versus seeking feedback) with the front-line staff, patients and families will add value and meaning. Ensuring realistic targets are set that are measurable and monitoring and adjusting as necessary are important. Sharing results widely is the final step.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
1.10 Support is provided to build the capacity of the governing body, leaders, and teams to use the ethics framework.	

Surveyor comments on the priority process(es)

The Labrador-Grenfell Zone has been part of a provincial ethics committee since 2012. It is referred to as PHENNL or the Provincial Health Ethics Network Newfoundland and Labrador. The committee is multi-disciplinary and includes a bioethicist. The bioethicist has a background in cultural anthropology which is an excellent fit for Labrador-Grenfell Zone which includes Innu and Inuit citizens. There is a robust ethical framework.

Anyone in the zone can submit an issue for an ethics consult. The submissions are reviewed and if appropriate, sent to PHENNL for an ethics consult. The consult is facilitated by a team member and includes the ethicist. A report is sent back to the individual(s) who submit the request. During the pandemic the number of ethical consults grew significantly with issues such as mandatory vaccination, protected code blues, PPE distribution, appropriateness of precariously housed, visiting policies and distribution of Paxlovid as the main issues. In the last year, the committee only reviewed three consults for this zone.

The current trends in ethical issues being reported across the province include individuals choosing to live at risk, substitute decision making, and consent issues. Formalized reporting to senior leadership and the board is encouraged.

The province also has an HREB or Human Research Ethics Board (HREB). There are four bioethicists on retainer from the Faculty of Medicine at Memorial University in St. John's. Part of this board includes a Research Protocol Approval Committee which determines if a proposal is appropriate for the health authority, looks at the resource requirements and potential privacy risks. The HREB conducts random audits of protocols and conduct.

Some sites report not knowing there is an ethical framework or how to report an ethical dilemma. Staff report that they may have had training during their onboarding, but nothing since then. It is recommended that the team make training in ethics mandatory annual training. The team is currently working with a consultant to develop a training video that will be put on the Learning Management System. Making the training mandatory could improve the uptake and reporting of ethical dilemmas and distress.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The communication “team” for the Labrador-Grenfell Zone (LGZ) is small but effective. They are most proud of their ability to work as a team, the positive energy despite the limited resources, and the great work that is happening. The things that worry them include the workload, the amount of communication needed, how to deliver on all platforms, and maximizing engagement.

The LGZ has a “draft” Communication Plan. Prior to the development of the plan the organization did work with their internal and external parteners to learn about dissemination of information for best effect as well as how best to receive information. A recent example of how this was done relates to the breast screening initiative. The team took some of their communication tactics and had them reviewed by partners. Suggestions for edits were made and these suggestions were incorporated into the plan. In addition, the team is planning to develop an advisory communications committee. This would be another way to engage with patients and families. The advisory committee could review/assist to develop upcoming communication documents such as Public Service Announcements (PSA’s), advertisements or bulletins. Recently patient/family members were asked to review communications tactics being used regarding emergency department closures/changes to service that the public were finding confusing. Suggestions for edits included bolding some sections, adding a table, putting it on the webpage. These suggestions were acted on resulting in improved communication.

With the change to one provincial health authority and zones, the communication team is very busy! The team is working with senior leadership, the board and partners to develop communications for the strategic plan. The team supports annual meetings of the new health authority. All the legacy organizations' webpages are being de-commissioned, and the staff/public are being redirected to a provincial webpage. Policies and procedures need to be “provincialized” and updated; health record policies and procedures need to be updated as well as digital policies and procedures. As well, some of the policies/procedures will require ongoing training and support (e.g. cyber-security).

The communications team monitors the media regularly, including social media platforms. Concerning issues are escalated to the appropriate senior leadership and CEO if necessary. The team heavily promotes the Client Relations Office as a way for the public to provide feedback and receive direct responses.

In addition to a Communications Advisory Committee noted above, the team works with a number of external partners. There are indigenous groups, municipalities and industry to name a few. The team has also worked on the Community Needs Assessment (2022).

Having experienced a recent cyber-attack, the team is sensitive to the cyber risks. They have implemented “Breakwater” to assist with cyber security. The team continues to raise awareness and promote appropriate use of the digital platforms used by the staff of the zone.

There is a "Crisis" Communication Plan that is currently being updated. Evaluation of communication plans is built into the individual plans. Some measures that are reviewed may include the number of hits to the website, particularly post PSAs or updates on specific program areas/projects. Other measures include the number of people accessing programs following communication (e.g. breast screening initiative) and the frequency that stories are re-shared or picked up by other media.

Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
9.1	The physical space meets applicable laws, regulations, and codes.	!
Standards Set: Perioperative Services and Invasive Procedures		
3.3	Heating, ventilation, temperature, and humidity in the area where surgical and invasive procedures are performed are monitored and maintained according to applicable standards, legislation, and regulations.	
3.6	Airflow and quality in the area(s) where surgical and invasive procedures are performed are monitored and maintained according to standards applicable for the type of procedures performed.	!
3.7	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!
Surveyor comments on the priority process(es)		

The hospital sites and clinics in each location are a source of pride of staff and community. The grounds are well maintained, and exterior signage is generally clearly identified.

The Labrador South Health Centre is clean and relatively uncluttered. However, the clinic in general has narrow hallways where only one person can pass at a time, and offices (especially for the mental health professional) are not arranged to optimize staff safety.

The Charles S. Curtis Memorial Hospital, which includes newly created LTC beds within the hospital, as well as the long-term care facility adjacent to the hospital and several housing properties.

The camera's at the Labrador West Health Centre waiting room and seclusion room are not working and camera's have yet to be installed at the Charles S. Curtis Memorial Hospital presenting a safety risk. Cell phone coverage at the hospital sites is often spotty.

Rooms where surgical and invasive procedures are performed have less than the required 20 complete air exchanges per hour. There is a system in place to monitor air quality, temperature and humidity within facilities. However, alerts are not monitored outside of regular weekday hours. Leadership is recommended to clearly define accountability for monitoring air quality, temperature and humidity and ensure alerts are monitored and addressed in a timely manner.

The Charles S.Curtis Hospital is commended for the recent addition of security staff on-site. The facility continues to have several renovation projects underway (i.e. primary care unit, pharmacy, infrastructure upgrades). The zone leadership is recommended to ensure a detailed plan is in place to help ensure line of sight and manage change at local levels.

Despite laudable investment in infrastructure, the buildings, especially hospitals, are dated making it challenging to maintain. Hospitals continue to struggle with space constraints, narrow hallways, holes in walls, wires hanging from ceilings, and insufficient storage areas. There is a considerable amount of wooden furniture and shelving as well as furniture is disrepair throughout the facilities that could present an IPAC risk.

The zone leadership is recommended to review the facilities to ensure departments are fit for purpose and meet legislative and safety requirements.

Priority Process: Emergency Preparedness

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

Unmet Criteria		High Priority Criteria
Standards Set: Aboriginal Integrated Primary Care		
12.8	The primary care component of the emergency response and recovery plan is reviewed and updated at least annually, with input from clients and families.	!
Standards Set: EMS and Interfacility Transport		
2.2	The role of the team in disaster and pandemic response is identified and the team participates in local, regional, provincial and federal disaster plans, responses, and exercises.	!
Standards Set: Leadership		
14.4	Education is provided to support the all-hazard disaster and emergency response plan.	
14.5	The organization's all-hazard disaster and emergency response plans are regularly tested with drills and exercises to evaluate the state of response preparedness.	!
14.6	The results from post-drill analysis and debriefings are used to review and revise the all-hazard disaster and emergency response plans and procedures as necessary.	
14.11	When disasters or emergencies occur, teams, clients, and the community are provided with support and debriefing opportunities.	
Surveyor comments on the priority process(es)		

Emergency preparedness started as a “regional” program in 2010. The program was built on four pillars: Mitigation, Prevention, Response and Recovery. In June of 2023 the team was given a “provincial” designation. The team is currently in the process of filling their emergency management and security operations positions in each of the zones. Moving to a provincial team has been positive for the team members who have assisted with emergency preparedness as there are provincial resources to support the smaller region.

A number of plans were reviewed for the survey. These include the All Hazards Plan (2024), Business Continuity Management Framework (2018), Adverse/Severe Weather Events Planning Framework: November 2022, Handbook for setting up and managing the EOC, June 2022, Fire Safety Team Handbook, May 2022, and the Labrador-Grenfell Pandemic/Outbreak Management Plan, February, 2023. The latter

document was developed in partnership with Public Health Nursing and the Medical Officer of Health. The All Hazards Plan is based on the ICS system. ICS100 training is available on the LMS (Learning Management System) and managers are encouraged to complete ICS100 and 200. It is recommended that all staff be encouraged to pursue ICS100 designation.

The nature of where Labrador is geographically situated predisposes the area to a number of significant weather patterns. The Warning Preparedness Meteorologist was able to participate in the survey visit. His role is to provide targeted information about advancing big weather events. He reported that 3-5 days ahead of weather events a "weather briefing package" is sent out. This briefing will provide potential outcomes, which includes worse case scenarios. Post storm there is an "after event" debrief where information is shared and reviews are completed. Examples of recent big weather events would be "Snowmageddon" of 2020 and Hurricane Fiona (2022). As some of the communities are quite remote they may be fly-in only and the area experiences many flight delays due to inclement weather.

One of the improvements made in the Labrador-Grenfell Zone since the last survey has been the addition of security officers. Staff reported not feeling safe at work and the region has responded by contracting Paladin to provide security services. This has been a welcome change for front line staff and physicians.

Due to the transient nature of the staff (locums and agency) the team has added "dry drills" to their arsenal of prevention and mitigation strategies. When contracts are signed with new staff, locums and agency staff they are requested to complete the module on the LMS about All Hazards. Because of the high turnover in some areas the team is worried that all staff may not be up to date so they conduct the dry drills which are essentially the team visiting a unit for example and going through a checklist with a staff member(s). The checklist includes things such as asking them where the fire extinguisher is located, where is the pull station located, what would you do if you were to hear a fire alarm and such questions. This is in addition to the usual fire drills and exercises. There are small pockets of staff who do not know about the training that is available. It is recommended that managers and supervisors ensure all staff review the emergency plans/training and provide support where needed.

The organization has developed a Critical Incident/Emergency Management Communications Plan, 2021 (Draft). Debriefs are held following critical incidents and "after action" reports are completed after all exercises are completed. An opportunity for the team is to ensure they engage patients/partners/families in planning and executing exercises.

There are Business Continuity Plans that address issues such as water or electrical failure. There is an up-to-date Pandemic Plan and the organization utilizes the Eastern Zone Outbreak Policy to deal with outbreaks.

Priority Process: People-Centred Care

Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

Unmet Criteria		High Priority Criteria
Standards Set: Aboriginal Integrated Primary Care		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
8.23	Planning for care transitions, including end of service, are identified in the care plan in partnership with the client and family.	
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Community-Based Mental Health Services and Supports		
4.10	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Critical Care Services		
2.6	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Standards Set: Emergency Department		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
10.3	Goals and expected results of the client's care and services are identified in partnership with the client and family.	
17.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: EMS and Interfacility Transport		
26.8	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from patients and families.	!
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from patients and families.	!
Standards Set: Home Care Services		
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Inpatient Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Standards Set: Obstetrics Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
13.3	Clients are empowered to self-manage conditions by receiving education, tools, and resources, where applicable.	
17.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
6.3	A comprehensive orientation is provided to new team members and client and family representatives.	
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

"Nothing about me Without me" the Person and Family Centered Care Framework embedded within the Strategic Plan of the Labrador-Grenfell Zone has been developed with extensive resources from the dissolved legacy LGH Board of Trustees. Consultation and collaboration with community members including recipients of care, providers, community partnerships and with Indigenous Communities has laid the foundation for an operational plan unique to the community of Labrador-Grenfell Zone.

The impact and interface of these collaborations has resulted in the establishment of a hybrid of internal and external partnerships that support the foundation of person-centered care; respect, information sharing, participation, and collaboration as evidenced by the survey team observations. Organizational chart reflects the reporting structure up to the Leadership, while structures and mechanisms have been developed to support the Person and Family Centered Care framework at all service and program levels as well as at the direct care level with the recipients of care.

Within the Labrador-Grenfell Zone, there are 3 CAC's (Central Labrador, Labrador South & GNP) plus the connection to Lab West Community Advisory Pannel (CAP). Within long term care there are four Resident and Family Councils. Internal to the organization are the Patient and Family Experience Advisors who are members of different committees that support the transformational work of the organization. Key initiatives include the Family Care Teams who support integrated team-based care, continuous quality improvement initiatives, the Evaluation sub-committee that measures impact of engagement efforts, as well as being paired with services/programs where they bring lived and living experience and expertise.

Foundational to the co-design, co-implementation, and co-evaluation of the framework are the mission, vision, and values of Labrador-Grenfell Zone which are framed in the Rights and Responsibilities of Clients.

Special recognition for the Nourish Project in long-term care where traditional meals from the land to the table are served to residents in long-term care. This is a community wellness that supports a belonging community familiar and comfortable with the culture of community members. The NOD (Name Occupation Duty) supports the recipient of care to understand who their care provider is and what their role is.

In long-term care across the organization efforts have been made to give a feeling of neighborhoods. Rooms are personalized by residents and family, murals are being added, and where possible meals from the land to the table are provided which are well received by the residents.

Noted in long-term care is a need to provide language services to support residents for whom English is not their first language. In addition, the Client Experience Survey also needs to be translated into the local language. In Labrador West Health Centre West the residents do not have access to recreation therapy services. Resident and Family Councils although started also need consideration for to become more robust and active within service design through recruitment and dedicated resources. This could also include a local quarterly newsletter. There is a developing patient and family advisory structure however, currently, patients/families are not involved at the local level with quality improvement.

Of special note are the needs of the Indigenous communities. Within these communities are different languages, customs, and ceremony. And for some locations there is an opportunity to consider the organization's commitment to Truth and Reconciliation through developing a trauma informed approach to care that recognizes what matters to the Indigenous communities. Written translation, interpreters, and navigation services that are accessible to all community members.

