ACCREDITATION AGRÉMENT CANADA
Qmentum

Accreditation Report

Labrador-Grenfell Regional Health Authority

Happy Valley-Goose Bay, NL

On-site survey dates: May 13, 2018 - May 18, 2018

Report issued: June 7, 2018

About the Accreditation Report

The Labrador-Grenfell Regional Health Authority (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in May 2018. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

Accreditation results are based on information provided by the organization. Accreditation Canada relies on the accuracy of this information to plan and conduct the on-site survey and produce the Accreditation Report.

Confidentiality

This report is confidential and is provided by Accreditation Canada to the organization only. Accreditation Canada does not release the report to any other parties.

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

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

A Message from Accreditation Canada

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 Client Engagement Lead 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

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

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

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

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

Accreditation Decision

The Labrador-Grenfell Regional Health Authority'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: May 13, 2018 to May 18, 2018**

- **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. John M. Gray Centre
  3. Labrador Health Centre
  4. Labrador West Health Centre
  5. Long Term Care Goose Bay
  6. Makkovik Community Clinic
  7. 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. Governance
  2. Infection Prevention and Control Standards
  3. Leadership
  4. Medication Management Standards

  Service Excellence Standards

  5. Biomedical Laboratory Services - Service Excellence Standards
  6. Community-Based Mental Health Services and Supports - Service Excellence Standards
  7. Critical Care Services - Service Excellence Standards
  8. Diagnostic Imaging Services - Service Excellence Standards
  9. Emergency Department - Service Excellence Standards
  10. EMS and Interfacility Transport - Service Excellence Standards
  11. Home Care Services - Service Excellence Standards
  12. Inpatient Services - Service Excellence Standards
  13. Long-Term Care Services - Service Excellence Standards

14. Obstetrics Services - Service Excellence Standards
15. Perioperative Services and Invasive Procedures - Service Excellence Standards
16. Point-of-Care Testing - Service Excellence Standards
17. Primary Care Services - Service Excellence Standards
18. Public Health Services - Service Excellence Standards
19. Reprocessing of Reusable Medical Devices - Service Excellence Standards
20. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	85	9	1	95
 Accessibility (Give me timely and equitable services)	109	4	0	113
 Safety (Keep me safe)	711	70	22	803
 Worklife (Take care of those who take care of me)	151	17	1	169
 Client-centred Services (Partner with me and my family in our care)	394	46	2	442
 Continuity (Coordinate my care across the continuum)	101	0	0	101
 Appropriateness (Do the right thing to achieve the best results)	1033	125	22	1180
 Efficiency (Make the best use of resources)	73	10	0	83
Total	**2657**	**281**	**48**	**2986**

Overview by Standards

The Qmentum standards identify policies and practices that contribute to high quality, safe, and effectively managed care. Each standard has associated criteria that are used to measure the organization's compliance with the standard.

System-wide standards address quality and safety at the organizational level in areas such as governance and leadership. Population-specific and service excellence standards address specific populations, sectors, and services. The standards used to assess an organization's programs are based on the type of services it provides.

This table shows the sets of standards used to evaluate the organization's programs and services, and the number and percentage of criteria that were rated met, unmet, or not applicable during the on-site survey.

Accreditation decisions are based on compliance with standards. Percent compliance is calculated to the decimal and not rounded.

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	41 (85.4%)	7 (14.6%)	2	25 (78.1%)	7 (21.9%)	4	66 (82.5%)	14 (17.5%)	6
Leadership	48 (96.0%)	2 (4.0%)	0	87 (90.6%)	9 (9.4%)	0	135 (92.5%)	11 (7.5%)	0
Infection Prevention and Control Standards	38 (95.0%)	2 (5.0%)	0	28 (90.3%)	3 (9.7%)	0	66 (93.0%)	5 (7.0%)	0
Medication Management Standards	67 (95.7%)	3 (4.3%)	8	50 (87.7%)	7 (12.3%)	7	117 (92.1%)	10 (7.9%)	15
Biomedical Laboratory Services **	71 (100.0%)	0 (0.0%)	0	105 (100.0%)	0 (0.0%)	0	176 (100.0%)	0 (0.0%)	0
Community-Based Mental Health Services and Supports	31 (70.5%)	13 (29.5%)	0	81 (87.1%)	12 (12.9%)	1	112 (81.8%)	25 (18.2%)	1
Critical Care Services	50 (83.3%)	10 (16.7%)	0	100 (95.2%)	5 (4.8%)	0	150 (90.9%)	15 (9.1%)	0
Diagnostic Imaging Services	63 (96.9%)	2 (3.1%)	2	67 (98.5%)	1 (1.5%)	1	130 (97.7%)	3 (2.3%)	3

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Emergency Department	60 (84.5%)	11 (15.5%)	0	100 (93.5%)	7 (6.5%)	0	160 (89.9%)	18 (10.1%)	0
EMS and Interfacility Transport	102 (93.6%)	7 (6.4%)	5	113 (97.4%)	3 (2.6%)	4	215 (95.6%)	10 (4.4%)	9
Home Care Services	35 (72.9%)	13 (27.1%)	0	63 (85.1%)	11 (14.9%)	1	98 (80.3%)	24 (19.7%)	1
Inpatient Services	45 (75.0%)	15 (25.0%)	0	72 (84.7%)	13 (15.3%)	0	117 (80.7%)	28 (19.3%)	0
Long-Term Care Services	42 (76.4%)	13 (23.6%)	0	84 (85.7%)	14 (14.3%)	1	126 (82.4%)	27 (17.6%)	1
Obstetrics Services	58 (81.7%)	13 (18.3%)	2	81 (92.0%)	7 (8.0%)	0	139 (87.4%)	20 (12.6%)	2
Perioperative Services and Invasive Procedures	99 (86.8%)	15 (13.2%)	1	93 (85.3%)	16 (14.7%)	0	192 (86.1%)	31 (13.9%)	1
Point-of-Care Testing **	38 (100.0%)	0 (0.0%)	0	45 (97.8%)	1 (2.2%)	2	83 (98.8%)	1 (1.2%)	2
Primary Care Services	47 (82.5%)	10 (17.5%)	1	81 (90.0%)	9 (10.0%)	1	128 (87.1%)	19 (12.9%)	2
Public Health Services	45 (95.7%)	2 (4.3%)	0	65 (94.2%)	4 (5.8%)	0	110 (94.8%)	6 (5.2%)	0
Reprocessing of Reusable Medical Devices	79 (91.9%)	7 (8.1%)	2	38 (95.0%)	2 (5.0%)	0	117 (92.9%)	9 (7.1%)	2
Transfusion Services **	75 (100.0%)	0 (0.0%)	0	69 (100.0%)	0 (0.0%)	0	144 (100.0%)	0 (0.0%)	0
Total	**1134 (88.7%)**	145 (11.3%)	23	1447 (91.7%)	131 (8.3%)	22	2581 (90.3%)	276 (9.7%)	45

* Does not includes ROP (Required Organizational Practices)
** Some criteria within this standards set were pre-rated based on the organization's accreditation through the Ontario Laboratory Accreditation Quality Management Program-Laboratory Services (QMP-LS).

Overview by Required Organizational Practices

A Required Organizational Practice (ROP) is an essential practice that an organization must have in place to enhance client safety and minimize risk. Each ROP has associated tests for compliance, categorized as major and minor. All tests for compliance must be met for the ROP as a whole to be rated as met.

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Biomedical Laboratory Services)	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
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 (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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Inpatient 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)	Unmet	3 of 4	1 of 2
Medication reconciliation at care transitions (Critical Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Inpatient Services)	Unmet	3 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	3 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	8 of 8	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 Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Unmet	4 of 4	0 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
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 (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Unmet	1 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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (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
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Critical Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Inpatient Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care 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 (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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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.

The organization, Labrador-Grenfell Health (LGH) is to be commended for participating in the Qmentum program. Participation in this program is but one example of the organization's commitment to quality.

LGH is one of four Regional Health Authorities across Newfoundland & Labrador; it is the smallest in terms of population, but the largest in land mass. The organization provides health services to a diverse population across a vast geographic area. The services are delivered by 1,500 staff out of three hospitals, three health centres, 14 community clinics and community services (including mental health and addictions, long-term care, public health, home care, rehabilitative care). The organization provides some dental services in addition to residential services. In the Indigenous communities, Labrador- Grenfell Health is joined by the Nunatsiavut Department of Health and Social Development, two Innu Band Councils, NunatuKavut (formerly the Labrador Metis Nation), Health Canada and private practitioners in delivering community health programs that meet the health needs of residents in the region.

Since the last survey, the organization has implemented a number of programs to improve their quality. The Home First approach was developed in response to a persistent number of Alternate Level of Care (ALC) clients in hospital. The Home First approach aims to ensure clients have the right care in the right place at the right time, reducing the ALC numbers, lengths of stay and emergency department visits. Other quality initiatives include the Youth Wellness Café, Tuberculosis (TB) Management & Prevention, LGH Model of Nursing Clinical Practice, Wound Care Project, Cancer Screening initiative/ the Doorways Program, the Mobile Crisis Response Team and Post Discharge Calls, as examples. In the latter project, scripted calls are made to clients post discharge to follow up on their care. This initiative was in response to frequent re-admissions to hospital. It has also become an opportunity to recognize staff: in more than 2,900 calls to date, over 300 staff have been recognized. Public health boasts a childhood immunization coverage rate of over 96%, the highest in the province.

The organization has become more data driven. This has allowed the organization to focus on the areas where they can make an impact. By reviewing utilization patterns, feedback from the community and staffing levels, the region expanded their hours of service into the evenings and on weekends, with the same core staffing at one of the health centres.

Like other organizations, LGH has its difficulties. Recruitment and retention of qualified, competent staff and leaders is a constant challenge for the organization. Specifically, the senior executive leadership is lean, with the CEO and CFO positions currently vacant. The board of directors, with the exception of one, are quite new (eight months) and, combined with senior leadership vacancies, leaves the organization vulnerable.

There is evidence of quality and safety across the organization; however, it is not listed as a strategic priority/value. The organization needs to identify these as priorities as they engage their clients/families in the services they provide. LGH has begun to develop a patient advisory council to be rolled out later this year. This will be a great benefit to aid the organization in increasing their overall commitment to being client and family centered.

LGH is building an ethical culture and has seen a renewed interest in ethics over the last 2-3 years. This renewed interest is related to an increased awareness of ethics and witnessing the value and types of ethical issues relevant to healthcare. Ethical awareness and utilizing the framework has served as a practical educational tool and helped providers be more confident in decision making.

The organization has many partners including the First Nations populations, Department of Health & Community Services, Schools, RCMP, Parent Resource Centres and private Home Support partners, International Grenfell Association, local businesses, post-secondary institutions, hospital auxiliaries, community groups/agencies as well as a number of volunteers. The partner groups reported very good relationships with LGH.

The organization is to be commended on continuing in their Accreditation Journey!

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	
Medication reconciliation as a strategic priority A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.NOTE: Accreditation Canada will move toward the full implementation of medication reconciliation in two phases.For on-site surveys between 2014 and 2017, medication reconciliation should be implemented in ONE service (or program) that uses a Qmentum standard containing the Medication Reconciliation at Care Transitions Required Organizational Practice (ROP). Medication reconciliation should be implemented as per the tests for compliance for each ROP.For on-site surveys in 2018 and beyond, medication reconciliation should be implemented in ALL services (or programs) that use Qmentum standards containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.	· Leadership 15.7
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	· Obstetrics Services 8.5 · Inpatient Services 9.7

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Medication Use	
Antimicrobial Stewardship There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	· Medication Management Standards 2.3
Patient Safety Goal Area: Worklife/Workforce	
Patient safety plan A patient safety plan is developed and implemented for the organization.	· Leadership 15.1

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: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
1.6	The governing body's by-laws and policies are consistent with its mandate, roles, responsibilities, accountabilities, and the organization's ethics framework.	!
2.6	There are written criteria and a defined process for recruiting and selecting new members of the governing body.	
2.10	The governing body's membership policies and/or by-laws address term lengths and limits, attendance requirements, and compensation.	
2.11	The governing body's renewal cycle supports the addition of new members while maintaining a balance of experienced members to support the continuity of corporate memory and decision-making.	!
5.2	The governing body collaborates with the organization's leaders to seek input from team members, clients, and families to define or update the organization's values statement.	
9.5	The governing body oversees the organization's resource allocation decisions as part of its regular planning cycle.	!
10.1	The governing body adopts patient safety as a written strategic priority for the organization.	!
11.1	The governing body works with the CEO to identify stakeholders and learn about their characteristics, priorities, interests, activities, and potential to influence the organization.	
11.2	In consultation with the CEO, the governing body anticipates, assesses, and responds to stakeholders' interests and needs.	

11.3	The governing body works with the CEO to establish, implement, and evaluate a communication plan for the organization.	
13.6	The governing body regularly evaluates the performance of the board chair based on established criteria.	!

Surveyor comments on the priority process(es)

The current Board of Directors (BOD) for the Labrador-Grenfell Health Authority was appointed in June-July of 2017 with the exception of one member. The board had a two-day orientation in September of 2017, followed by their first board meeting. There are three committees of the BOD: Finance, Quality Assurance, and a Planning Committee. Each of these three committees has a Terms of Reference and there are board policies as well as by-laws. Board members applied to an ad by government to recruit new board members and then participated in interviews prior to being appointed (Independent Appointments Commission).

The board (except for one) has only been together for eight months and there is currently an interim CEO to assist with their Accreditation Survey. This has lead to some challenges in assessing standards - as the board has not sat for a full cycle, some standards could not be assessed or have had to be not applicable/not met. It has also put the organization at significant risk with an interim CEO for the survey, two vacant vice president positions as well as the board of directors that is in its infancy.

The by-laws and board policies have not been revised since 2011; consequently, they do not reflect the current values that have been added to the organization's values and they still include a mission statement that has since been removed at the direction of the provincial government. The board needs to update the policies and by-laws to reflect the current state. In addition, in the board policies there are no set terms of renewal or plan to avoid the current state where all but one of the board members are new. The bylaws do make reference to Section 8 of the Regional Health Authorities Act and Section 3 of the Regulations regarding terms; however, these need to be visible within the by-laws. The organization is encouraged to develop terms that are renewable for one or two cycles and alternate so that there are never more than 2-3 new board members at one time.

Board members appear to be in good contact with members of the community and are approached regularly with feedback about services/facilities. The board needs to find ways to formalize this feedback, report it and act on it in a transparent way.

The board is to be commended for raising concerns to government, particularly around their patient flow issues. Similar to other organizations in the country, the organization does have some flow issues, some of which is related to clients who require other levels of care having to stay in the hospital due to lack of other resources (e.g. Long Term Care).

There is quarterly reporting to the board that is comprehensive and provides the information the board needs to do their role. This is a real strength of the organization.

In addition to hiring a new CEO, the board is challenged to ensure that their senior leadership vacancies get filled as quickly as possible as this presents ongoing risk to the organization. The organization has decreased their senior leadership team by three over the last 2-3 years and they will have to continue to monitor the impacts to ensure there are no negative impacts to quality or safety.

As this is a new board, it is important that the board continue to ensure ongoing development and education for them and the next CEO .

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		
1.3	Client- and family-centred care is identified as a guiding principle for the organization.	!
1.5	Policies addressing the rights and responsibilities of clients are developed and implemented with input from clients and families.	
4.1	There is a process to develop or update the mission statement with input from team members, clients, families, and key stakeholders.	

Surveyor comments on the priority process(es)

The organization has a vision of "healthy people living in healthy communities." They have eight values that they aspire to live day to day. There is a Strategic Plan (2017-20) that is being used to guide the organization.