Within Obstetrics there is an opportunity to expand existing programs available in NL Health Services to clients' in Labrador-Grenfell Zone to include midwifery, and doula services.

It was also noted gender room sharing in some locations and this has been uncomfortable for the recipients of care.

The survey team observed the concern of the community for access to a primary care provider and consideration could be given to sharing with all community members how the organization will support them in navigating access to primary care and what those options look like. All community members have expressed a concern about long wait times in the Emergency Department as their access to primary care.

Opportunities for consideration in maturing both the experiences of care and the outcomes of care include a review of the public website to include a section for NLHS People Centred Care in a strength-based approach using plain language to celebrate and bring awareness to how PCC is embedded in the organization. This is an opportunity to celebrate patient stories through storytelling with video and podcasts as well as to provide education on health literacy and data literacy. Health literacy and data literacy also provided an opportunity for residents and community members to learn more about how health data supports service and program design based on local data. This could also be shared on the public website.

Further opportunity exists to explore a measurement tool for patient engagement through software such as the MyImpactPage.com which tracks activities, hours, levels of engagement as indicated by the International Association for Public and Patient Engagement as well the software has the capacity to be adapted to the unique needs of the organization. Recruitment of Patient and Family Experience Advisors can be done informally through already existing relationships with members of the integrated health care team and through creating posters and infographics around the roles and responsibilities.

Priority Process: Patient Flow

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

Unmet Criteria			High Priority Criteria
Standards Set: Emergency Department			
3.2	A proactive approach is taken to prevent and manage overcrowding in the emergency department, in collaboration with organizational leaders, and with input from clients and families.		!
3.9	Discharge planning is completed with other health care services and includes information about referrals.		
Standards Set: Leadership			
13.1	Client flow information is collected and analyzed in order to identify barriers to optimal client flow, their causes, and the impact on client experience and safety.		
13.2	Information about barriers to client flow is used to develop a strategy to build the organization's capacity to meet the demand for service and improve client flow throughout the organization.		
13.4	Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors. NOTE: This ROP only applies to organizations with an emergency department that can admit clients.		ROP
	13.4.2	Client flow data (e.g., length of stay, turnaround times for labs or imaging, community placement times, consultant response times) is used to identify variations in demand and barriers to delivering timely emergency department services.	**MAJOR**
	13.4.3	There is a documented and coordinated approach to improve client flow and address emergency department overcrowding.	**MAJOR**
	13.4.4	The approach specifies the role of teams within the hospital and other sectors of the health system to improve client flow.	**MAJOR**

13.4.5	The approach specifies targets for improving client flow (e.g., time to transfer clients to an inpatient bed following a decision to admit, emergency department length of stay for non-admitted clients, transfer of care times from emergency medical services to the emergency department).	**MAJOR**
13.4.6	Interventions to improve client flow that address identified barriers and variations in demand are implemented.	**MAJOR**
13.4.8	Client flow data is used to measure whether the interventions prevent or reduce overcrowding in the emergency department, and improvements are made when needed.	**MINOR**
13.5	The effectiveness and impact of the client flow strategy is evaluated.	

Surveyor comments on the priority process(es)

Labrador Grenfell Zone struggles with patient flow challenges, particularly at the Labrador Health Centre. This is impacting the inpatient and day surgery wards and the emergency department.

There wasn't strong evidence to support a proactive approach to get upstream and reduce overcrowding. Instead, the approaches taken, while responsive, appear to be more reactionary. There could be solutions to manage high patient volumes in the emergency department using rapid turnover spaces, identify patients for diversion to primary care, and initiate measures such as medical directives that could proactively address flow challenges.

There is an urgent need to improve discharge planning and timely linkage of resources to patients awaiting discharge from Labrador Health Centre. Multidisciplinary teams huddle regularly to discuss appropriate patients and barriers preventing timely discharge. The promise of a single health authority may need to be leveraged to provide on-the-ground mentorship and guidance from social workers skilled in complex patient discharge planning to build capacity within the team.

To improve system flow, the inpatient team at the Labrador Health Centre should consider implementing Structured Interdisciplinary Bedside Rounding to enhance communication, situational awareness and patient-centredness. Such a model would follow a structured rounding process that involves all care team members and is led by the hospitalist physician at a consistent time each day. Such models have demonstrated improved patient satisfaction, decreased length of stay, improved patient safety and optimized discharge planning.

Heart Force One is an important innovation in Newfoundland and Labrador, established in January 2023, which provides cardiac patients across the province with timely access to cardiac catheterization procedures. From April 1, 2023, to March 31, 2024, 16 patients from the Labrador-Grenfell Zone accessed this service. Specific criteria (i.e., no chest pain, being able to sit, not requiring continuous monitoring while on the flight) must be met to be transported via this mode of transport. While this initiative is

laudable, it isn't without challenges, as patients are still waiting a disproportionately long time in a medical bed for transport. There is an opportunity to refine the processes, criteria, and resources so that patients waiting for angiograms in acute care beds are transported in a more timely manner, and the impact on flow is mitigated. There is a goal to create equity regarding cath lab access, but that hasn't yet been achieved. Fundamentally, tertiary beds are a resource to the people of the province as a whole, not to the large urban centre primarily and periphery secondarily. That notion must be reinforced and championed to achieve bed access equity in tertiary centres.

The Charles S. Curtis Memorial Hospital describes following an informal surge capacity response during times of increased volume. The site does not report that daily and routine bed management or patient flow huddles take place. It is recommended that the site establish a proactive and regular approach to managing their bed capacity and patient flow.

Indeed, while the overcapacity algorithms within the organization’s Category A sites offer an approach to managing overcapacity situations, they are insufficient to fully address the issue. A more nuanced evaluation of the specific patient characteristics that can be placed in non-conventional treatment spaces and where doubling rooms may make sense needs to be conducted.

It is well-established that maintaining assessment spaces for emergency department patients while admitted patients receive temporary care in the hallway or other non-conventional spaces so that ED overcrowding doesn’t impede flow and so complete and appropriate initial assessments can occur.

Basic emergency department metrics and data are not collected, measured or tracked to inform system performance. The lack of triage data is inexcusable, and a deeper dive using Lean tools and methodologies could be utilized to uncover both problems and solutions. Acuity mix, case mix index, time to physician initial assessment, low acuity non-admit length of stay, high acuity non-admit length of stay, admitted patient length of stay and time to inpatient bed following the decision to accept the patient should be the basis of understanding emergency department flow performance. Targets should be established against current timeframes and best practice recommendations to inform performance.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices		
2.3	An appropriate mix of skill level and experience within the team is determined to support quality service delivery.	
3.3	Access to the MDR department is controlled by restricting access to authorized team members only and being identified with clear signage.	!
3.4	The MDR department has an area for decontamination that is physically separate from other reprocessing areas and the rest of the facility.	!
3.5	Appropriate environmental conditions are maintained within the MDR department and storage areas.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
5.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.12	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
7.5	Clear and concise Standard Operating Procedures (SOPs) are developed and maintained for reprocessing services.	
8.2	The reprocessing area's designated hand-washing sinks are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, electric eye controls, automated soap dispenser and single-use towels.	
11.10	The record of flexible endoscopic device reprocessing includes the identification number and the type of flexible endoscope, the identification number of the automated endoscope reprocessor (if applicable), the date and time of reprocessing, the name or unique identifier of the patient, the completion of the individual inspection and leak test, and the name of the person reprocessing the flexible endoscope.	!
12.2	Access to the sterile storage area is limited to authorized team members.	!

14.2	SOPs are applied for inventory control of sterilized devices.	
14.4	SOPs are used by staff to identify when there may be a problem with sterilization and when a recall is needed.	!
14.5	SOPs are applied to recall sterilized items that may have been compromised.	!
15.1	There is a quality improvement program for reprocessing services that integrates the principles of quality control, risk management, and ongoing improvements.	
15.2	Information and feedback is collected about the quality of services to guide quality improvement initiatives with input from stakeholders and team members.	
15.3	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities with input from stakeholders.	
15.4	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives with input from stakeholders.	!
15.5	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from stakeholders.	
15.6	Quality improvement activities are designed and tested to meet objectives.	!
15.7	New or existing indicator data are used to establish a baseline for each indicator.	
15.8	There is a process to regularly collect indicator data and track progress.	
15.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.11	Information about quality improvement activities, results, and learnings is shared with stakeholders, teams, organization leaders, and other organizations, as appropriate.	
15.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from stakeholders.	

Surveyor comments on the priority process(es)

There is an emphasis on ensuring that the team has the necessary qualifications and skills to feel confident and competent to complete their work. The team is expected to obtain certification to work in the area within 6 months of hire date and they receive 6-8 weeks of orientation within the department. Consideration of planned visits between sites, and more work together, may be beneficial to the MDR team members within NLHS due to processing levels (case numbers) and sole practice sites, to ensure practice and standards are maintained over time.

Additional SOP's are needed and should be developed. Having the electronic or hard copy of CSA Standards set Z134 - Canadian Medical Device Reprocessing regulations is appropriate.

Manufacturer's recommendation for cleaning and sterilization of medical devices are adopted according to standards. The team would benefit from access to electronic and/or paper copies of instrument sets with pictures to aide in the accurate assembly of the sets. Computer access for the MDR areas would benefit the program for all for all of the above needs, and allow for ease of organization photo sets and tracking across the areas.

The physical department at CCMH needs to be renovated and updated to comply with current standards. LHC (Goose Bay) should also be included with attention to workflow, physical environment (lighting, temperature, humidity and air flow) ergonomics and appropriate surfaces and plumbing should be a focus as should the ability to access to SOPs and other needs via computer access within the department.
Not all sites are monitored for temperature and humidity after hours or on weekends. There needs to be a plan in place to alert the team if temperature and humidity parameters exceed normal limits. This can be achieved manually or through automation in place to send alerts.

Some reprocessing is taking place in the Operating room, including immediate use flash sterilization in CCMH. The team is encouraged to continue to centralize reprocessing, removing flash sterilization from the OR Suite.

The MDR areas may be staffed by one loan employee and there is a need to continue to have casual and relief staff available and trained to avoid delays and errors.

With the NLHS there is an opportunity across the province to use data now collected on service volumes, to identify workload and needs overall, and plan to address these needs and growth in a prioritized and organized way.

Endoscopy is an area where service numbers and waitlists are being examined within sites to meet needs and improvement. New 'Blitzs' with committed surgeon leadership, where the process to review and triage current waitlists, and had dedicated weeks of service have begun with great success in Labrador Health Centre, and this is now being considered at additional sites. This approach for Endoscopy and its champions should be considered for leading practice sharing.

Equipment purchase, age and need varies site to site. The managing group and leader are highly encouraged to compile and share information regarding state and age of equip that they see as upcoming needs so that purchasing can be prioritized overall, and/or group purchased. For example, 2 of the 3 departments would like a new Scope hanger for endoscopes. Their level of need and current state is different. Assessment should be made as to overall need and which should proceed before the other.

The closer the 3 sites work together toward common goals and needs, the stronger and less onerous the work needed will be.

All sites in the Zone have highly committed staff who go above and beyond (usually alone) to serve their communities. They are interested and engaged in a way that not often found. Thank you!

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:

Point-of-care Testing Services

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

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

- Partnering with clients and families to provide client-centred services throughout the health care encounter.

Decision Support

- Maintaining efficient, secure information systems to support effective service delivery.

Impact on Outcomes

- Using evidence and quality improvement measures to evaluate and improve safety and quality of services.

Medication Management

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

Organ and Tissue Donation

- Providing organ and/or tissue donation services, from identifying and managing potential donors to recovery.

Infection Prevention and Control

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

Diagnostic Services: Imaging

- Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions

Public Health

- Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and to assess, protect, and promote health.

Transfusion Services

- Transfusion Services

Standards Set: Aboriginal Integrated Primary Care - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.2	Information is collected from clients and families, partners, and the community to inform service design.		
Priority Process: Competency			
3.8	Education and training are provided on the organization's ethical decision-making framework.		
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
Priority Process: Episode of Care			
7.12	Ethics-related issues are proactively identified, managed, and addressed.		!
8.15	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.		
9.14	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	9.14.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	9.14.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
10.5	Appropriate follow-up services for the client, where applicable, are coordinated in collaboration with the client, family, other teams, and organizations.		
Priority Process: Decision Support			
13.7	The flow of client information is coordinated among team members and other organizations, in partnership with the client and in accordance with legislation.		
13.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.		!

Priority Process: Impact on Outcomes		
17.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The primary health clinics are located at all sites with in Labrador-Grenfell Zone. In addition, there is very low uptake on patient satisfaction surveys. Information gathered informally from patients and families are therefore used to inform service planning.

The organization is in the initial stages of implementing Patient & Family Experience Advisors (PFEAs). That said, in addition current efforts to solicit participation, the team is encouraged to adopt a more proactive approach to patient advisor recruitment in order to ensure meaningful involvement and to harness the full potential of these partners.

There is an opportunity for this team to actively seek to engage potential partners to facilitate effective co-design. For example, at the Mani Ashini Community Clinic, there's a unique opportunity to involve influential members of the Sheshatshiu Innu First Nation as formal patient partners through intentional, direct engagement.

Priority Process: Competency

Team members receive many training and continuing education opportunities, both on the online learning platform as well as opportunities in-person training.

Although team members receive mandatory training on how to work effectively with indigenous communities, the team is encouraged to pursue its own strategy to involve patients and community representatives at all levels, and to invite indigenous patients to share their healthcare experiences in order to continue to raise awareness and sensibility to the communities' needs.

Team members cannot recall the information received from their initial education on the Ethics framework. The organization is encouraged to explore communication strategies to maintain ethics awareness.

Team members and managers indicate that, since the COVID pandemic and with the amalgamation, team member performance appraisals have not been done consistently. However, despite the lack of formal feedback, team members feel supported by their managers for continued professional growth.