The organization is using HIROC to assist with their risk management - they have conducted 47 risk assessments over the last year. They visit program areas, identify risks and improvements and develop policies as required. Over the next year the plan is to develop mitigation strategies.

The organization uses a MAP-IT Framework (Mobilize, Assess, Plan, Implement, Track) for initiatives and change management. The tool has been used in a number of projects (e.g. Home First).

The organization has recently begun to develop operational plans that will align with the strategic plan. The organization continues to work on their Community Health Needs Assessment - Phase I has been to look at information from census data, CIHI etc. It is recommended that the organization continue their journey to complete the Community Needs Assessment and involve clients/families and communities as much as possible.

The organization has client rights and responsibilities - these are on the website and provided to patients on admission.

The organization is using data to assist in decision-making around resource allocation. When positions are vacated they are reviewed and the organization may re-allocate or change the position if the needs are greater in another area. The organization has many initiatives to address some of the chronic diseases that are most prevalent (e.g. TB, Cancer, Diabetes, Obesity).

Priority Process: Resource Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
8.5 Set criteria are used to guide resource allocation decisions.	!

Surveyor comments on the priority process(es)

The organization is at a particularly vulnerable time with the CEO position currently not filled, the Chief Financial Officer (CFO) position unfilled and a Board of Directors that has been in place for only eight months with the exception of one member. To mitigate this risk, there are tight financial controls with monthly forecasting and almost daily monitoring of the budget. A retired CFO has been assisting the organization's senior and executive leadership team. He makes himself available to the organization by telephone and makes onsite visits as well. He has assisted the organization in the development of their financial policies that were approved earlier this month. While there has been diligent attention to financial accounting principles, there were not formalized policies/procedures for all processes.

The other current challenges for the organization includes a funding envelope that is less than what is required for operations as well as high travel costs for the regional positions.

Budgeting is de-centralized with ongoing support provided to managers; support can be one on one and group education sessions are provided as well. Managers receive monthly variance reports to assist them in managing their budgets. The organization had a process of bringing directors to the executive leadership team to update on their budgets regularly; this process has stalled with the senior level vacancies.

The organization reviews every position that is vacated (retirement, leaves etc.) and makes a decision about whether to fill it or modify it or change it completely. In reviewing overtime costs, the organization noted it was spending a great deal of money on overtime for call-backs in the evening and on weekends at the health centres. The team reviewed the hours, paid attention to complaints from the clients/families and realized they needed to change the hours of the health centres. By staggering staff shifts and having staff do weekend shifts, they were able to extend the hours at the health centres within their current core staffing and save in excess of $500,000 while expanding hours of service.

Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Due to its northern and remote locations, it can be difficult to recruit and retain qualified and trained staff. Some of the recruitment strategies are mentoring/coaching for remote nursing positions, succession planning for manager positions, northern allowances and financial incentives, market adjustments for difficult to recruit positions, promoting a safe and healthy work environment. To retain staff, the organization has a retention committee. Some of the work to retain includes: promotes a workplace free of discrimination/harassment, staff recognition events (BBQ's and Christmas Turkey Dinners as examples), social clubs, funding for employees to continue lifelong learning, recognition and a thank-you program. For the thank-you program, anytime a staff is recognized as going "above and beyond" (by manager or client/family) a note of thanks is mailed to their home. This is greatly appreciated by staff. When staff do leave the organization for any reason they are offered exit interviews. This information may be used to make improvements if required. More importantly the organization has begun to conduct "stay interviews" to understand what is working well so that they can apply to other areas.

"Agency nurses" are sometimes employed to cover off vacancies. While this is necessary to cover off vacancies, it can be problematic in that these staff may not be as culturally sensitive, particularly to the First Nations populations.

The organization has been working hard to raise their immunization rates and is having some success. A new policy has been drafted on Employee Immunizations and this policy will direct that all new hires are screened for necessary immunization as per the Provincial Immunization Manual. The organization needs to have this policy approved, implemented and monitored for compliance.

The organization has been reviewing their injured workers and developing ways to return to work as soon as possible. Many of the injured workers are from long term care. Staff are trained on proper assessment/lifting techniques and proper equipment, including ceiling lifts, is in place.

Personnel files are generally well done, with most staff having performance reviews completed and signed off in the file. There is evidence of ongoing training and recertification. Position profiles are up to date and it is clear who the staff report to as well as their roles and responsibilities. There is evidence of ongoing patient safety training.

A Worklife Pulse Survey was completed in late 2015. The results reveal that there could be some issues with staff satisfaction with their workplaces. The organization recognizes that the timing of the survey happened to be close to a time when a new Model of Care was being rolled out as well as changes to

some roles. It is not clear if "agency" nurses were completing the tool as well. These issues could have influenced the results and the organization will be monitoring this closely.

The span of control of the senior executives and several managers is large and this will need to continue to be monitored. The current leadership vacancies (two vice presidents and the CEO) are a strain and place risk on the organization. An offer has been made to a potential CEO replacement and this is certainly welcome news.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
15.1 A patient safety plan is developed and implemented for the organization.	ROP
15.1.3 The plan includes patient safety as a written strategic priority or goal.	**MAJOR**
15.7 A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions. NOTE: Accreditation Canada will move toward the full implementation of medication reconciliation in two phases. For on-site surveys between 2014 and 2017, medication reconciliation should be implemented in ONE service (or program) that uses a Qmentum standard containing the Medication Reconciliation at Care Transitions Required Organizational Practice (ROP). Medication reconciliation should be implemented as per the tests for compliance for each ROP. For on-site surveys in 2018 and beyond, medication reconciliation should be implemented in ALL services (or programs) that use Qmentum standards containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.	ROP
15.7.5 There is documented evidence that team members, including physicians, who are responsible for medication reconciliation are provided with education.	**MAJOR**
15.7.6 Compliance with the medication reconciliation process is monitored and improvements are made when required.	**MINOR**
Surveyor comments on the priority process(es)	
The organization has developed a comprehensive Integrated Patient Safety Plan. The organization is monitoring employee incident/accident trends through a number of systems: Clinical Safety Reporting System (CSRS), Risk and Safety Management Alert System (RASMAS), compliments and complaints,	

financial audits, accreditation requirements, Risk Assessment Checklists (RAC) and an integrated risk management program. The team has completed 47 RACs over the last year and use these to identify risks. Once risks are identified, they are assigned to team member(s) to manage. A workplan is developed, goals identified, indicators developed, timelines identified and then the workplan is monitored until complete.

The number one complaint to the organization is related to access and this is their number one strategic priority. In terms of their overall highest risk they look at their human resources. With a vacant CEO and CFO position as well as a new governance team, the organization is vulnerable and open to risk.

The organization is constantly working on building and ensuring a just culture (no blame) and encouraging reporting of safety risks and incidents. The organization uses a Patient Safety Incident Management System. With BIll 70 (Patient Safety Act) proclaimed in 2017, physicians and staff have felt more protected to report incidents. The organization has worked hard to ensure staff/physicians know that this is valued. Upon entering a close call or actual incident, a standard email goes to the staff member thanking them for taking the time to log the incident. The organization is using the data from this system to trend their incidents, do follow up and "close the loop" on each and every incident. There is a strong reporting system in place: reports are reviewed by the Quality Council, Senior Leaders and then go to the board on a quarterly basis.

Another strength of the organization is their disclosure policy/process. More than 100 managers, leaders and staff have been provided "disclosure" training. Feedback from clients/families is that the process has worked and they have appreciated the efforts of the staff to be transparent and honest. Support is offered to clients/families during the process; support may be in the form of emotional, spiritual, and/or financial.

The organization has completed a Prospective Analysis in March 2017: Failure Mode Effect Analysis: Transportation of Laboratory Specimens and Supplies. The organization reviewed processes and best practices and have implemented changes: e.g. no longer use dry ice to transport the specimens. This has lead to improvement in overall quality and significant costs savings (no longer purchase dry ice, decreased repeat collections of specimens due to being misplaced or damaged). This has been a quality improvement for patients as there has been a decrease in the number of re-collections of specimens due to leakage/being lost/loss of integrity of the specimen.

One of the challenges for the organization is that patient safety is not a written priority - there is no mission statement and it does not show up in the value statements, strategic priorities. The organization may wish to consider including this in their values or strategic priorities. While it is implied, it may be helpful in building and nurturing a just culture to be constantly reminded that quality and patient safety is very important to this organization.

Another area that the organization has been working on is the implementation of Med Rec (Medication Reconciliation). The organization feels relatively confident that Med Rec on admission appears to be embedded into their programs/facilities. Audits reveal fairly good compliance. An interdisciplinary

committee, co-chaired by the VP Chief Nursing Office and the VP of Medical Services, has developed a policy on Med Rec on Transfer and Discharge. The policy has been approved, the training developed and they are ready to implement. It is anticipated that Med Rec on Transfer and Discharge will be implemented across the organization over the next three months. While some standards relating to Med Rec will be unmet during the actual survey visit, the organization could potentially meet those standards in the next year.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Labrador-Grenfell Health has been continually building an ethical culture and have seen a renewed interest in ethics over the last 2-3 years. It is believed that this renewed interest is related to an increased awareness, directly seeing the value and the types of ethical issues that are being addressed/focused on for education (highly relevant).

There is a Provincial Health Ethics Network for Newfoundland Labrador (PHENNL) with a provincial advisory committee. All four regional health authorities participate in this network and benefit from being able to share information provincially. In some cases (e.g. MAID or medical assistance in dying) a consultation is opened to the province to promote learning and be efficient. There are four ethicists in the network and the ethicists are available to the organization; they do not work for the health authorities - they are employed by the Memorial University. It is felt among the group that this is a strength of the process in that the ethicists are not biased by being an employee.

The organization is monitoring the types of ethical issues being presented to the ethics committee and trending these. The top issues recently are related to social media, MAID and living at risk. Participants in ethical consultations were able to describe the value-add in the ethical consultation process in being able to add the ethical lens to difficult issues. They have been able to share this knowledge with their peers and assist them to put aside their personal values for the good of the client and/or family.

Recently the Nunatsiavut Government reached out to the organization and requested assistance with an ethical issue; they participated in an ethical consultation and their feedback was quite positive.

The organization uses a number of strategies to increase awareness of the ethical framework/process. There are quarterly education sessions (in person or by webinar) that are advertised in the newsletters as well as education calendars. The organization also uses Twitter, posters, National Ethics Week ads, and plan to incorporate into their "Take 5's" beginning in June. Staff can also obtain a certificate in Ethics by taking 16 modules in Ethics Education.

Priority Process: Communication

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
7.5	There is an organization communication plan that addresses disseminating information to and receiving information from internal and external stakeholders.	
11.7	The quality and usefulness of the organizations' data and information are regularly assessed, and the assessment results are used to improve the information systems.	

Surveyor comments on the priority process(es)

The organization has just hired their new Director of Regional Communications (began two weeks ago). She comes from a local municipal role which will be an asset for the organization to have that direct linkage and background.

There are policies and procedures in place for patients to access their own records. There are a number of safeguards in place to protect patient's electronic information: every staff member/physician must take an education course (on-line) at hire related to health information management (including PHIA or the Privacy Health Information Act); all staff/physicians sign an oath of confidentiality; policies outline expectations relating to privacy; there is a privacy awareness week; IM&T has set role-based access as well as location-based access to IT systems; Meditech times out after 30 seconds and the network at 5 minutes of inactivity; staff/physicians must pass a competency assessment prior to accessing IT systems and finally there is routine auditing of the IT systems.

The organization has purchased several enterprise-wide licenses for access to research-based evidence for clinical staff: Up to Date; Mosby's; More OB; MicroMedics/eHealth and staff use NurseOne (CNA) as well as the new Health ENL for patient drug information. All of these make information more accessible to staff.

There is not a formalized communication plan; the former communications leader had an informal plan and it is recommended that the organization formalize this plan. There is a gap in that the organization has not been monitoring communication formally and consequently does not know if there are gaps and where those gaps are. While the Work Life Pulse indicates there may be some pockets of staff who believe communication could improve, it is not clear if those are small pockets or if this is a widespread issue. It is recommended that the organization spend some time/energy trying to understand these results and incorporate that into their communication plan when it is developed.

In a meeting with First Nations representatives it was noted that the region lost a position that had a liaison role with First Nations (Indigenous Liaison Position). The senior leadership team is aware of the impact this loss may have had on their First Nations Partner and has instituted an Inuit Liaison Committee as well as an Innu Liaison Committee. Both of these committees have been formed over the last several months. They have a Terms of Reference, take/share minutes of the meetings and book appointments bi-monthly a year ahead. The organization is commended for being proactive and reaching out.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Fleet vehicle maintenance is contracted out to Precision Automotive and the fleet is being well managed. The contract is being monitored and the vendor is fulfilling their obligations. Onboard and portable vehicle communications equipment is in good condition. Drivers have the qualifications and training required and update the employer if their status changes. Paramedics are managed by the Provincial Medical Oversight group.

The organization has a comprehensive plan for back up for their utilities. There are back up generators that are tested/documented routinely; additional telephone lines have been installed; satellite telephones are available; extra water is stored. The organization works to decrease its impact on the environment. Examples include: recycling of electronics/batteries; improved disposal of biohazardous waste; chemicals are biodegradable; air handling units are ramped down to 40% during the evenings and nights in areas where there are no staff; there is a concerted effort to reduce the amount of paper that is printed. All these efforts help the organization to be “greener”.

The buildings are inspected and meet applicable codes and regulations. There is a sink (soiled utility) at the Happy Valley Goose Bay Hospital that needs to be replaced immediately - this was identified to staff during the onsite tour. At this site it was noted there are numerous overhead pages that are disruptive to patients.

The organization needs to pay attention to clutter - there are rooms filled with old furniture in Labrador Health Centre; libraries and shelves filled with old (1980's) text books; boxes in the Emergency Departments and other departments. These are fire hazards as well as create risks for falls and other accidents. Another recommendation is to look at space as a "regional" asset. For example: Flower's Cove is renting space for old charts while there appears to be capacity at Charles S. Curtis Memorial Hospital - this may be an option.

There is a bio-med department and equipment is maintained as directed by the manufacturer. The province is working with the regional health authorities to buy from pre-qualified vendors. The advantages to this are that the equipment is becoming standardized (easier for parts) and the bio-med department will not have as many different brands of equipment to contend with.

Infection Prevention and Control (IPAC) are consulted about renovations and should be consulted about equipment purchases for the clinical areas.

There is evidence of follow up from the last survey: air temperature issues in exam rooms at Charles S. Curtis Memorial Hospital were addressed in 2014-15; the wooden chairs were removed from the John M Gray Centre (unable to properly clean) and Med Sleds have been purchased for the John M Gray Centre to assist to bring residents down the stairs during an emergency evacuation.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

There is a comprehensive and robust emergency preparedness plan that has regional, local, and facility components. The plans and their components are tested on a regular basis and these exercises, including drills and mass casualty exercises are used to inform updates to the plans.

The emergency management plans have also been used in actual emergencies, including hospital evacuations in recent years. This has kept a focus on the value of having robust plans in place.

The emergency management plans have been developed in collaboration with numerous community partners, and include mutual aid agreements with local industries and with the Province of Quebec (for limited service support). There are fulsome business continuity plans.

The system of emergency codes has recently been updated to include Code Silver - Active Shooter, and this update to the code system has been universally deployed and implemented across the region.

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: Community-Based Mental Health Services and Supports		
3.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
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.	
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from 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.	
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: Governance		
2.2	There are established mechanisms for the governing body to hear from and incorporate the voice and opinion of clients and families.	