The team is encouraged to consider implementing a team-effectiveness tool that encourages patient and family integration. Although there is an appropriate skill mix of providers, the team is encouraged to continue to develop true interdisciplinary care through integrating mechanisms, shared goals and objectives, and improved collaboration so that members can work together by relying on each other's strengths and areas of expertise.

Priority Process: Episode of Care

Clinics visited indicate have little to no waitlist. Appointments can be given the same day or withing 24 hours. There is also a nurse on call on a 24-hour basis for urgent and emergent situations. Upon confirming appointments, the patient care attendant administers an intake questionnaire by phone, which includes questions on potentially contagious situations.

Although translation services are available, the team indicates that paper versions of patient satisfaction surveys are only available in English, making it inaccessible for some patients from indigenous communities.

The team is gradually rolling out Medication Reconciliation practices, starting with patients returning from hospitals. For this group of patients, during the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers. Any discrepancies are notified to the physician so adjustments can be made. The team is encouraged to continue the rollout of this initiative.

Routine laboratory specimens are transported to St. Anthony for analysis Mondays and Thursdays each week. More specialized tests are transported to St. John's on a weekly basis. The team is encouraged to continue their analysis of the necessity and the feasibility of a point-of-care test strategy for the more commonly required tests, such as Troponin.

The team indicates that although they send patients out to hospitals via Medevac, they are not informed of the return of these patients to the community for follow-up. LG Zone is encouraged to explore strategies by which communication can be made with the primary care team in order to ensure continuity of care for patients.

Priority Process: Decision Support

The primary care team uses the Telus EMR for its clinical documentation. This appears to be quite efficient as team members are not only able to document clinical findings, but also leave each other messages to ensure follow-up.

However, since multiple systems of electronic medical record are used within LG Zone and are not interoperable, team members often do not have access to the complete files of patients. The upcoming implementation of a new EMR for the entire organization will be welcomed solution to centralize access for clinical information.

Although there is a process to evaluate record-keeping practices using chart audits, this process has been inconsistent as managers are waiting for post-amalgamation directives, including where to cosign the results of these audits.

Priority Process: Impact on Outcomes

Although local quality improvement initiatives can be observed (ex. the acquisition of a bed for patients who might have a longer stay at the primary care clinics), there was little evidence that initiatives are data-driven. In addition, the team is encouraged to look for opportunities to integrate patients and their families into quality improvement activities.

Patient safety incidents are recorded. However, the team indicates that not many occurrences are reported each year. The organization is encouraged to pursue an education campaign to ensure awareness of the importance of reporting even minor occurrences in order to contribute to the identification of opportunities for improvement.

Once these opportunities are identified, the organization is encouraged to identify concrete objectives for these initiatives, so that progress toward these goals can be measured and celebrated. The sharing and celebration of quality improvement activities and results with team members as well as patients and their families is important in order to encourage their participation.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
3.6	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
4.9	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
7.1	There is a process to respond to requests for services in a timely way.	
7.2	Hours of operation are flexible and address the needs of the clients and families it serves.	
8.12	Ethics-related issues are proactively identified, managed, and addressed.	!
Priority Process: Decision Support		
13.2	A standardized set of health information is collected to ensure client records are consistent and comparable.	
13.7	The flow of client information is coordinated among team members and other organizations, in partnership with the client and in accordance with legislation.	
13.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
17.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
17.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	

17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.6	New or existing indicator data are used to establish a baseline for each indicator.	
17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This team appears to be committed to use input from clients and their families to inform service design, it is still early on in this process. A Patient & Family Experience Advisor (PFEA) has just recently been assigned to this program, and this PFEA role within this service is still to be further defined. In addition, because of the low rate of return of client satisfaction surveys, the team relies on informal feedback from community partners and patients on which to plan and design services. The team is encouraged to continue to develop the role of PFEA, and to formalize a vision of how feedback from clients can be gathered and used.

The Community Based Mental Health team is located mostly within existing spaces in community clinics. The spaces visited during this survey can be small and not always located with easy access for clients with reduced mobility. The team is encouraged to assess the accessibility of its treatment spaces. In addition, the team is encouraged to ensure that these spaces are adequately adapted to ensure the staff safety.

Team members have demonstrated initiative to participate in community and to seek collaboration from community partners in an effort to promote awareness of mental health. The team is encouraged to find strategies to share these initiatives so that they may be replicated in all regions.

Work and job design of team members vary by region, influenced by population needs but also capacity to recruit. Although there exists a common set of requirements for employment within this team, some flexibility is built into the position descriptions so that employees with diverse profiles can access these opportunities. The team is encouraged to be vigilant to ensure balance between this agility and respecting the scope of services offered by this program.

Priority Process: Competency

Team members indicate having many offers to continuing professional development both via online platforms and in-person training.

Although staff can confirm having received education on the organization's ethical framework, most staff interviewed are not familiar with this framework. The organization is encouraged to pursue opportunities to reinforce communications regarding ethics to ensure that staff is familiar with the process and can recognize ethics dilemma which might require further support.

Most staff and managers report that, since COVID, and because of the high turnover rate of management personnel, most performance appreciation exercises are overdue. Given the context of health human resource rarity, the team is encouraged to seek strategies to resume meaningful discussions with staff to ensure alignment with professional development plans and ambitions to maintain motivation and loyalty.

Despite the overdue formal performance appreciation meetings, staff indicate that managers are supportive and encourage professional development.

Priority Process: Episode of Care

The Doorways program has provided rapid access to mental health screening services to the community, and has served to reduce most wait-lists.

With Doorways, the clients have a point of contact who can guide them through navigation of available services. In addition, clients have a 'safety net', a resource to whom they can turn should they have other concerns/questions. With this, however, the team is encouraged to be vigilant to define the scope of services provided by this team, while at the same time maintaining flexibility to respond to the diverse needs of their clients.

Staff in this program administer standardized tests and evaluation tools. There appears to be different tools used by different members of the team for the same purpose. The team is encouraged to harmonize clinical practice across the zone in order to ensure uniformity of practice and a consistent quality of service.

Priority Process: Decision Support

There is a hybrid system, with parts of the patient document in paper formant and other parts documented electronically. Multiple systems of electronic medical record are used within LG Zone and are not interoperable, team members often do not have access to the complete files of patients. The organization is encouraged to seek to implement a single clinical document in order to ensure adequate communication and documentation amongst team members and programs.

Although there is a process to evaluate record-keeping practices using chart audits, this process has been inconsistent. The leadership of this team is encouraged to ensure that periodic monitoring is done to ensure the quality of clinical documentation.

Although team members all collect similar data from clients for their clinical documentation, the team is encouraged to pursue it's initiative to standardize charting practices by implementing report outlines with specific headings and sections to ensure uniformity amongst team members.

Priority Process: Impact on Outcomes

This team appears to be committed to use input from clients and their families to inform service design, it is still early on in this process.

A Patient & Family Experience Advisor (PFEA) has just recently been assigned to this program, and this PFEA role within this service is still to be further defined. In addition, because of the low rate of return of client satisfaction surveys, the team relies on informal feedback from community partners and patients on which to plan and design services. The team is encouraged to continue to develop the role of PFEA, and to formalize a vision of how feedback from clients can be gathered and used.

Although teams are aware of the procedure to report Patient safety incidents, the team indicates that not many occurrences are reported each year. The organization is encouraged to pursue an education campaign to ensure awareness of the importance of reporting even minor occurrences in order to contribute to the identification of opportunities for improvement.

The team is encouraged to continue to seek ways to seek significant client input. The recent assignment of a Patient & Family Experience Advisor (PFEA) will help to identify a strategy that could address this situation.

With the participation of the PFEA and front-line staff, the team is encouraged to structure a coordinated data-driven quality improvement approach, with concrete objectives and targets. These targets can then be shared with stakeholders including staff and clients to further encourage participation.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	A tailored approach is used to provide critical care to various client populations including neonatal, pediatric, and/or adult clients.	!
1.3	Information is collected from clients and families, partners, and the community to inform service design.	
1.4	Service-specific goals and objectives are developed, with input from clients and families.	
1.6	Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of clients and the community.	
1.7	There is a framework for providing outreach critical care within the organization and/or to other organizations, if applicable.	
2.1	Critical care units are designed with input from clients and families to be self-contained and dedicated to the 24-hour care of clients with life threatening or potentially life threatening conditions.	
2.7	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.9	A universally-accessible environment is created with input from clients and families.	
4.2	There is a process to communicate with admitting and referring team members and family physicians about their respective roles in the client's care.	
4.3	The critical care unit model of care is appropriate to the level of care provided.	
Priority Process: Competency		
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.14	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.6	Standardized communication tools are used to share information about a client's care within and between teams.	!

4.7	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
6.1	There is a process to screen potential clients against admission criteria for critical care.	
6.2	The critical care team works with other teams in the organization to determine the process for monitoring clients that includes escalating care to the critical care unit.	!
7.13	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	
9.6	Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.	!
9.10	The client is regularly screened for delirium and receives interventions to help prevent delirium.	
Priority Process: Decision Support		
13.6	Policies and procedures for securely storing, retaining, and destroying client records are followed.	!
Priority Process: Impact on Outcomes		
15.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
16.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
16.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
16.4	Safety improvement strategies are evaluated with input from clients and families.	!

17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
Priority Process: Organ and Tissue Donation		
12.8	Training and education on organ and tissue donation is provided to the team.	
12.9	Training and education on how to support and provide information to families of potential organ and tissue donors is provided to the team, with input from families.	
12.10	When death is imminent or established for potential donors, the OPO or tissue centre is notified in a timely manner.	
12.12	Data gathered on all ICU deaths is accessible and there is a process for reviewing the data to identify lost opportunities for donation and refer the information appropriately.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ICU provides a wide scope of critical care services to residents within the LG zone. Information is currently not collected and/or available to inform service design and planning.

The ICU follows an open access model of admission. All physicians with admitting privileges (i.e. ED, surgeons, GPs) can directly admit patients to the critical care service. Emergency physicians usually hand-over patient care responsibility to ongoing Emergency physicians each shift. There is also no defined medical director specific to critical care / ICU within the site or zone. Staff report experiencing inconsistent medical practices and challenges most responsible physician for ICU patients.

The unit consists of four critical care beds and one NICU bed which is equipped with telemedicine. The unit is staffed with Registered Nurses consisting of core staff as well as agency staff. Nursing staff complete on-the-job critical care training. There is one Respiratory Therapist on staff for the hospital and provides on-call support to manage ventilated patients. The department has been challenged with recruitment and retention of critical care staff and a focused recruitment and succession planning is needed for all critical care roles.

The ICU unit is self-contained within the hospital. However, the unit is kept unlocked. Open access to the unit and limited staff creates a safety risk to both staff and patients. The organization is recommended to install a locking mechanism to secure the unit.

The department is in a hub and spoke layout with the nursing station in the centre. Patient area use curtains for privacy however this is not ideal from either a confidentiality or an IPAC perspective. There is one patient washroom on the unit. The washroom is small and narrow and unsuitable for patients. Much of the furniture on the unit is wooden and in various states of disrepair.

There is not yet a zone or provincial critical care network or system to monitor critical care beds. The staff and physicians are appreciative of the informal consultations and referral system to closest tertiary centre in St. John's. Establishing a critical care network, formalizing consultation and referral protocols, and advocating for a critical care registry would significantly strengthen critical care service and utilization.

Priority Process: Competency

There have been significant leadership changes within the team. Performance appraisals have not been fully completed. However, staff feedback is provided during staff meetings, emails, and informal discussions. Ongoing opportunities for professional growth and development are offered to staff.

The effectiveness of team collaboration and functioning has not been evaluated. The team is encouraged to assess the team effectiveness and act on identified opportunities for improvement.

Staff in ICU do not consistently use standardized communication tools. The use of available tools to standardize and document communication at shift change and transitions in care is recommended. Team members are pleased with recent enhancements to security at the Charles S. Curtis Memorial Hospital. The presence of on-site security has been well received by staff.

Priority Process: Episode of Care

The ICU team has a dedicated team of health professionals who feel a strong sense of belonging to the both the unit and this community. Clients and families report feeling safe and engaged in their care.

The ICU has an open admission. The unit has a broad scope of services with an admission criterion largely dependant on individual physician clinical assessment. There is no established discharge or step-down criteria for patients transitioning to different levels of care. Defining admission and discharge criteria would help to ensure effective utilization of beds, especially during times of increased patient volumes or reduced staff.

The critical care team is encouraged to explore ways in which they could provide outreach and/or support to other teams in the organization for monitoring clients that includes escalating care to the critical care unit. For example, implementing early warning trigger tools or a rapid assessment response team supported with medical directives may help reduce medical emergencies, augment staffing, and promote bedside shared learning.

There are several available treatment protocols. However, there was inconsistent usage of evidence-informed protocols (i.e. CAUTI, sepsis, delirium screening and management) and guidelines. There is currently only one approved medical directive in place in the organization (1st dose of epinephrin). The consistent use of available resources and the development of medical directives to ensure staff (i.e. nursing and respiratory therapy) can work to their full scope of practice is recommended.

The organization is encouraged to strengthen their partnership with academic and research institutions. Increasing capacity for health professional placements could help with recruitment and provide students a rich learning experience and insight into the challenges and benefits of rural practice.

Priority Process: Decision Support

Documentation in the ICU is paper-based. There are a number of forms used to document client care. The Kardex, medication record, and 24-hour assessment flow sheets are completed consistently however, forms are each kept in separate binders making it cumbersome to review the client record in its entirety. When not in use, clients current and previous chart is kept on an open and accessible shelf not compliant with privacy regulations. The organization is recommended to use a closed cart of cabinet for active client files to maintain patient confidentiality.

With the planned implementation of an electronic health record (EPIC), the team is recommended to explore ways in which to standardize and streamline documentation across NLHS critical care units.

Staff handover report is not currently conducted at the bedside or through verbal staff-to-staff exchange of pertinent information. Currently, staff write patient information on a separate paper that is not part of the health record. This practice is not consistent with best practice. Leadership is strongly recommended to revisit the way in which transfer of accountability occurs and establish a consistent process and practice is used, ideally at the bedside, and inclusive of clients and/or family.

Priority Process: Impact on Outcomes

The team does not currently report having a standardized way in which to review, select, and implement evidence-informed guidelines in ICU. Staff are aware of clinical practices that have the potential to reduce catheter and ventilator associated infections, and to manage sepsis. However, staff were unable to provide evidence of consistent use of clinical tools.

With the current open model of care and admitting physicians this could lead to increased variation in practice and clinical outcomes. The zone leadership is recommended to formalize partnerships with other critical care centres and establish a way in which to implement best practices in critical care.

Staff in the department report incidents using the electronic reporting system. Incidents are disclosed to patients and families and actions are taken to make improvements as identified. There are some metrics available to the team. Using evidence to inform planning and improvement activities could be strengthened, The department would also benefit from engaging patients in ICU specific safety and quality improvement activities.

The team could consider implementing an ICU unit-based quality counsel, with local patient advisors as members, to help foster a proactive approach to quality improvement and risk management.

Priority Process: Organ and Tissue Donation

Policies and procedures on organ and tissue donation are in place. The team are generally aware of organ and tissue donation procedures however, reportedly rarely discuss organ donation with patients/families, or the care team. Information regarding clinical triggers and lost opportunities for donation are currently not being monitored.

There is an opportunity to provide education and training to clinical, transport teams, and public regarding organ and tissue donation to strengthen this program potential across sites.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
15.6	Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The Diagnostic Imaging services in Labrador-Grenfell Zone have long been supported provincially. This positive feature will advance with the recent amalgamation of regional health authorities.

An off-site radiology team from Eastern Zone supports the Charles S. Memorial Hospital. The team is diligently working towards being a designated breast screening centre. We commend the team for their unwavering commitment to patient—and family-centred care. Their dedication is evident in their efforts to bring as many services as possible close to home, and we encourage them to explore other ways in which technology (e.g., telemedicine) could be used to expand the scope of services.

A clear organizational structure has been created with the provincialization of diagnostic imaging services. NL Health Services is still recruiting for medical leadership positions within the newly defined structure.

Policy and procedures for notification of critical, urgent findings are outlined. The radiologist interpreting the exam first attempts to contact the ordering provider. If they cannot be reached, the radiologist contacts the patient directly, and arrangements are made to ensure the patient is directed to receive appropriate care.

It's important to note that there is regular albeit informal communication and input from referring medical professionals regarding improvement opportunities and delays. To further enhance this, we strongly encourage the team to formalize a process for incident reporting. This will help track trends and make necessary improvements as indicated.

However, the team reports that a provincial quality dashboard has been developed and is currently being tested. The dashboard reports data from Meditech for each location, as well as wait times and other KPIs. The team considers various service access barriers and develops business cases and/or requests to support change. For example, in the stroke program, 5 of 6 staff completed additional training in CT for the EVT program and hired a regional ECHO technologist to travel between hospitals to provide ECHO service.

Wait times are monitored internally via a dashboard. Benchmarks for routine and emergent wait times are based on the standards outlined by the Canadian Association of Radiologists. Requisitions are placed on a priority scale of 1-6. The approach is consistent provincially.

The Labrador-Grenfell Zone has proactively pursued staff cross-training across imaging modalities, and this approach should be lauded. Several Medical Radiation Technologists members can provide X-rays, mammograms, ultrasounds, and CT imaging.

The team is encouraged to move forward with plans for international recruitment. A focused and documented recruitment plan is recommended.

The organization may wish to consider a few areas for improvement.

First, a high-falls-risk patient presented to the department during the tracer. It wasn't apparent that any screening regarding fall risk occurred as a matter of routine process. Reinforcing the importance of fall prevention should be considered.

There is an opportunity for collaboration between Diagnostic Imaging and the emergency department to simulate a medical emergency occurring in DI and how this would be managed between the different departments.

Finally, limited diagnostic imaging availability is on weekends due to human resource challenges. The busy emergency departments often divert patients to return for imaging during the week. Not only does this carry medico-legal risk for the providers and the organization, but it is inconvenient for patients and impacts patient flow. Efforts to recruit another medical radiation technologist should be prioritized. Scheduling an MRT to work on the weekends, when some routine scans could also be booked to distribute the workload, could be an interim measure to address flow and risk.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
1.5	Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of clients and the community.	
1.6	The role of the emergency department in the organization's all-hazard disaster and emergency response plan is clearly defined.	!
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
6.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
4.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
5.4	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
5.6	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
6.1	The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	

6.3	Workload is assessed and team members are reassigned as required during periods of high volume and surges in the emergency department.	
Priority Process: Episode of Care		
7.1	Entrance(s) to the emergency department are clearly marked and accessible.	!
8.1	The Canadian Triage and Acuity Scale (CTAS) is used to conduct the triage assessment.	
8.2	The Pediatric-CTAS is used to conduct the triage assessment of pediatric clients.	
8.3	A triage assessment for each client is completed and documented within CTAS timelines, and in partnership with the client and family.	!
8.4	A triage assessment for each pediatric client is conducted within P-CTAS timelines, and in partnership with the client and family.	!
8.8	Clients waiting in the emergency department are monitored for possible deterioration of condition and are reassessed as appropriate.	
10.2	The assessment process is designed with input from clients and families.	
10.11	Priority access to diagnostic services and laboratory testing and results is available 24 hours a day, 7 days a week.	!
12.3	Client privacy is respected during registration.	
12.7	Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.	!
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
14.2	A standardized set of health information is collected to ensure client records are consistent and comparable.	
Priority Process: Impact on Outcomes		
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
18.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	

18.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.5	Ambulance offload response times are measured and used to set target times for clients brought to the emergency department by EMS.	
18.6	Data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen is tracked and benchmarked.	
18.7	Quality improvement activities are designed and tested to meet objectives.	!
18.8	New or existing indicator data are used to establish a baseline for each indicator.	
18.10	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
18.11	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		
11.6	Training and education on how to support and provide information to families of potential organ and tissue donors is provided to the team, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Patient engagement surveys are collected, but there is no evidence that patient perspectives inform service design or that changes occur as a result. Patients and their families should be meaningfully engaged in co-design to achieve optimal outcomes.

Through enhanced social work services dedicated to the emergency department at the Labrador Health Centre specifically, there is an opportunity to strengthen relationships with community partners and primary care to discharge and divert patients from the emergency department.

The space in the emergency departments at the Labrador Health Centre and Charles S. Curtis Memorial Hospital does not appear to adequately meet the needs of the people using this space (staff and patients). The staff raised numerous concerns about space, layout, processes and staffing models. The organization is encouraged to undertake additional process improvement events, such a Kaizen improvement event, to reimagine the space and processes to optimize flow within the department. This would be an excellent opportunity to co-design with patient and family partners while engaging front-line healthcare providers in process improvements.

While the Labrador West Health Centre has better space, this site would also benefit from identifying a rapid assessment space for low-acuity patients within the department using similar tools and engagement.

Priority Process: Competency

Physicians, medical learners, and nurses work collaboratively to provide care in the emergency department. Nursing at all sites advocated for additional nursing resources. However, there isn't evidence to support that additional nursing resources are actually needed. Rather, team effectiveness and optimization of current staffing resources and processes should be the focus in the near future.

There is an opportunity to improve communications and situational awareness within the emergency departments in the Labrador-Grenfell Zone by implementing daily visual management through twice-daily huddles following shift change at a huddle board. Nurses, physicians, clerical staff, housekeeping, social work, EMS staff and leadership should all attend so that there is a shared mental model about what the department is collectively facing. This provides the opportunity to share new initiatives, report on data and metrics, problem-solve staffing shortages and understand patient flow challenges. There is an opportunity to ask questions and share ideas.

The heavy reliance on casual and locum nursing staff within the emergency department at the Labrador Health Centre should concern the organization. There are only two permanent full-time registered nurses in the emergency department. Further, the financial incentive provided to casual and locum nursing disincentivizes a move towards more stable staffing. The organization should take a systematic approach to moving casual nurses to full-time roles and discontinuing incentives to non-permanent roles to ultimately create stability in the workforce and improve morale in the long term amongst members.

There is an opportunity to better define paramedics' role in the emergency department when not dispatched to a call. Currently, the department takes an inconsistent approach to this role. The team's effectiveness should be further evaluated, and paramedics should be more clearly integrated into the care team.

The team at the Labrador Health Centre also mentioned that social work is situated in the ER but due to shortage has been providing support on the inpatients units. There is an opportunity to evaluate how team collaboration can work to utilize social work services to better match emergency department patients to appropriate community resources.

Priority Process: Episode of Care

While there are reports that CTAS is used by nursing at triage, the data doesn't support the fact that it is consistently happening. This is particularly true at the Charles S. Curtis Memorial Hospital and the Labrador Health Centre.

CTAS should be supported by electronic tools, either on a computer or a mobile device, to ensure that it is conducted in a standardized and consistent manner that is simple to record, track, and monitor.

It is understood that nursing may be hesitant to record CTAS scores consistently, but scoring and tracking should be non-negotiable, and performance should be managed if the omissions continue.

While nursing reassesses patients regularly, patients at the Labrador Health Centre are placed in a hallway external to the department after being triaged. There is no clear line of site from any emergency department personnel, which presents a risk for deterioration without appropriate monitoring.

At the Labrador Health Centre, efforts have been made to improve confidentiality; however, no evidence exists that patients and families were involved in the work. The triage and registration process violates confidentiality. Further, patients told me they are hesitant to go to the emergency department because they can overhear nursing staff conversations about patients being cared for in the department.

A few treatment protocols and order sets have been established, but they are used inconsistently. With the launch of NL Health Services, there is an opportunity to establish and adopt provincial treatment protocols, order sets, and medical directives, allowing for more standardized and consistent care provision.

There is evidence that suicide screening occurs according to the organization's policies and procedures. However, the organization is encouraged to implement universal mental health screening for all patients presenting to the emergency department so that those at risk of suicide are consistently identified. This could include a simple question at triage or during the RN's primary assessment that enquires about mental health concerns. Asking about mental health should be normalized and akin to asking if a patient has a headache or chest pain.

While diagnostic imaging and laboratory services are available 24/7, technicians are not in-house in category A hospitals during the evenings and/or weekends. Many patients are sent home without imaging or laboratory investigations performed and instructed to return on Monday, which presents medico-legal and system flow challenges for the organization. The organization is urged to consider evening and weekend staffing as human resources challenges allow.

Priority Process: Decision Support

Due to the limitations of predominantly paper-based charting and documentation, health information is not collected consistently, and medical records are not maintained at the level expected in modern times.

There is a lack of integrated electronic medical systems in the Labrador-Grenfell Zone. However, it is encouraging that the organization will become digitized when EPIC launches across the province in the upcoming years.

Priority Process: Impact on Outcomes

There needs to be a concerted focus on quality improvement within Labrador-Grenfell Zone. Across multiple areas of the zone, there was a lack of understanding about quality improvement when leaders and front-line healthcare workers were asked about quality improvement initiatives. In fact, in multiple instances, team members confused quality improvement for quality assurance. Without the basic literacy in quality improvement and understanding of the tools needed to tackle wicked problems facing the organization, it is unlikely that the improvements will be realized.

Some protocols and produres exist but are not consistently followed by all members of the team. Expanding the protocols and procedures used in the emergency department to standardize care is an opportunity. It is anticipated that this will occur with the development of some provincial order sets, medical directives, and procedures.

There is no evidence of quality improvement initiatives that have recently occurred in the emergency department.

Basic emergency department metrics and data are not collected, measured or tracked to inform system performance. The lack of triage data is inexcusable, and a deeper dive using Lean tools and methodologies could be utilized to uncover both problems and solutions. Acuity mix, case mix index, time to physician initial assessment, low acuity non-admit length of stay, high acuity non-admit length of stay, admitted patient length of stay and time to inpatient bed following the decision to accept the patient should be the basis of understanding emergency department flow performance. Targets should be established against current timeframes and best practice recommendations to inform performance.

Priority Process: Organ and Tissue Donation

While processes and policies exist to support organ donation, staff are not aware of what they should do if someone wishes to be an organ donor. There is an opportunity to educate staff and increase awareness about organ donation across the zone.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Transport planning is undertaken with input from patients, families, and partners.	
1.5	Demand for services is regularly reviewed against the deployment plan and adjustments are made as necessary.	
2.1	There are formal mutual aid policies and agreements with neighbouring EMS and transport teams that describe how to initiate and respond to mutual aid requests.	
3.2	There is a communications policy for sharing information and raising awareness about the services the team provides.	
Priority Process: Competency		
5.4	Education and training are provided to team members on how to work respectfully and effectively with patients and families with diverse cultural backgrounds, religious beliefs, and care needs.	
5.8	Education and training are provided on the organization's ethical decision-making framework.	
5.20	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.21	Patient and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
5.22	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
6.5	Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		

Priority Process: Impact on Outcomes		
27.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from patients and families, team members, and partners.	
27.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from patients and families.	
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from patients and families.	
27.6	Quality improvement activities are designed and tested to meet objectives.	!
27.7	New or existing indicator data are used to establish a baseline for each indicator.	
27.8	There is a process to regularly collect indicator data and track progress.	
27.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
27.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
27.11	Information about quality improvement activities, results, and learnings is shared with patients, families, teams, organization leaders, and other organizations, as appropriate.	
27.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from patients and families.	
Priority Process: Medication Management		

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

EMS services in Newfoundland and Labrador are undergoing transformation. Recent initiatives to provincialize and standardize services have fundamentally changed some service elements within the Labrador-Grenfell Zone. These changes hold promise and have garnered enthusiasm from leadership and front-line providers.

June of this year saw the launch of a provincial 9-1-1 call system for emergencies province-wide, with central dispatch marking a departure of local arrangements for dispatch. Local communities are generally embracing this change; however, further public messaging would benefit them by helping them understand the importance of this change and how the system works to promote service improvements and care.