5.3	The governing body provides oversight of the organization's efforts to build meaningful partnerships with clients and families.	!
10.5	The governing body regularly hears about quality and safety incidents from the clients and families that experience them.	!
Standards Set: Home Care Services		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.11	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.	
14.11	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
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.	
3.12	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.	
15.9	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from 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: Leadership		
1.4	Teams are supported in their efforts to partner with clients and families in all aspects of their care.	

3.6	There are regular dialogues between the organization's leaders and clients and families to solicit and use client and family perspectives and knowledge on opportunities for improvement.	
6.2	When developing the operational plans, input is sought from team members, clients and families, and other stakeholders, and the plans are communicated throughout the organization.	
9.2	There are mechanisms to gather input from clients and families in co-designing new space and determining optimal use of current space to best support comfort and recovery.	
10.4	Education and training are provided throughout the organization to promote and enhance a culture of client- and family-centred care.	
Standards Set: Long-Term Care Services		
1.1	Services are co-designed with residents and families, partners, and the community.	!
8.3	Goals and expected results of the resident's care and services are identified in partnership with the resident and family.	
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families.	!
Standards Set: Obstetrics Services		
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.	
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.	
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		
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.	

24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Primary Care Services		
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
3.11	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.	
15.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from 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: Public Health Services		
16.3	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)

The organization has worked with clients and families on improving mental health services after receiving feedback that there were not enough services to meet the needs of the community. This has been positive news and partners and clients/families are pleased to hear that acute care services and psychiatry will be provided.

A concentrated effort to have clients fill out the Labrador-Grenfell Health Client Experience Survey (May 2016-17) has been made and during that period over 600 patients provided feedback. 91% of the patients reported that staff respected their cultural values and 90% reported that the facility and grounds were safe. 58% of patients believed they received care in a timely manner and only 52% believed they were given information on what to expect during their visit/appointment. The senior executive has reviewed these results, reported them to the board and have identified that access is their #1 strategic priority.

The new EMS team members receive a comprehensive orientation. Some work has been done in involving patients, families and the community to mitigating issues impacting services, but there are opportunities to involve the communities more throughout the region.

The Strait of Belle Isle has a hospital representative on the Straits Development Association which has representatives from all communities on that coast. While not specific to healthcare, it is a forum in which concerns of individuals and communities can be brought forward for review.

When asked to describe the organization in one word, partners, families, clients used words such as supportive, professional, partnership, vital, sporadic engagement and frustrating. Patients found staff (nursing, kitchen, housekeeping as examples) very respectful, professional and responded in a timely manner. Families found the organization "frustrating" at times; they reported not "feeling heard". Partners (particularly First Nations) reported having sporadic engagement; they do see recent evidence of the organization reaching out to them in an effort to solicit their feedback and involve them in their care.

Priority Process: Patient Flow

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

Unmet Criteria	High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures	
9.5 Scheduling strategies, such as block times, are used to achieve an optimal flow of clients.	
9.6 There is a standardized, proactive process to prioritize and schedule elective procedures.	

Surveyor comments on the priority process(es)

The organization is in its infancy in terms of Client and Family Centred Care (CFCC). There are pockets where the approach is client and family centred, but it is not organization wide and not a strategic priority. A step the team needs to take is to assign responsibility for CFCC to someone on the organizational chart. A strategy needs to be developed to embed the philosophy into the culture of the organization and policies need to be developed, such as family presence (e.g. open visiting hours).

The organization has identified concerns around patient flow and implemented guidelines and policies which support staff in managing flow issues. For example, promoting communication between nurses and physicians in order to make a decision on which patients will be transferred or sent to the overflow room in the emergency department. The daily huddle supports staff in making decisions on patient flow as the process provides staff with information about the census in each area and pressures that need to be addressed.

Concerns related to flow and patient backup have been identified in peri-operative services at Labrador Health Centre and the manager is aware of the issues and will consider strategies to address them.

Currently strategies are under way to address flow concerns in St. Anthony where renovations have been under way to move the ambulatory care area and make room for emergency services.

An ongoing issue for the organization is cardiac patients awaiting stenting at the tertiary care facility in St John's. There are frequent delays in these patients accessing cardiovascular interventions thus requiring prolonged hospitalization awaiting transfer. Currently, if the patient is discharged, they lose their priority for the procedure as they are no longer inpatients. This significantly impacts the availability of beds, particular at the Labrador Health Centre.

High level discussions about access to these services at the provincial level will need to be held to ensure that rural patients are prioritized appropriately to minimize impact on areas with the most critical patient flow issues.

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: Diagnostic Imaging Services		
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: EMS and Interfacility Transport		
13.1	Vehicles are equipped with all the medical equipment and supplies specified in organizational requirements and align with provincial and federal legislation and requirements where applicable.	!
Standards Set: Perioperative Services and Invasive Procedures		
4.9	Contaminated items are transported separately from clean or sterilized items, and away from client service and high-traffic areas.	!
4.11	Immediate-use (or “flash”) sterilization is used in the operating/procedure room only in an emergency, and never for complete sets or implantable devices.	!
4.14	The education, certification, and competency of team members involved in reprocessing in the operating/procedure room are verified.	!
Standards Set: Reprocessing of Reusable Medical Devices		
2.5	The effectiveness of resources, space, and staffing is evaluated with input from the team, and stakeholders.	
3.2	The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
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.	!

3.7	The MDR department is clean and well-maintained.	!
4.6	Preventive maintenance is documented for reprocessing equipment.	!
8.1	The reprocessing area is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	!
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.	
12.1	The MDR department has an appropriate storage area for sterilized medical devices and equipment.	!

Surveyor comments on the priority process(es)

The organization is encouraged to review the location, layout and design of the MDRD spaces at the Labrador Health Centre and the Charles S Curtis Memorial Hospital. Consideration should be given to removing reprocessing from the Operating Room areas.

Appropriate and secure storage for sterile supplies needs to be reviewed at both hospital sites. Sterile supplies should be stored in dedicated space(s) away from traffic, air flow and moisture. More instrumentation and equipment should be ordered and available to remove the need for flashing of instruments.

To ensure staff have the necessary knowledge and skill sets to perform safe, quality work in their role, essential courses are required. When hiring staff into MDRD, plans for education and enrolment into courses should be arranged and completed within a defined time period.

The current CSA standards need to be obtained and reviewed with staff to ensure the criteria for the standards are understood and met. Infection Prevention & Control leads and the leads for MDRD need to take a participatory role to ensure standard compliance. "Recall" policies and protocols for instrumentation needs to be reviewed with MDRD staff. A monthly report is prepared by the MDRD Lead. It is informative and provides relevant information for the staff at a specific hospital location. A good topic of focus for the newsletter would be specific to MDRD staff.

Entry to MDRD should be limited to the MDRD staff. All other staff must change clothes or wear appropriate overall covers and hair covers. "No Entry" signs need to be hung and clearly visible at the entry of the soiled and clean MDRD rooms.

Hand wash sinks dedicated to MDRD staff need to be considered and placed at key entry/exit points and PPE attire needs to be placed at entry points to soiled rooms. With the aging building structure, redevelopment and space are both limited. However, the organization is encouraged to consider enhancing MDRD space, equipment and work flow.

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

Diagnostic Services: Laboratory

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

Public Health

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

Transfusion Services

- Transfusion Services

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Laboratory	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Diagnostic Services: Laboratory

The Biomedical Laboratory and Transfusion services at Labrador-Grenfell have recently undergone the vigorous evaluation of the Institute for Quality Management in Healthcare (IQMH) and ISO 15189 Plus. The organization is commended for submitting to this rigorous process and putting the financial and personnel resources behind making this effort a success.
Two patient identifiers are often challenging in smaller communities as patients and staff are well known to each other. While staff make an effort to utilize two patient identifiers consistently, ongoing education for both staff and the community will help to reinforce this important patient safety element.
Community involvement is ongoing when providing care in a rural community but formalizing the mechanisms for education and feedback is important to ensure that a variety of voices are heard and that the community feels they have a voice in their healthcare.

The Strait of Belle Isle site has limited staff resources for laboratory services which they share with diagnostic imaging. To address patient concerns on wait times, they now schedule laboratory services which has resulted in better patient satisfaction and improved staff work efficiency. This success has resulted in a trial of a similar booking system at another site. Unfortunately, this booking system is currently paper based which limits the ability of staff to provide appointment reminders, and no shows continue to be an issue. Staff are encouraged to consider monitoring no show rates to quantify predicted success once a computerized booking system and appointment reminder system is introduced.
Patient and work flow are optimized in the Laboratory at Labrador Health Centre. TV monitors show staff when a patient is in the waiting room and needing a blood draw. A number system is used to protect the

privacy of the patient. Patient identifiers and blood work orders are displayed on monitors at the work stations, so staff are aware of stat and urgent orders, and the wait times and volume of blood work needing to be processed.

The laboratory area is small. However, it has gone through LEAN Methodology and has minimal supplies with everything in its' place. Staff feel they have the essential resources and time to meet their job requirements. The equipment and technology throughout the laboratory is current and in good working condition. Preventative maintenance is scheduled on a regular basis.

The Quality Coordinator for the Region has identified quality indicators and objectives for 2018. Data collection and analysis occurs and monthly reports are provided to the site hospitals.
Staff noted that the leaders for this Regional program are engaged and provide timely responses when the need arises.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.7	Processes and policies are established to meet the diverse needs of the community, with input from clients and families.	
1.8	Services are reviewed and monitored for appropriateness, with input from clients and families.	
3.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
3.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
3.6	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
4.1	Required training and education are defined for all team members with input from clients and families.	!
4.9	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
5.5	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.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
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.	!
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	

Priority Process: Impact on Outcomes		
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.	!
15.6	There is a policy on ethical research practices that outlines when to seek approval, developed 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.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
16.4	Safety improvement strategies are evaluated with input from clients and families.	!
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

There is a dedicated and committed team with strong clinical skills who provide comprehensive Community Mental Health and Addiction services in Goose Bay and Labrador City.

They have developed strong partnerships throughout both communities where they offer numerous and varied mental health and addiction information and educational sessions to raise awareness and knowledge on these topics within the general public domain. They are commended for their leadership in the development of a number of important community initiatives that include a very comprehensive Suicide Management Risk Protocol, the Mobile Crisis Response Team and the Doorways Program.

Priority Process: Competency

The team confirms that there are many opportunities for training and development on a large variety of topics to maintain and enhance skills and knowledge.

This includes education and training on preventing and managing responsive behaviours. However, the organization is encouraged to review it's Code White direction/drills and to define specific expectations of various Code White team members roles and responsibilities when responding to a Code White. (eg: Security, Mental Health Team).

Priority Process: Episode of Care

The Province of Newfoundland and Labrador released an "All-Party" report and vision for a renewed Provincial Mental Health and Addictions System in March 2017. This report was followed up with a five year Action Plan to implement 54 recommendations that are broken down into short term, medium term and long term actions. The Mental Health and Addictions Leadership and teams are commended for their work to date in completing the short term recommendations that were directed to be finalized by March 2018.

Leaders and front line staff report that these new initiatives have made tangible improvements to the way they provide mental health and addictions services to their clients and they are excited and inspired by the changes being made and believe they will make a tangible difference and improvement to those living with mental health and addictions challenges. They feel particularly proud of the work they have done and the initial successes they have seen with the roll-out of the "Doorways" program; the "Mobile Crisis Response Team" initiative and; the streamlining/updating of the Mental Health Website which is now much more user friendly. Clients that were interviewed also reflected their knowledge and appreciation of several of these new initiatives.

The Mental Health and Addictions team are also particularly proud of the work they have done to develop a comprehensive Suicide Risk Management Protocol that is evidenced based and now standardized across the Province.

Priority Process: Decision Support

The organization uses a mix of electronic and paper based client record management. Accurate and up-to-date records are maintained for all clients and the flow of client information is well coordinated between team members and partner organizations.

Priority Process: Impact on Outcomes

Good work has been done in developing a number of relevant and meaningful quality improvement audits that are regularly completed and subsequently reported to Senior Management and the Board. Written updates are also provided on various "quality boards" to inform staff. The organization is further encouraged to share these results formally at departmental staff meetings to seek additional direct feedback from staff and/or "close the loop" on the outcome of the various quality initiatives.

A large number of the criteria within this standard set also require the direct inclusion of clients and family members in order to be rated as met. The organization is encouraged to consider adding client/family members to their Quality Improvement Committees as an avenue to seeking client perspective on their quality improvement activities.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.12	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		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
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.	!
15.6	There is a policy on ethical research practices that outlines when to seek approval, developed 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.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
16.4	Safety improvement strategies are evaluated with input from clients and families.	!

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.	!
17.10	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.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The critical care services have developed educational resources for patients and families admitted to the unit which help them to understand what to expect while they are in the unit.
Staff are given the opportunity to provide suggestions and feedback at the monthly unit meetings and they feel well supported when requesting resources for specialty services such as pain management and palliative care.

Priority Process: Competency

The organization has implemented a comprehensive education, training and skills recertification process for orientation. There is a process in place for staff requiring training and updates to participate in the orientation training. When changes and new policies and protocols are implemented staff are made aware of them and managers are able to track that the information has been read by all staff.

Staff receive feedback from managers anecdotally and the team is planning to set targets and benchmarks around performance evaluation in order to ensure performance evaluations are done annually. This will support staff in identifying learning objectives and planning for education and training.

Priority Process: Episode of Care

The team does daily rounds with the physician and nurse at the patient bedside in order to review the patient's progress. They also conduct weekly interdisciplinary rounds with participation from other health care providers in order to ensure clients receive seamless and continuous care.

Priority Process: Decision Support

The critical care services have made extensive improvements in managing and storing their equipment in an effort to support workflow processes. They have an excellent documentation flow sheet which enables staff to have a snapshot of the client's status. Staff are encouraged to update the patient care plan with expected outcomes as part of the collaborative care planning process.

Priority Process: Impact on Outcomes

The team has just recently started to collect data and has not reached the point where they have analyzed it for quality improvement activities. The team is encouraged to compare the intended and actual effects of its quality improvement activities, and, if the objective has not been achieved, adjusts its actions accordingly to meet the objective. Analyzing data helps identify trends and may reveal areas that could be considered for future quality improvement initiatives.

Priority Process: Organ and Tissue Donation

The critical care team has the means to facilitate organ and tissue donation processes. The organization has set up a reference binder with all the policies and call number for situations considered for organ and tissue donation.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Diagnostic Services: Imaging	
17.8 The team uses results of the utilization management review to educate referring medical professionals and diagnostic imaging providers on the appropriate use of diagnostic imaging services.	

Surveyor comments on the priority process(es)

Priority Process: Diagnostic Services: Imaging

The DI departments at Labrador-Grenfell Health have benefited from the provincial partners and access to resources. The provincial radiology group provide timely reports and are available for urgent consultation on images.

The team collects information on volumes, wait times and client perspectives. This information can be utilized to direct future program to help to mitigate problem areas. The online client satisfaction survey is a relatively new initiative and more results are needed to determine meaningful trends.

Maintenance of competency is an ongoing issue for the technicians. The majority are cross trained on multiple diagnostic imaging (or laboratory) modalities which is critical for a small hospital. The team may benefit from peer review CME with a peer audit of charts, film quality and technique monitoring to ensure that skills stay current and care is consistent across the organization. Ongoing education for technicians is an issue for all locations. Radiologists do provide comments on inadequate images but peer review from other technologists would be a benefit. The organization may consider formally engaging other regions for locum back-fill from larger centres, not only to cover vacation short-falls but also to provide educational and technical reviews for local technologists.