With all changes, leadership at all levels will need to ensure staff can manage their workload and maintain work-life balance.

There is a written response and deployment plan for paramedic services in the province of Newfoundland and Labrador that has not been updated since 2006. As the province moves towards a more consistent approach to EMS services across zones, there is an opportunity to produce a response and deployment plan with specific details about the zones and their unique resources and service demands. However, at present there is no evidence that demand for services is reviewed against the 2006 Paramedic Services Plan.

With the move to provincial oversight, there are intentions to better integrate patients and families into the EMS processes. However, the involvement of patients and families in transport planning has not occurred to date, and this remains an opportunity for improvement.

Awareness of the role of EMS and safety promotion through outreach events occurs ad hoc. A more streamlined and standardized approach could be taken to community outreach.

Provincial medical oversight for EMS in Newfoundland and Labrador is led by a Provincial Medical Director and Assistant Provincial Medical Director with formal training in transport medicine. This oversight preceded the amalgamation of the regional health authorities. This positive formal structure provides consistent and standardized clinical support and consistent protocols to paramedic teams.

Priority Process: Competency

Paramedic staff do not consistently participate in emergency department functions while not responding to calls. This is specifically true at the Labrador Health Centre, where it was noted that the staff are inconsistent in fulfilling tasks within the department. Clearly defined roles and expectations are needed for paramedics working within the emergency departments. This effectively builds team and collaboration, integrates services, maintains skills, and responds to workload demands locally. There is an excellent opportunity for this model to succeed if the staff are set up for success through clearly defined position profiles with defined roles, responsibilities and expectations.

Performance evaluations are not being conducted annually, as is the expectation outlined in the most recent human resource policy on performance evaluations.

The service is recommended to develop a structure and process for offering a post-incident debrief following difficult and/or traumatic events. Additionally, the distribution of ‘mental health matters’ cards to first responders and doorways programs has made an important contribution to supporting the mental health of paramedics.

Priority Process: Episode of Care

Over the past year, many changes have been made to standardize EMS and transport care provincially through NL Health Services, with the launch of major initiatives just this month, including centralized dispatch.

The move to a provincial Personal Health Record (PHR) is a positive one that strengthens standardized communication. This will be further strengthened once the electronic PHR rolls out provincially. EMS services in NL Health Services may consider implementing a standardized transfer of information tool such as ATMIST AMBO or a standard SBAR format to ensure that the verbal handover of information is standardized for consistency of care transition.

There is concern about the ability of the emergency department staff to receive alerts from EMS now that they are not involved in dispatch processes because they are often not at the desk to answer the phone when it rings in the department. Further, there are areas of the ED where cell phone coverage is spotty. The emergency department sites should implement a process of calling a dedicated cell phone that is only called by EMS and carried on shift by a registered nurse. Cell phone coverage within the ED must improve for this to work. In the interim, a number could be called where someone is consistently at a desk and could answer the phone.

Priority Process: Decision Support

The move to a provincial Personal Health Record (PHR) is a positive one that strengthens standardized communication. This will be further strengthened once the electronic PHR rolls out provincially. EMS services in NL Health Services may consider implementing a standardized transfer of information tool such as ATMIST AMBO or a standard SBAR format to ensure that the verbal handover of information is standardized for consistency of care transition.

Priority Process: Impact on Outcomes

There needs to be a concerted focus on quality improvement within Labrador-Grenfell Zone. Across multiple areas of the zone, there was a lack of understanding about quality improvement when leaders and front-line healthcare workers were asked about quality improvement initiatives. In multiple instances, team members confused quality improvement for quality assurance. Without the basic literacy in quality improvement and understanding of the tools needed to tackle wicked problems facing the organization, it is unlikely that the improvements will be realized.

Priority Process: Medication Management

There were no concerns regarding medical management.

Priority Process: Infection Prevention and Control

Regular inspections of the ambulance units occur with a regular cadence of cleaning, including deep cleaning of the units. This process is standardized. The local leadership in Labrador-Grenfell Zone should be commended for their innovation in creating an electronic checklist that team members complete. The checklist auto-populates the results into an email to their supervising manager. This innovation could be adopted more broadly in a single health authority.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	

15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Home care team in CCMH provides holistic, coordinated care in a collaborative way to ensure the individualized needs of their patients are met. They are challenged with the vast geographical area and variable weather conditions but manage to provide the necessary services in creative ways. The team struggles with resource issues but overcome the shortages by providing care with a team approach. In some regions, there is a gap in resources for PCA, Social Work and Nurse Practitioner positions that creates a need for everyone on the team to do more.

The team recently integrated Patient & Family Experience Advisor (PFEA) at its Accreditation committee. In addition, the team struggles to get feedback through surveys therefore there is not specific indicators tracked for improvement opportunities. It is worth mentioning that, in order to compensate for the low rate of return for the electronically administered satisfaction surveys, the team did attempt to mailout paper versions. The return rate of these surveys was approximately 50%.

The Person and Family Centered approach framework/model is new (since 2022)- “Nothing About Me Without Me” to help guide practice. The goal of the model is to engage clients, families, partners, and community members in partnering and collaborating to improve healthcare services, experiences, and outcomes. Part of the model is the new Patient and Family Advisor program where patient partners would align with programs to have input into policies and procedures

In order to help guide clinical decision making and define scope of service for providers, as well as to eventually measure the effectiveness of its interventions, the team is encouraged to develop service-specific goals and objectives with input from clients and families. Service effectiveness is currently evaluated via informal feedback from patients to providers.

Guidelines exist for healthcare staffing agencies contracted by LG Zone. However, self-managed contracts by clients and their families with provider agencies are not monitored.

Case managers and team members often go “above and beyond”, and use their creativity to assist clients to resolve sometimes non-health-related issues. Given the rarity of health human resources, the team is encouraged to review the staff mix including the use of support staff with input from clients and families in order to ensure optimization of the scope of practice of all staff.

Although teams are geographically very dispersed, the leadership of the team has created numerous opportunities for team development such as weekly huddles and monthly meetings.

Priority Process: Competency

There is a process for evaluating, auditing RAI and giving feedback to individuals completing this tool. There is no auditing of the CRMS at this time. As the Province moves towards EPIC for documentation there will be better collaboration and accessibility to health records as well as an opportunity for auditing processes to be put in place.

Although team members have received the education on the ethics framework, the team is encouraged to pursue continuing training in order to maintain awareness so that team members will be able to recognize potential ethical dilemmas and will know the process to seek support.

The Home Care team just received new infusion pumps. Team members indicate having received ample training, and a plan is in place for re-training every 2 years.

Despite the tardiness of performance discussions, management appears to have a supportive approach with staff with respect to professional development.

Case managers and team members often go “above and beyond”, and use their creativity to assist clients to resolve sometimes non-health-related issues. Given the rarity of health human resources, the team is encouraged to review the staff mix including the use of support staff with input from clients and families in order to ensure optimization of the scope of practice of all staff.

Team members often work in remote and isolated communities with limited cellular phone and internet coverage. To try to minimize risk to personnel, the team has put in place safeguards such as home safety risk assessments, check-ins with the office, satellite phones to certain staff, etc. The team is encouraged to continue to be vigilant, and continue to seek additional strategies to ensure that risks to staff safety is minimized.

Priority Process: Episode of Care

Upon reception of a request for service, staff determine if it is a service that Community Supports provides. Staff state they initiate the process by contacting the client and completing an intake

assessment using either a RAI-CA or an intake screening tool created for clients with intellectual disabilities. Based on the outcome, a referral is made to the appropriate case manager (nurse or social worker based on client needs) for full RAI-HC assessment. If the need for home supports is identified at that time, a financial assessment is then completed as per provincial program guidelines.

Relationship with clients and families appear open, transparent and respectful. Patient expresses ability to dictate/determine some treatments, or at least negotiate with providers.

Although team members have received the education on the ethics framework, the team is encouraged to pursue continuing training in order to maintain awareness so that team members will be able to recognize potential ethical dilemmas and will know the process to seek support.

Services are provided by professionals from various disciplines. This interdisciplinary collaborative practice can be further enhanced by the eventual implementation of a single electronic medical record to facilitate communication and documentation of team objectives.

Priority Process: Decision Support

The team has a hybrid patient record, some information being documented in an electronic medical record, while others are kept in paper format. Each professional has their own paper chart of their evaluations, and documents pertinent to their work. As the Province moves towards EPIC for documentation there will be better collaboration and accessibility to health records.

Currently, there is a process in place for evaluating, auditing RAI and giving feedback to individuals completing this tool. However, there was no evidence of auditing of the CRMS or paper charts held by the professionals at this time. The team is encouraged to look for opportunities to implement audits to ensure compliance with documentation policies as well as consistency across the team.

Priority Process: Impact on Outcomes

Services are very personalized to meet needs of patients. However, the team is encouraged to develop protocols from which teams could base in order to ensure minimum quality of interventions and equity amongst clients.

Home safety risk assessments are done for each patient prior to initiation of services, and also on a regular basis. Although teams are familiar with the process to document and address client safety incidents (occurrences), very few reports are filed each year.

The team is encouraged to pursue training to team members, in order to raise awareness of the importance of reporting even minor occurrences or near-misses, to contribute to the identification of quality improvement opportunities.

To this end, the team is also encouraged to continue to seek ways to seek significant client input. The recent assignment of a Patient & Family Experience Advisor (PFEA) will help to identify a strategy that could address this situation.

With the participation of the PFEA and front-line staff, the team is encouraged to structure a coordinated data-driven quality improvement approach, with concrete objectives and targets. These targets can then be shared with partners including staff and clients to further encourage participation.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
9.1	The areas in the physical environment are categorized based on the risk of infection to determine the necessary frequency of cleaning, the level of disinfection, and the number of environmental services team members required.	!
9.5	Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.	
14.1	There is a quality improvement plan for the IPC program.	!
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

The Infection prevention and control (IPAC) program includes a strong and collaborative team from across the organization. The IPAC team has access to the infectious diseases physician for questions, but it does not appear as though the infectious diseases physician is embedded for interprofessional collaboration. As well, there appears to be lack of routine IPAC and OHS team collaboration to maintain optimal environmental conditions for patients and staff.

There is a gap in meaningful engagement of point of care/ clinical nurses, patients, and families in strategies to promote IPAC or address increased prevalence. The IPAC team develops strategies for versus with and in collaboration of these groups. In smaller sites increasing access to consultative service and being involved in developing IPAC approaches was an identified need.

IPAC practitioners, Nutritional, and Environmental Services have partnered to complete audits and share results with teams and individual staff. The approach has led to a culture of pride in individual and team performance. Environmental and Nutrition services leadership is committed to a high-quality environmental services, food safety, laundry, and waste management.

Hand-hygiene compliance is measured using direct observation by IPAC practitioners, Environmental and Nutrition services leadership. The four moments for hand hygiene are used in education content delivered to teams and volunteers. In the moment education is provided for opportunity one and four by hand

hygiene auditors when an opportunity is missed. Hand-hygiene compliance results are shared with team members and posted on huddle boards. Hand-hygiene compliance rates are generally variable across the organization and sites (e.g January to March 2024 rates were between 74-83%). Compliance rates are given to unit leaders, but it was unclear how or if those rated were used to make improvements to or sustain hand hygiene compliance. There was some concern that hand-hygiene compliance may be falsely elevated where staff are aware that an audit is taking place. Supplementing the current formal audits with a hand-hygiene champion audits of clinical nurses, front line leaders and volunteers may assist with capturing hand-hygiene compliance. Increasing visibility of hand-hygiene trends within the departments would increase transparency to staff, patients, and families.

The IPAC team is actively sought out for their expertise in any physical environment challenges, planning and designing construction and renovations. This includes varied scopes of initiatives from minor renovations to large scale construction. Some support is available from NL Health Services centralized resources, but developing increased expertise and specialization in rural specific experiences and challenges would optimize the impact of this zone's IPAC team.

IPAC teams does not have a quality improvement (QI) plan, although in 2023 there IPAC planning goals developed.

High priority IPAC consideration would include a developing a mechanism to ensure clarity regarding “clean” and “dirty” equipment. An initiative such as a “clean” sticker on equipment (e.g. beds, assistive devices) would validate that Environmental Services had cleaned the device prior to use or confirm that the point of care clinician that the device is dirty.

High priority IPAC challenges moving forward include physical space and infrastructure in vintage buildings. There were several examples of paper posters and patient room furnishings with fabric in poor condition making proper cleaning difficult and risking entry and accumulation of microorganisms at the point of patient care. Furnishings, surfaces, finishes, and equipment should be able to withstand repeated cleaning and be compatible with hospital detergents, cleaners, and disinfectants. Items with torn fabric or scratched or chipped surfaces should be removed from the patient care setting and repaired or discarded.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Service-specific goals and objectives are developed, with input from clients and families.	
1.6	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
4.1	Education and training are provided on how to work with pediatric and youth clients to ensure safe and effective care.	!
Priority Process: Episode of Care		
7.1	There is a process to respond to requests for services in a timely way.	
8.7	Translation and interpretation services are available for clients and families as needed.	
9.2	A comprehensive geriatric needs assessment is completed, when appropriate, in partnership with the client and family.	!
9.3	The inpatient services team works with the emergency department team to initiate the geriatric needs assessment, where appropriate, for clients who enter into the organization through the emergency department.	!
9.14	Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.	
10.6	Clients who have received sedatives or narcotics are monitored.	!

11.8	The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.	!
Priority Process: Decision Support		
12.1	An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.	!
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
14.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
15.4	Safety improvement strategies are evaluated with input from clients and families.	!
15.5	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	!
15.6	There is a process to ensure client safety and effective client monitoring when the client is receiving care off service.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!

16.9	Information and data on bed availability is collected and used for quality improvement initiatives in collaboration with organizational leaders, and with input from clients and families.	!
16.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Leadership is stretched throughout the organizations that were surveyed, and this is felt most at the point of care. Many positions also hold other roles due to vacancies. Some Leaders who are in place, will get pulled to take a patient load to cover staffing needs at the bedside. There has been a great deal of turnover within these positions which can be a frustration for frontline staff.