Two patient identifiers are utilized in the diagnostic imaging department. A risk in many smaller hospitals is that patients are well known to the staff and consistent identifier use can be challenging. Ongoing education for staff and for patients is critical for continued success in this area.
The Strait of Belle Isle site has x-ray services staffed by one half time position. Mitigating the impact of lack of call coverage will be an ongoing issue for the facility and team. The imaging department itself is well laid out, clean and uncluttered. The x-ray machine is an older model that is no longer supported. The process to acquire a new direct-read x-ray machine is in process.

The Charles S. Curtis Memorial Hospital is a large diagnostic imaging department, offering a wider range of services. The imaging rooms are spacious and the ultrasound rooms include ensuite bathrooms. Ongoing monitoring of the services to ensure that the needs of the community are aligned with the resources available will require ongoing monitoring and evaluation.

The Labrador Health Centre unfortunately has limited space to service the volume of clients and the organization will continue to need to be creative to ensure these services have the required space. The imaging rooms are clean, and uncluttered with adequate space for the examination and the ultrasound rooms have attached bathrooms though one room is located just outside the department. Sterilization of ultrasound probes follows the manufacturer's specifications but the work space does not permit a clean and dirty flow and the space is too small for its purpose. It is recognized that moving this process to CSR will adversely impact the work flow but this cleaning process needs to be considered as the department moves forward.

Staffing is an ongoing challenge for the organization and recruiting and retention are an organizational priority. Bursaries have been offered to students undergoing radiography studies and the organization is encouraged to delve into the contracts signed to ensure that it allows the geographic flexibility to meet the needs of the organization at the time of graduation. Further, ensuring that the training is at the level required (e.g. ultrasound) as a requirement for future bursaries, is recommended.

Call coverage is an issue for some sites with staff who do not have the required training (CT) to cover emergency imaging. This increases staff burden as double coverage to overlap this lack of training is required. The organization may want to consider their use of untrained personnel for emergency coverage and call rotations.
Labrador-Grenfell Health will need to evaluate position locations of personnel resources. As patient population and demographics shift, the organization must forecast future needs and ensure that personnel resources are matched to where they are required. This will require ongoing community engagement and political support to ensure that services are provided where they are needed most.

Regional radiology technician assets need review to ensure that the position's time resources are allocated appropriately. Currently, the regional position is predominately utilized at a low volume location and allocation review is required to ensure that higher volume locations in the region are able to utilize this asset.

Labrador Health Centre is a high volume diagnostic imaging department with the longest wait times in the region. Many appointment times are scheduled according to flight availability but when the flight is cancelled due to bad weather, it is often too late to reschedule local patients for these time slots. Engaging the supported communities and airlines to potentially get earlier notice of cancelled flights may enable staff to fill these appointment spots and maximize this valuable resource.

Diagnostic imaging utilization is an area that should be reviewed to ensure that this resource is being optimally utilized. Primary care clinicians should be educated on best practice guidelines to minimize ordering of unnecessary tests. Audits of usage should be completed (perhaps as a resident research project) to further educate clinicians on imaging usage and help to minimize inappropriate ordering. The utilization of clinician bedside ultrasound should also be audited as ultrasound is an operator dependent skill and inexperienced usage often leads to inappropriate technologist consultation. Bedside ultrasound is inconsistently documented in the chart and if it is utilized, must be documented by the clinician performing the test.

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.	
2.11	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
12.3	Client privacy is respected during registration.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
16.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!

17.4	Safety improvement strategies are evaluated with input from clients and families.	!
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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergency department team at Labrador Grenfell Health is proactive in their community involvement and work to be transparent in their quality improvement process. They have included clients and families in their committee meeting and actively engage the elderly population to provide feedback and evaluation of their services by having volunteers approach patients in the department to assist them with completing satisfaction surveys.

At Labrador Grenfell Health the team conducted a LEAN project last year which was driven by staff and included participation from housekeeping, health records, maintenance, nursing and DI). Leadership gathered ideas on how to optimize flow in ED and make changes. This was another opportunity to understand each other's perspective and develop a collaborative plan.

The team in St. Anthony is also considering plans for redesigning the emergency department once the ambulatory care area is moved. Leadership is encouraged to look to clients, families, the community and other emergency departments that provide similar services for guidance in redesigning the department.

Priority Process: Competency

The team has done a terrific job in ensuring that provincial targets and benchmarks are met. With the addition of EMS services to the emergency department, additional improvements have been achieved as the paramedic roles have been expanded to include supporting the emergency department triage.

Outreach activities are in place and community involvement has also supported ongoing improvements. Access to specialty medical services is available in St. Anthony so that the medical team is supported. The telestroke program in the call room also has linkage with every community. The physicians in LHS supports the team on on code blue calls in the region.

Priority Process: Episode of Care

The team is very proactive in engaging client, family and community feedback about their services. They are involved in many initiatives to support health promotion targeted at population needs.

Data is actively collected for quality improvement and results are evident following implementation of the nursing led initiative for a mental health liaison, which has reduced readmission of mental health patients.

At Charles S. Curtis Memorial Hospital changes to the emergency department triage process were implemented following the recommendations of the X32 project. Staff identified concerns related to privacy and confidentiality as patients are offloaded from the ambulance bay and then travelling through a high traffic area to get into the emergency department. Since this is a small community where everyone knows everyone, it does pose potential for breaches in privacy.

At the Labrador Health Centre, the registration area is open to the common waiting room and backs onto the triage and an examination area. There have been modifications made to address this potential breach in privacy by having the registration clerk not ask the patient the 'reason for visit'. The data is entered after the patient is triaged, but this process is less efficient and the team is encouraged to look for ways of improving the registration process.

Priority Process: Decision Support

The emergency department has contributed to improved care through maximizing use of available technology. Implementation of the telestroke program has greatly facilitated stroke management in the region. The emergency department's doctors also run the cardiac arrest codes remotely using the webcam which provides significant support to the region.

Priority Process: Impact on Outcomes

The team implemented safety rounds where they walk about in the department to identify safety issues and as a result they produced a document which identified 10 safety issues and strategies to correct them. This was shared with staff and the team received very positive feedback following this initiative. The team is encouraged to standardize processes for engaging client and family input with regards to evaluation of quality improvement initiatives, patient safety incidents and service design.

Priority Process: Organ and Tissue Donation

The organization has a process in place for facilitation of organ and tissue donation. The staff is well aware of the resources needed to support patients through this process.

Standards Set: EMS and Interfacility Transport - 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		
5.1	Required training and education are defined for all team members with input from patients and families.	!
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.	!
Priority Process: Episode of Care		
	The organization has met all criteria for this priority process.	
Priority Process: Decision Support		
23.9	There is a process to monitor and evaluate record-keeping practices, designed with input from patients and families, and the information is used to make improvements.	!
24.2	Policies on the use of electronic communications and technologies are developed and followed, with input from patients and families.	
Priority Process: Impact on Outcomes		
26.4	Verification processes are used to mitigate high-risk activities, with input from patients and families.	!
26.5	Safety improvement strategies are evaluated with input from patients and families.	!
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

The Emergency Medical Services (EMS) for Labrador-Grenfell Health fall under the provincial program with central oversight. The Provincial Medical Oversight (PMO) office provides a medical director, standardized medical protocols and delegated acts, and sets the requirements for maintenance of competency throughout the province. The Manager of Paramedicine, Fire and Emergency Services is a relatively new position of Labrador-Grenfell Health and provides oversight for the paramedics and the paramedicine program. Under this leadership, audits of processes and clinical provision have been initiated to ensure efficient and quality provision of service. The team will need to ensure that they are utilizing suitable benchmarks to gauge their performance against other regions in the province or comparable services in other regions. As this program matures, communicating the rationale for collecting data to front-line staff and the community will become increasingly important to ensure these efforts are meaningful. Once baseline data is in place, communicating the impact of interventions will help staff to recognize the impact of changes and demonstrate that tracking and measuring data does result in practical and meaningful results.