There is a dedicated leadership team, committed to ensuring safe delivery of care to patients admitted to Charles S. Curtis Memorial Hospital (CCMH). Inpatient care is provided within 38 beds divided onto two separate units and having 2 LDR rooms dedicated for obstetrical care. The team divides patients into acute and medically stable to ensure appropriate staffing to care for the patients on the individual units. This causes extra work and moving of patients to the appropriate designation. Within the acute unit the team cares for paediatric, maternal/child, medical, surgical, and mental health patients. There is a seclusion room on the unit that can be used if needed following set criteria.

The department has improvement projects but no specific goals and objectives identified. Other than survey data no indication of soliciting input from patients and families on goals and objectives. There is no proactive or formalized engagement with patients and families. There is a heavy reliance on the complaint process and survey information to solicit input from patients and families.

Patients and families, the team, and community partners should be involved in developing team goals and objectives that align with the organization's strategic direction and further with the regional/provincial direction. The Person and Family Centered approach framework/model is new (since 2022)- "Nothing About Me Without Me" to help guide practice. The goal of the model is to engage clients, families, partners, and community members in partnering and collaborating to improve healthcare services, experiences, and outcomes. Part of the model is a Patient and Family Advisor program where patient partners would align with programs to have input into policies and procedures, planning, evaluation or design for Inpatient Services. Patients and families can provide valuable input regarding education and training that could benefit team members and enhance services. Examples include identifying a need for training on working with patients with diverse cultural backgrounds, religious beliefs, and care needs.

Priority Process: Competency

The team has developed a very comprehensive orientation program designed to ensure staff are confident and competent to provide care on the unit. Ongoing education ensures that staff have additional skills to provide safe care. The team has expected competencies that they must demonstrate as they progress from novice to competent in all aspects of care on the unit. The team monitors staff progression to ensure an appropriate skill mix to meet the needs of the patients cared for on the units. There needs to be more educational opportunities to ensure staff feel competent and confident to deliver safe care for the pediatric population. The team is encouraged to develop a strategy to foster this education.

There are additional tools available that could assist new staff to recognize patients that may be deteriorating. Consider the use of a Paediatric Early Warning Signs (PEWS). The goal of PEWS is to provide an assessment tool that can be used by multiple specialties and units to objectively determine the overall status of the patient and guide interventions using a response algorithm to improve outcomes. For adults there is a Modified Early Warning System (MEWS) that is a simple, bedside scoring index that evaluates the patient's physiological state based on objective clinical findings to identify an escalation pathway for review of the patient.

There is evidence of a documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, training, evaluation of competence and a process to report problems with infusion pump use is implemented. This is in alignment with the organization's strategy for infusion pump safety.

There is a strong leadership presence within the in-patient program to help support staff and guide practice at CCMH. The expectation is to provide formal feedback to staff annually however it has not been a current priority. The team is encouraged to continue to move this project forward and imbed into routine practice. Staff interviewed felt like they received informal feedback but were looking for more feedback on performance.

At the Labrador Health Centre in Goose Bay there appears to be some gaps in preparation for roles, or preparation for times of overcapacity and pressure as exists now. This impacts flow, and timely or appropriate decision making on a day-to-day basis. For example, it would be helpful to prepare the ER/PCU social worker with added support or mentorship to enable leadership of the daily patient review process, and demonstrate work step by step, in a timely way, to achieve discharge, placement goals or ongoing momentum to address care needs. The Social worker as a lead in this work would benefit from a learning visit to a colleague in a similar position and community who is achieving improved results. This is a time where these pressures are relatively new and it is not unusual that support for learning and acquiring tools for the tool box will be helpful

The team has adopted standardized tools for transition between care providers and other teams. The tools were observed to be consistently used. Consider the implementation of bedside shift report to continue to improve delivery of safe patient care. White boards in patient rooms are used as a communication tool for patients and were noted to be consistently filled out.

Priority Process: Episode of Care

Heart Force One is an important innovation in Newfoundland and Labrador, established in January 2023, which provides cardiac patients across the province with timely access to cardiac catheterization procedures. From April 1, 2023, to March 31, 2024, 16 patients from the Labrador-Grenfell Zone accessed this service. Specific criteria (i.e., no chest pain, being able to sit, not requiring continuous monitoring while on the flight) must be met to be transported via this mode of transport. While this initiative is laudable, it isn't without challenges, as patients are still waiting a disproportionately long time in a medical bed for transport. There is an opportunity to refine the processes, criteria, and resources so that patients waiting for angiograms in acute care beds are transported in a timelier manner, and the impact on flow is mitigated. There is a goal to create equity regarding cath lab access, but that hasn't yet been achieved. Fundamentally, tertiary beds are a resource to the people of the province as a whole, not to the large urban centre primarily and periphery secondarily. That notion must be reinforced and championed to achieve bed access equity in tertiary centres.

The team reports frustration in the ability to transfer to a higher level of care for patients requiring additional supports. There is a process to respond to requests for services, but these are not timely related to barriers outlined in policy and with transportation. Transport delays such as pilot time outs, weather, and available flights delay access to timely care. Available beds in the tertiary care centre also delays access to services, in some examples provided some services at the tertiary centre could be a same day service (e.g. cath lab) but requires an inpatient bed at the other centre to receive the service (versus a treat and return or treat and discharge). In some examples patients cannot be discharged from their inpatient bed or they will lose their priority status on the wait list. To help mitigate some of the risk associated with managing these high-risk patients there is now the ability to link with specialists via telehealth.

The physician team also reports very collegial relationships where teams come together to ensure patients are cared for. Recruitment and retention for staff and physicians is an ongoing challenge. More efforts need to go into supporting recruitment of both physicians and staff. Consider asking staff what they need to remain in the facility. Staff reported working in continuous part-time (CPT) lines with FT hours. There was a desire to secure a FT line with benefits but there was not the ability to move into these positions. It is important to review the PT to FT compliment to ensure there is the right mix. Look at where agency/traveling nurses can be replaced with unit specific FT lines.

Physicians are experiencing severe shortages leaving solo specialty positions causing increased call and potential burn-out. Review what can help to recruit new physicians, survey current physicians for initiatives and incentives that will encourage them to remain at CCMH.

Many unmet areas in the Episode of care could be met if Protocols were developed and used consistently for identified situations. This applies to staff and leaders.Despite this, patients shared their appreciation for care of staff and the good work they do.

Current translation services should be reviewed to understand if they are meeting the needs of a changing population to ensure good communication. Review new technology to understand if it is appropriate in your setting.

Comprehensive geriatric needs assessment not currently available. Components incorporated into individual clinician practices but no standardized or consistently applied. Social work support in the ED and post ALC designation, but there needs to be a focus on acute care of the geriatric patient to prevent functional decline, poly-pharmacy assessment, and avoidance of institutionalization. The team recognizes that there is a changing community demographic resulting in older patients presenting to ED. A more thorough geriatric needs assessment needs to begin in ED and CCMH is mobilizing resources to make the necessary resources available to aid in assessment of seniors with chronic and complex health issues, with a goal of reducing hospital admissions and improving quality of life for patients and their caregivers by connecting them with appropriate resources. The team is encouraged to continue to make this a priority.

Lab and diagnostic imaging (DIRAD) are available during regular working hours, on-call after hours and weekends. All DIRAD staff can perform x-rays and a head CT without contrast (for Code Stroke). Other after-hours procedures will depend on the area of expertise of the staff member on-call (e.g. ultrasound, CT, ECHO). Physicians report necessary laboratory testing used as a diagnostic tool can sometimes be delayed leading to frustration. There are challenges to ensuring timely access to some testing and expert consultation to support comprehensive assessment and care planning. Barriers related to tertiary care capacity, travel delays and access to required health human resources. The team is encouraged to monitor after hour usage of DIRAD to understand where gaps may be apparent that can be addressed.

Priority Process: Decision Support

The team is currently working towards upgrading the organizational health information system. Current state is a hybrid of paper and electronic documentations. A more robust system can help coordination of care and improve patient outcomes. The desire is for the new system to facilitate clear and comprehensive documentation of all aspects of patient care including care planning and the transition of patients from one area of care to another. EPIC has been chosen as the electronic health record of choice for the province. The team recognizes the amount of work and effort that lies ahead. Staff are looking forward to this change. Recommended is clear and consistent communication to staff regarding the upcoming changes and the impact to their workflow to ensure success. Ensure that all stakeholders are included in the planning and implementation of a new system.

There is no proactive or formalized engagement with patients and families. There is a heavy reliance on the complaint process and survey information to solicit input from patients and families.

In Labrador West Health Centre nursing and allied health documentation was accurate, up-to-date, and complete for each client record reviewed. There were gaps in physician documentation in the records reviewed. One patient had been admitted to the unit for over a week waiting transfer to St. John's there was one medical note with admission from emergency

Priority Process: Impact on Outcomes

The team is moving towards having a Patient Family Advisor for the inpatient program. This initiative will help ensure the voice of the patient is imbedded in informing the team. The Person and Family Centered approach framework/model is new (since 2022)- “Nothing About Me Without Me” to help guide practice. The goal of the model is to engage clients, families, partners, and community members in partnering and collaborating to improve healthcare services, experiences, and outcomes. Part of the model is a Patient and Family Advisor program where patient partners would align with programs to have input into policies and procedures, planning, evaluation, or design for Inpatient Services

There is not a formal process for engaging patient partners in planning, design, functioning or evaluation of programs or providing input into policies or procedures. No formal or proactive engagement sessions with patients and families, reliance on surveys and complaint process for input from patients and families.

At the Labrador Health Centre in Goose Bay, the protocol(s) for movement of patients within the site during overcapacity are not specific enough to ensure ease of decisions and safety. Staff consider this is an area of focus needed for the organization as pressures grow. A clear, specific and step by step protocol is needed. This should include identification of spaces for use, preparation of spaces if needed, and evaluation of patients for appropriate movement of those who could safely use those spaces. Staffing and access to others should be included as well. At this time there was no evidence that protocols were satisfactory or able to be followed by staff, particularly after hours.

Patient safety incidents are reported according to the organization’s policy. The team reviews incidents to understand opportunities for improving process and patient satisfaction.

Quality huddle boards display indicators to reflect the key metrics the team is monitoring to assess performance. Continue to link data to show the improvements achieved or where there is a need for process improvement. Information sharing will enable staff to understand the magnitude of the problem and engage frontline staff in problem solving as they are a valuable resource for understanding the problems and bringing forward suggestions for improvement. Attention to targeted data that is collected, followed, and shared with the organization, staff and families, is essential to identify and measure areas of improvement.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from residents and families.	
Priority Process: Competency		
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
3.16	Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
3.17	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
Priority Process: Episode of Care		
7.7	Translation and interpretation services are available for residents and families as needed.	
11.1	Policies and procedures for POCT are developed with input from residents and families.	
Priority Process: Decision Support		

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from residents and families.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from residents and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Labrador-Grenfell Zone Long Term Care Services are coordinated across the region to ensure that there is consistent delivery of evidence-based care guided by the Newfoundland and Labrador Provincial Long Term Care Operational Standards. These guidelines help set the expectation for high quality, holistic, resident-centered care in a homelike, safe environment. The region is geographically vast and can present

challenges for resident placement to areas that are close to home. Facilities have varying waitlists that are monitored for deterioration of patients waiting. The team works collaboratively across the region to ensure timely access to beds while maintaining a Home First philosophy. MD coverage is strong, and staff are flexible and supportive to keep stable residents in their home for treatments such as IV, IV therapy and O2. This directly affects flow to ER and the in-patient unit by avoiding visits or admission. Well done!

The Region strives to invest in leaders to ensure they are confident in their roles. There have been new leaders put in place since the last survey and they have worked hard to move projects and process improvement forward. Projects include renovations, practice improvement and implementation of Resident and Family Councils. The teams report feeling supported and engaged with leadership, leading to a positive environment on the unit.

There is a multidisciplinary team that work collaboratively with residents and families to meet the needs of the residents providing spiritual, psychosocial, cultural, and physical needs of residents. The team strives to foster independence and freedom of choice by involving residents and families in their care planning. The Recreation department is active in facilitating hairdressers, music entertainers, youth groups and intergenerational programs. Community partnerships also provide support within the LTC setting. The team is encouraged to review services offered to ensure that they are providing what the residents need/want in a culturally sensitive way.

At the Labrador Health Centre in Goose Bay, ongoing evaluation of risk and mitigation has led to increased safety and codesigned interventions such as the constant presence of Paladon security in the supported, closed access wing. Security was witnessed settling and supporting resident and know techniques to avoid escalation.

Priority Process: Competency

The team has a clear focus for providing the education and training to support staff feeling competent and confident in their role. The leadership works with frontline staff to advocate for the team members working to their full scope as evidenced by the advancement of the role of the LPN. There is an opportunity to review the PCA role to ensure that they are working to full scope as well to spread the workload across the disciplines. There is a robust orientation program, and the team is supported by a LTC educator. There are a large number of mandatory and optional educational offerings. Team members expressed that it is difficult to find the time at work to complete all of the mandatory education required on an annual basis. Partner with the staff to understand how to best support them to complete all education and training. Consider skills days or educational fairs that can cover off some of the topics required.

There is mutual admiration between leadership, professions, residents, and families. MD coverage is strong, and staff are flexible and supportive to keep stable residents in their home for treatments such as IV, IV therapy and O2. This directly affects flow to ER and the in-patient unit by avoiding visits or admission. Well done!

Leadership has experienced a high turnover rate leading to a gap in performance appraisals being completed for staff. It is important to review the current process for completing reviews and understand how to return to formal, regular reviews with follow up for goal setting and growth opportunities to ensure staff have access to ongoing professional development.

There is a documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pumps is implemented. The team is confident and competent in the administration of IV pump therapy to aid residents to stay in their home (LTC) setting rather than have to be transferred to acute care.

Team members are recognized for their contributions. There is a WOW board to recognize a job well done, intentional leadership rounding, thank you cards, service awards, breakfasts, and celebrations. Continue this great work!

Priority Process: Episode of Care

There is clear evidence of a desire to provide compassionate, empathetic, kind, individualized, care to the residents within LTC. The team strives to create a homelike atmosphere conducive to the delivery of holistic care. The LTC is welcoming and inviting. There is an effort to remove the institution from the care and make residents feel part of a community. Nomenclature is important to the team, and they make conscious efforts to bring “home” into the daily operations. Units are renamed to match the community (Iceberg Ally, Puffin Lane, Bakeapple Lane, Wildflower Lane, Partridgeberry Path). There has been a lot of attention to décor and the safety of the residents. The team at the John M. Gray Centre is commended for embracing the least restraints efforts to become leaders for the region by improving reducing the use of restraints while promoting allowing residents to live within risk safely. The residents and families spoke highly of the staff and leadership and the care they received.

Consider continuing to review the area from an infection control lens. Remove wooden surfaces, handrails, and desks, replacing with a more durable, cleanable solution.

There has been a focus on ensuring Medication Reconciliation is completed accurately on all residents. Audits are regularly completed and documented for improvement. All other applicable ROP’s are in place. Falls risk assessments are completed using a Morse Falls Risk Assessment Tool on all residents with strategies implemented to reduce falls as indicated. Each resident’s risk for a pressure ulcer injury is assessed using the Braden Scale, documented and interventions put in place to reduce/prevent injury based on best practice guidelines. Risk for suicide is assessed and documented with appropriate follow up as required as outlined in the suicide risk management protocol that outlines the timeframes for contact, assessment, and reassessment. The team uses resident photos to help with two person-specific identifiers to confirm that residents receive the service or procedure intended for them.

Residents and families feel fully involved in their care. Comments like “there is nothing I ask for that they don’t do”; and “they asked me to consider a move and I said no, where we are, is best for us”. Residents knew who was assigned to care for them and commented positively on the cleanliness of the residence, care received and the quality of the food.

There is an opportunity to look at the translation services currently available for residents. Review current technology to support communication with a changing population. In Goose Bay 2 full time translators are now available to the hospital and LTC. All share that this is a recent and big improvement. Additional common languages are easily available from Staff as well.

Priority Process: Decision Support

There is a hybrid mix of electronic and paper documentation. A hybrid approach presents challenges for communication and collaboration among team members. The region will be moving to a Provincial Model of an Electronic Health Record (EPIC). This should improve resident safety through standardization of documentation with built in features to prompt staff to complete necessary interventions within the individualized care plans. It will enhance data access to facilitate decision making for patient care and provide easier access to information relevant to the care of the resident.

The team is encouraged to ensure all relevant stakeholders are engaged in the education and roll out of the new EMR. Consider advocating for closed loop medication administration for LTC to reduce medication errors. Bar Code scanning is not typically implemented in LTC but can be an important safety tool.

Priority Process: Impact on Outcomes

The teams in long term care are working towards improving how they engage residents and families meaningfully. The Person and Family Centered approach framework/model is new (since 2022)- “Nothing About Me Without Me” to help guide practice. Resident-family council meetings are held regularly at each site with virtual attendance options. At NLHS there is a PCC Steering Committee which assists with the development, collection, and dissemination of feedback from clients and families. There continues to be opportunities to advance practice in a more formal way, by involving dedicated resident and family advisors at a program level that reviews service delivery, sets goals and objectives to guide practice and monitors key priority indicators for LTC. The team also recognizes the need for development and implementation of Community Advisory Councils to help inform care.

QI and outcomes are in place with areas of interest such as IPC, Glucometer use and UTIs.

Data is tracked; education occurs, changes are monitored, and success is shared across other sites. For example, the move to stop Glucometer testing for those whose Diabetes is controled by diet unless they are clinically symptomatic.

In Goose Bay ongoing evaluation of risk and mitigation has led to increased safety and codesigned interventions such as the constant presence of Paladon security in the supported, closed access wing. Security staff member was witnessed settling and supporting resident with knowledge techniques to avoid escalation. Staff, residents and security were appeared as partners for safety and care.

The team has a patient-centered care approach through ongoing work to treat their residents with dignity and respect and involving them in all decisions about their health. This is demonstrated through their family conferences to help guide planning and care for residents that are consistent with the resident's goals. They try to incorporate information gathered from residents during the initial assessment, yearly and as conditions may change to understand resident preferences and needs to develop individualized care plans.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
3.3	The organization has developed local implementation action plans that include prioritizing which high-risk client populations or units receive the evidence-informed care activities from pharmacists.	
14.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	!
15.1	A structured program has been implemented to reduce the risks associated with polypharmacy, especially with frail or vulnerable clients.	!
15.4	Standardized, pre-printed forms shall be used to order medications that are commonly prescribed or have been identified as high risk.	!
17.4	Sterile products are prepared in a separate area that meets standards for aseptic compounding.	!
21.1	Medications are delivered securely from the pharmacy to client service areas.	!
24.5	To allow for immediate administration during emergencies, antidotes, reversal agents, and rescue agents shall be available to team members along with standardized protocols or coupled order sets and directions for use.	!
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

There is good evidence of strong interdisciplinary care within the pharmacy's developing structure across the system. Due to a shortage of pharmacists, locum pharmacists are relied upon, and pharmacy technicians work to their full scope of practice.

There is a newly implemented Provincial Clinical Pharmacy Specialist (Cardiovascular) role. The role was established because of collaborative student research and mentorship. This Nationally recognized and published work is commended. The use of Pharmacy Keeper when preparing hazardous medications (chemotherapy meds) allows for remote checks and the team to optimize workflow. This use of technology to support practice across sites and remote locations demonstrates the team’s ability to innovate.

The NLHS team is commended for their work to address medication management recommendations during their last accreditation survey. Medication reconciliation is consistently completed across the zone. Several info graphics have been developed and have helped clinicians adopt medication safety standards including, high alert medication, heparin safety, do not use abbreviations, independent double checks, and narcotic safety. Forms are available when issuing drug recalls.

The interdisciplinary antimicrobial stewardship committee has established a strong foundation from which to continue to build on the success of the program. The evaluation of intravenous therapy is linked to the antimicrobial stewardship program and applies to antibiotic medications only.

A pharmacist and physician co-chair the interdisciplinary Pharmacy and Therapeutics (P&T) Committee. Moving forward in NL Health Services, a provincial Pharmacy and Therapeutics Committee will report to the provincial medical advisory committee. The existing zonal P&T committees will report to the provincial P&T committee.

There is an opportunity to expand the use of order sets in Labrador-Grenfell Zone and all sites across the zone. Very few order sets exist, and those that exist are inconsistently used. As work to standardize care provincially advances, it will be important to ensure the adoption of order sets for disease presentations within the province.

There are currently no automated dispensing units at Labrador Health Centre. The Charles S. Curtis Memorial Hospital has implemented automated dispensing cabinets. There is a plan to fully implement automated dispensing cabinets and utilize computer physician order entry features within electronic medical record, EPIC, that is also set to be implemented in the near future.

Medication orders are placed in a folder on the inpatient ward and are collected by pharmacy personnel at regular intervals throughout the day. The implementation of EPIC, dispensing units, and CPOE will result in automation and streamlined processes that will significantly reduce pharmacy workload and improve safety in medication practice.

The new space at the pharmacy at the Labrador Health Centre now allows chemotherapy medications to be stored in a separate negative pressure room. However, the renovated space at Charles S. Curtis Memorial Hospital has experienced delays. Delayed renovations have resulted in an inability to meet National Association of Pharmacy Regulatory Authority (NAPRA) standards. The team has implemented measures to comply as much as possible to NAPRA standards but are limited by space constraints in existing location.

Medication information stored in the pharmacy computer system is updated annually. Medication shortages were handled during COVID-19 through inter-facility collaboration. This was a manual and inefficient process. Because it is labour-intensive, it isn't routinely used. There is an opportunity to automate processes so that medications are used efficiently, enabling optimization of drugs in short supply across the system and appropriately managing expiry dates on drugs.

The Labrador-Grenfell Zone Pharmacy and Therapeutics Committee has determined the zone's formulary. Moving forward, the provincial formulary will allow for consistent medication choice across the province and align with the provincial drug plan.

The pharmacy department uses two computer systems. Meditech Magic for inpatients and Kroll for outpatients. Both systems are maintained by the Information Technology department of Newfoundland and Labrador Health Services. Regular updates are part of the licensing agreements for these platforms.

There is a process to determine the type and level of alerts required by the pharmacy computer system that includes, at minimum, alerts for medication interactions, medication allergies, and minimum and maximum doses for high-alert medications. Meditech will alert drug interactions, renal dosing concerns, and all pt allergies. High alert medication alerts are not available in Meditech are anticipated with the replacement health information system expected in 2026.

A provincial RFP was issued last year to transition Long Term Care medication management to community pharmacies. However, community pharmacist shortages has created challenges in moving this initiative forward.

There is a critical yet long-standing shortage of pharmacists at the Labrador Health Centre and Charles S. Curtis Memorial Hospital. This results in limited time spent consulting with patients for direct counselling regarding medications or time spent conducting medication reviews. This also severely limits the pharmacist's role in discharge planning. There are no local implementation plans that determine which populations are prioritized for this type of care. Recruitment of four provincial managers as well as several currently vacant pharmacist positions is underway. There is also recruitment underway for two client advisors to represent the regions and provide input.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.1	The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.	
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.5	Quality improvement activities are designed and tested to meet objectives.	!

18.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
18.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team and front-line leadership is highly dedicated to proving obstetrical care and building capacity and skill in the region. The team is commended for the improvement activities made since the last survey and being “a little place that can achieve so much”.

There are no reported specific service goals for the Obstetric Services (OBS) program at the local level. There are no forums to proactively develop OBS specific goals and objectives with patient/ family experience advisors (PFEA). Embedding PEFAs into committee and operational structures to provide input and suggestions related to service planning, design and evaluation would enhance obstetrical care at the organization.

Health human resource shortages have led to gaps in the knowledge, skill and experience in specialized obstetrical nursing practice. Novice generalist nurses coupled with at times low volumes of obstetrical cases has created increased challenges to develop and sustain the knowledge and skill of clinical nurses. Opportunities to enhance current skill set and knowledge includes expanded consistent use of MORE OB, internships of existing nurses at high volume OBS sites, and consideration of including midwifery and / or obstetrical clinical nurse specialist roles into the interprofessional team.

Priority Process: Competency

There are no forums to proactively engage patient/ family experience advisors (PFEA) in developing training and education. Embedding PEFAs into committee and operational structures to provide input and suggestions would enhance obstetrical training and education for team members at the organization.

There are designated OB nurses available to manage OB patients at the CSC site expanding the team from one credentialed OB nurse to four which is a welcome enhancement to the service. This approach should be considered for all sites.

Feedback on performance is provided in the moment but there are no formalized performance appraisals being completed at this time.

Coverage of obstetrical patients during active labour requires 2 nurses at times. When this occurs on a night shift nurses are pulled from the inpatient units leaving no nursing coverage on the wards. This model creates gaps in nursing coverage, and potential delays in care, and patient risk on either the inpatient unit or the obstetrical unit.

The team follows MORE OB. Most staff on the unit have completed breastfeeding online education courses. Some programs and communities do not have local lactation practitioner support. This may be an opportunity to support staff to become Lactation consultants and provide breastfeeding support to inpatients as well as those choosing to breastfeed in the broader community.

Priority Process: Episode of Care

The site is a designated Baby Friendly location and is encouraged to keep a line of site of policies and measures required to maintain the BFI designation.

No evidence that space is co-designed with input from clients and families. At Charles S. Curtis Memorial Hospital there is no designated antenatal space to assess patients. Staff need to move to available space and carry required assessment devices with them.

There is a process to consult services for high risk babies, when this occurs during active labour the baby must be delivered before medivac is sent to transport the baby to a higher level of care. This approach leads to a long wait for NICU access and when coupled with a lack of specialized OB nursing there is a high risk for negative outcomes. This risk is mitigated by virtual support. Charles S. Curtis Memorial Hospital does not have onsite access to internal medicine. Consultation occurs via phone, patient travel to alternate location as needed.

Priority Process: Decision Support

Patient records are up to date and complete. There are comprehensive assessments and tools to guide practice. Policy and procedures are in place to support decision support processes. Meaningful engagement of patients and families in process and policy changes will enhance collaboration.

Priority Process: Impact on Outcomes

There is no evidence of involvement with clients and families in identifying risks in a proactive manner. Heavy reliance on surveys and complaint process for input from patients and families. Given the patient mix on the unit with OB along with mental health, LTC, inpatients, there is a need to proactively assess and mitigate risk of infant abduction.
Patient safety incidents are reported according to the organization's policy. The team reviews incidents to understand opportunities for improving process and patient satisfaction.

No obstetric specific quality improvement objectives, activities, results, or learnings were identified. There was an improvement initiative at Labrador West Health Centre creating a Cesarean Section terminology infographic. Building on work such as this would start a journey to formalize the quality improvement processes, targets, results and spread to other sites.

Quality huddle boards display indicators to reflect the key metrics the team is monitoring to assess performance. Continue to link data to show the improvements achieved or where there is a need for process improvement. Information sharing will enable staff to understand the magnitude of the problem and engage frontline staff in problem solving as they are a valuable resource for understanding the problems and bringing forward suggestions for improvement. Attention to targeted data that is collected, followed, and shared with the organization, staff and families, is essential to identify and measure areas of improvement.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
Priority Process: Competency		
6.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
6.13	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.	!
12.8	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
10.9	Translation and interpretation services are available for clients and families as needed.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
23.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	

25.5	Quality improvement activities are designed and tested to meet objectives.	!
25.6	New or existing indicator data are used to establish a baseline for each indicator.	
25.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
25.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
25.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

While standards appear as met there is a high risk that current use and pressures on physical space use are impacting at least one site negatively at this time. Review and evaluation of leadership and staff decisions around the surgical space use and risk/safety is recommended. For example the round-the-clock overflow use of day care and core spaces. Debriefing and updating of Over Capacity Pathways for space use, should be evaluated and updated on an ongoing basis for sites.

Staff at sites are highly committed despite ongoing turnover. Efforts should be made to acknowledge the regular staff who at times work weeks of on-call in a stretch.

Priority Process: Competency

The OR team in place is highly trained and committed. Students and residents are welcomed warmly. All members of the team play a role and an Award of Excellence was won for this work. Well done! In addition there is an extended orientation program for new grads that has had some success in attracting new staff. The teams work cooperatively to discuss, plan and share workload/practice needs each day. This is posted on white boards for communication. The interprofessional team works closely together.

Priority Process: Episode of Care

Perioperative support and information sharing for patients and families is a strength. The Required Organizational Practices (Those practices which are proven to impact safety) were difficult last survey, and this year are done and in action.

At the Labrador Health Centre in Goose Bay, the team is largely locum and agency staffed at this time, with one new grad hire just onboard. All are excited to share their knowledge. Other sites also have some staffing challenges though the work is getting done and wait times are appropriate or improving. All 3 teams work well together.

When/If over capacity occurs as has happened recently at the Labrador Health Centre in Goose Bay, the team worked to alert the organization to new risk occurance as concurrently they worked on mitigation. At the same time, they participated when able to assist with the care for these In patients while the OR proceeded with adjustments.

It is hoped that teams will be invited to review and participate in Over Capacity Flow pathway review so that all teams are prepared for possible situations, and patients are placed as appropriate for optimal care in difficult situations. See more in Flow.

There is still work to do as has been noted. With NLHS, the OR teams in the zone may find it helpful to connect and identify joint areas of work to build strength and capacity. For example consider sharing virtual education sessions or presentations, organized and done together with all as it can be difficult to go away for education. In addition, QI may also be interested in sharing ideas for learning and improvement that could be pursued.

Keep up the good work.

Priority Process: Decision Support

Efforts to improve information sharing and common standards or tools for practice communication and information are evident since the last survey. The teams continue to hope for electronic capability over paper based methods and hope for improvements with NLHS.

Priority Process: Impact on Outcomes

As provinces work toward reducing surgical waitlists to improve outcomes, work has proceeded in NLHS and is a good example and model for data use, action, evaluation and spread. The concept of Blitzes involving one program or procedure, dedicated space, equipment, and manpower for a limited focused time is making a big impact on wait times. This approach is spreading successfully.
It may offer a template for different efforts such as over capacity work? It is worth considering and documenting. QI could assist in pulling a project together.

Priority Process: Medication Management

Medication management processes are generally strong in theatre.
Any alternate use of OR space including over capacity patient admissions, should consider medication safety in the areas.
In OR area spaces, general medication safety measures should be monitored by pharmacy in medication rooms. This includes shelving safety for "high alert" and "look alike sound alike" medication placement.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
9.6	The health care professional delivering POCT completes a comprehensive and accurate report for every point-of-care test carried out that is distinct from clinician notes in the record.	
9.9	The health care professional delivering POCT files the POCT report in the client record.	
Surveyor comments on the priority process(es)		
Priority Process: Point-of-care Testing Services		

The Lab was easily able to demonstrate a thorough well supported POCT program that includes 3 hospitals, 3 health centres and 14 community clinics.

The Lab team and Lab leadership are to be commended for the steps taken to ensure proper training and attention are given to maintaining the privilege of POCT to ensure validity and a maintained standard. POCT benefits patients, the inter-professional team, and flow.

There is a limited number of POCT testing done at the Charles S. Curtis Memorial Hospital. There is a regional POCT coordinator who provides support for POCT implementation, monitoring, and proficiency testing. There is a regional POCT interdisciplinary committee meeting regularly (quarterly).

At this time, the laboratory chemistry staff support the blood gas equipment situated in the ICU. Use of the blood gas analyzer is limited to laboratory staff, and respiratory therapists authorized to perform blood gas POCT. Clarity is needed in terms of whether blood gas testing in ICU falls within POCT scope. Required quality controls are performed on POCT and monitored by the regional coordinator.

For the Zone, with current processes in place the team was/is able to identify non compliance for requirements of POCT through auditing and follow up.

To this end, it was necessary that in December 2023 the approval and support for POCT was removed from Charles S. Curtis Memorial Hospital's ICU and Obstetrical Units, as well as John M. Gray LTC-Levels 2 and 3, due to noncompliance from Nursing to recertify skills as required despite repeated efforts by lab.

The NLHS is encouraged to review the POCT recertification policy against evidence and best practice for skill renewal and maintenance. Once renewal frequency is agreed upon by QI and Lab professionals, failure of employees to comply should be considered a Manager and HR issue to be resolved with individual staff members, as a practice issue impacting patient care, unit flow, function and overall costs.

The Lab QI and Leadership need the partnership of Nursing Leaders to work toward Nursing accountability and responsibility to ensure POCT is available when appropriate.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Public Health	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Job design, roles, responsibilities, and assignments are customized to the population, service, patients and community served.will vary depending on the type of services being delivered, the clients being served, and the individual team members involved.

Priority Process: Competency

The public health team is very experienced and well qualified. The team has both public health generalist roles and specialized skill set and assignments based on population needs, trends and priorities. Each team member projected a passion for their work and their community's health and wellness.

Priority Process: Impact on Outcomes

The team has a focus on design the services to positively impact outcomes and wellness in the community. Public health evaluates the services provided and the team has adapted services based on this feedback and outcomes (e.g. immunization clinics, child development, and sexual health programming). Enhanced public health programs to increase uptake of programs and target demographics has lead to positive impact and outcomes. Programming changes such as adding portable x-ray in remote communities for TB program, "Health Check 2 1/2" and "wellness cafes". Some of these forums have included "Wellness Coalitions", partnerships with schools and students in "Wellness Cafes". Other changes such as working with local industry and events to increase immunizations have had a positive impact to rates, "herd immunity", and overall wellness.

Priority Process: Public Health

Working with patients, families, and the community to design and evaluate public health services, risk, and wellness is very apparent and a source of great pride.

Public health has worked with the communities and its members to use local and provincial resources to share information that is available. The teams have customized how information is shared and adapted programs and services based on the unique needs of communities and their populations to increase knowledge translation and ultimately health and wellness.

The team uses a holistic approach to individual patient, family, and community physical and psychosocial health. The team assessed social determinants of health of the individual and the communities to assess health, develop strategies to increase wellness and identify gaps in processes and care.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Transfusion Services	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

The Epidsode of care is validated by the ACDx, with the exception of evidence for Universal Falls Precautions which was reviewed and found in place .

Priority Process: Transfusion Services

The Transfusion Service is a well set up and organized service. SOPs and support for quick Nursing Reference tools assist with ease of use and reference.There is evidence of committment to monitoring and tracking of reactions and adverse events, for follow up, reporting, and resolution as needed. There requires a team approach with Lab which includes Nursing.

The Canada Blood Service is a support at the national level and the move to a provincial wide Health Service (NLHS) with its strenghts is felt to be valuable. For example, it is appreciated that the "consultants" are now in a formalized role and can provide medical and scientific directives.

Instrument Results

As part of Qmentum, organizations administer instruments. Qmentum includes three instruments (or questionnaires) that measure governance functioning, patient safety culture, and quality of worklife. They are completed by a representative sample of clients, staff, senior leaders, board members, and other stakeholders.

Governance Functioning Tool (2016)

The Governance Functioning Tool enables members of the governing body to assess board structures and processes, provide their perceptions and opinions, and identify priorities for action. It does this by asking questions about:

- Board composition and membership
- Scope of authority (roles and responsibilities)
- Meeting processes
- Evaluation of performance

Accreditation Canada provided the organization with detailed results from its Governance Functioning Tool prior to the on-site survey through the client organization portal. The organization then had the opportunity to address challenging areas.

- **Data collection period: October 4, 2021 to November 12, 2021**
- **Number of responses: 6**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	0	0	100	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	17	83	94
3. Subcommittees need better defined roles and responsibilities.	50	17	33	69
4. As a governing body, we do not become directly involved in management issues.	0	0	100	86
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	17	83	92

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	17	0	83	92
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	33	67	94
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	17	0	83	93
9. Our governance processes need to better ensure that everyone participates in decision making.	67	0	33	63
10. The composition of our governing body contributes to strong governance and leadership performance.	17	0	83	92
11. Individual members ask for and listen to one another's ideas and input.	17	0	83	94
12. Our ongoing education and professional development is encouraged.	17	17	67	81
13. Working relationships among individual members are positive.	0	0	100	96
14. We have a process to set bylaws and corporate policies.	0	0	100	94
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	98
16. We benchmark our performance against other similar organizations and/or national standards.	17	17	67	77
17. Contributions of individual members are reviewed regularly.	17	33	50	66
18. As a team, we regularly review how we function together and how our governance processes could be improved.	0	0	100	80
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	50	50	61

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	33	67	84
21. As individual members, we need better feedback about our contribution to the governing body.	50	0	50	43
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	17	17	67	78
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	95
24. As a governing body, we hear stories about clients who experienced harm during care.	17	0	83	75
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	33	17	50	88
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	40	0	60	90
27. We lack explicit criteria to recruit and select new members.	83	0	17	77
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	67	0	33	84
29. The composition of our governing body allows us to meet stakeholder and community needs.	17	17	67	90
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	17	0	83	90
31. We review our own structure, including size and subcommittee structure.	17	0	83	85
32. We have a process to elect or appoint our chair.	40	0	60	87

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	17	17	67	84
34. Quality of care	17	17	67	86

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2021 and agreed with the instrument items.

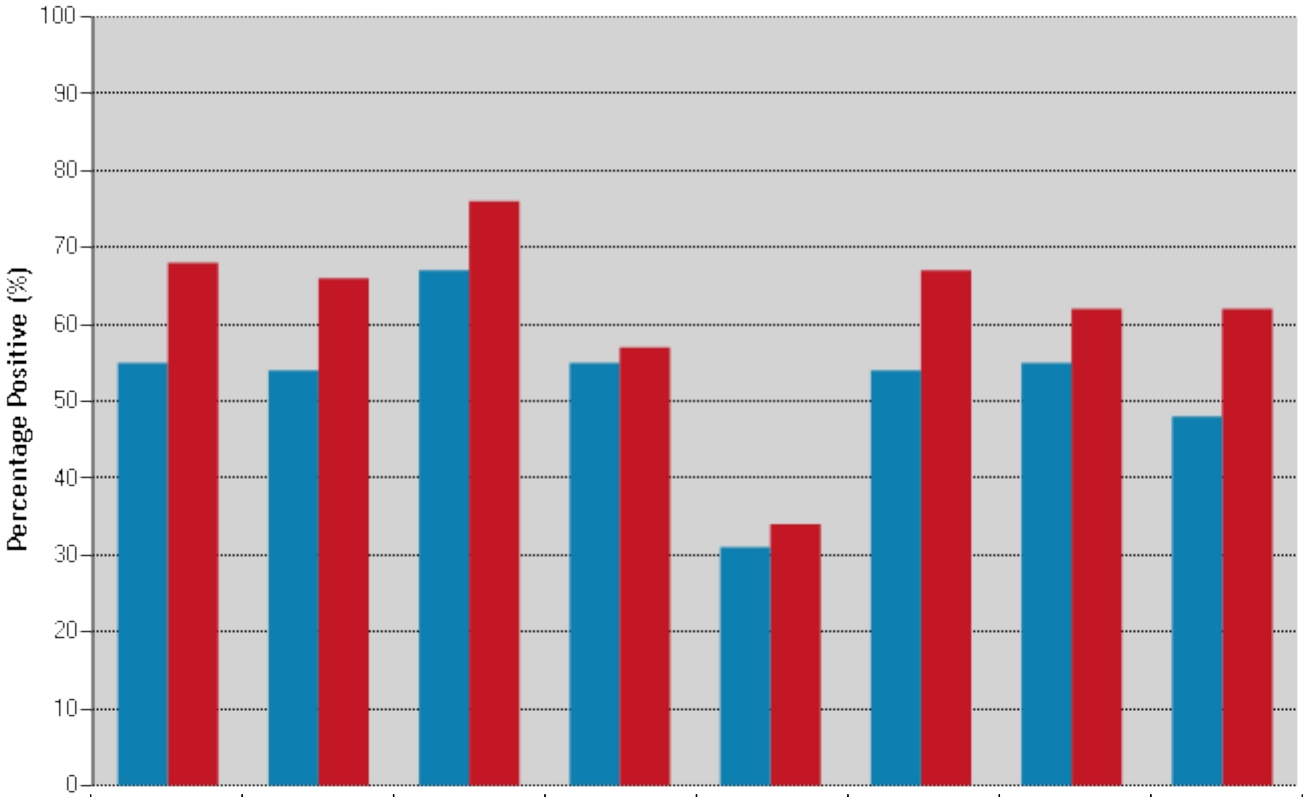
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: October 21, 2022 to November 7, 2022**
- **Minimum responses rate (based on the number of eligible employees): 268**
- **Number of responses: 405**

Canadian Patient Safety Culture Survey Tool: Results by Patient Safety Culture Dimension



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	55%	54%	67%	55%	31%	54%	55%	48%
	68%	66%	76%	57%	34%	67%	62%	62%

Legend

NL Health Services Labrador-Grenfell Zone

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2023 and agreed with the instrument items.

Worklife Pulse

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

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

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

Client Experience Tool

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

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

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

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

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

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

The organization then had the chance to address opportunities for improvement and discuss related initiatives with surveyors during the on-site survey.

Client Experience Program Requirement	
Conducted a client experience survey using a survey tool and approach that meets accreditation program requirements	Met
Provided a client experience survey report(s) to Accreditation Canada	Met

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 20 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.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

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

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