The team at Labrador-Grenfell Health has developed linkages with Police, Indigenous Communities and Fire Departments to better tailor their services to meet the needs of its partners and community. Further improvement plans have been identified by developing linkages with the First Nations population. An excellent example of this effort followed the identification of inappropriate EMS usage in a community. The leadership of the community was engaged and were successful in providing education and additional non-emergent transportation services, thus improving utilization of the EMS resource.

In the development of future infrastructure to support the EMS teams, the organization is strongly encouraged to consult with the teams and patients and families on areas they identify for improvement. The EMS teams are the local experts on out of hospital care and patients and families have first hand experience on area of concern and the means to improve.

One area that the leadership is encouraged to review is the ambulance ramp at the Charles S. Curtis Memorial Hospital. The current carport is too short for the newer box ambulances and visible damage from prior impacts due to the scalloping of the roof are visible. A recent renovation to provide a luggage storage area for patients awaiting transport is underway but in doing so has disrupted flow into the emergency and out patient departments which is the primary area through which patients access health care. The EMS ambulance is garaged across the road and requires that EMS staff cross the road to get the ambulance and respond to a call. More concerning is that when the ambulance returns, the patient must be brought out into the elements and received by nursing staff who are exposed to the inclement weather

before being brought into the department. During this time, the patient is also exposed to those awaiting emergency and outpatient services, adversely impacting patient privacy and confidentiality. Tearing down the current structure and replacing it with a dual door pull though garage would eliminate weather exposure, allow the ambulance to be garaged at the hospital, limit the requirement to leave the ambulance running, protect staff from weather and the injury potential of crossing the road to get in the ambulance and most importantly, protect the patient's comfort and confidentiality. These infrastructure changes may be considered during the next emergency department structural review.

Priority Process: Competency

The EMS team must maintain competency through both qualification courses and ongoing maintenance of skills, as set out by the PMO. Many of these courses are provided through the organization and EMS providers are paid while taking mandatory courses.

Due to the rural population, EMS call outs are less frequent then encountered in many larger centres and the EMS staff are utilized in the emergency departments between calls. When not on call out, they provide front-line patient care within their scope of practice, which additionally helps them to maintain competency. They also provide security and portering services. This multi-faceted utilization of the paramedics' extensive training is commendable, providing much needed medical support within the facility as well as supporting continuation of this valuable service, despite the relatively small call volumes.

Performance appraisals are not consistently completed across the organization. The organization is encouraged to ensure that their performance appraisal system is utilized and to review options that support the leadership to complete these necessary appraisals in accordance with hospital policy. Once appraisals are completed more consistently, they will provide an opportunity to identify and support individuals in a uniform way across the organization.

Team members are recognized for their contributions but there are opportunities to solicit and provide this feedback on a more regular and consistent basis. While feedback is provided informally, not all staff interpret informal feedback as having the same importance as written or more public recognition of their efforts.
Involving patient and family representatives to provide input and advice is being considered but has not yet been implemented throughout the organization.

Priority Process: Episode of Care

The 911 system dispatch is centrally managed. While 911 service is available throughout the region, many patients continue to access the ambulance through the local number. Continuing to educate the population about the 911 service is encouraged to provide them with the additional support available through the central number while awaiting the first responders.

Ambulances are equipped with satellite phones as there are many areas in the region that do not have cellular service and the hills block radio reception.

Formal addresses, road signs and house numbers are inconsistently available throughout the region making emergency response a challenge for those unfamiliar with the area. This will become a larger issue with retirements and the presence of new staff. The organization is encouraged to engage the leadership in their communities to provide road signs and 911 numbers to aid responders and increase the safety of their supported populations.

For suspected infectious disease, providers are trained to recognize, protect themselves and report the potential infection to the organization. Continuing to educate and remind staff and the community about the importance of identifying infectious disease to help protect staff, families and other patients.

Interpretation services and tools are utilized by EMS in providing care to indigenous communities. They do not have access to other interpretation services for dealing with international workers or tourists. The organization may consider checking with other regions to see if accessing their services is an option or utilizing cell phone apps to verify if this is adequate to meet the rare interpreter needs.

Priority Process: Decision Support

EMS charting is consistent across the province and the Patient Care Report (PCR) is regularly audited for completeness and clinical protocol adherence. IPAD access on the ambulance for tracking of all checklists has successfully streamlined and standardized these processes.

Priority Process: Impact on Outcomes

The EMS services fall under the province and thus benefit from the resources available at the larger population centres. The medical director and team for the province develop the evidence based protocols and disseminate them and regular updates to the regions. Within Labrador-Grenfell, these updates are confirmed as being received through their email tracking system. Standardized charting, monitoring and compliance with procedures is done both locally and centrally.

The organization provides education to patients and families on how to protect themselves in receiving health care such as information on expecting to provide two client identifiers. Continuing to educate patients and families and involve them improving these processes is encouraged as the organization moves forward.
Formal patient and family involvement is in the early stages in the region and formalizing this involvement is in the organizational plans moving forward.

Priority Process: Medication Management

Medication management for EMS is managed centrally by the province. All medications are standardized so that all ambulances carry the same types of medication with no deletions or additions, although increased quantities are carried due to the distances involved in providing out of hospital care in these rural and remote regions. The organization may consider standardizing these quantities by region to ensure consistency. There are no narcotics carried by the EMS as it is outside of the Primary Care Paramedic scope of practice.

Priority Process: Infection Prevention and Control

Infection prevention and control (IPAC) is coordinated though the organization's IPAC team. The EMS undergo hand hygiene and personal protective equipment training with other hospital staff. Hand hygiene audits completed by their EMS peer is a new program which seems well received by staff. Continuing to educate and monitor compliance with this initiative is encouraged.

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.	
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.	!
3.10	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
10.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
12.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
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.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
14.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
14.3	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
14.7	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
14.8	Safety improvement strategies are evaluated with input from clients and families.	!
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.11	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

Home Care Services are provided using a collaborative approach. Where possible clients and families are included and key to the planning of care. Standard assessments are utilized such as the interRAI assessment, a universal standardized tool that was designed to be person centred.

Additionally Home Care services fit with the core values of Labrador-Grenfall including collaboration, compassion, respect, empowerment, integrity and efficiency and effectiveness.

Services are designed to meet the needs of the communities and while are standardized, care is individualized.

Partnerships are many and contracts are developed such as for personal care. Resources are always a challenge and the team of staff work closely to cover for one another, addressing gaps with innovation and teamwork.

Dedicated regional coordination including staff are available for palliative care across the health continuum.

As the geography is vast team members in other offices take the opportunity to communicate electronically and by teleconference.

Services are reviewed and the organization might consider formalizing the process with input from clients and families.

Some clients and families described resources as adequate and staffing as very good. Staff are very aware of space limitations and challenges. The organization might consider engaging with clients and families for program wide input to resources, space and staffing.

Priority Process: Competency

Home care staff reported having all the required orientation, training and updates needed to perform their roles. Though there is no wait list in home care, workload can be a challenge and in at least one area the program (Goose Bay) is going to ambulatory care clinics 7 days per week. This will hopefully decrease emergency room visits. Credentials and competencies are up to date and quality and safety and client care are priorities An example is the safe use of infusion pumps.

An excellent rapport exists with partners such as biomed, who are responsive should their support be needed. Recent education and training opportunities include Home First, Medication Reconciliation, Compassion Fatigue and Palliative Care Training.

Yearly performance appraisals are conducted where possible. To continue the good work of the Home Care Program it is recommended to engage clients and families seeking their input in programs and services. Home Care and Public Health are complex areas and cross training of staff may require additional review, support and consultation

Priority Process: Episode of Care

Clients and family reported a high degree of satisfaction with Community and Home Care Services. They feel included and involved in care planning and see the staff as supportive and advocates. Staff take pride in their work and their community. Each community is unique with varying challenges such as a younger community in Lab City, and an aging community in St Anthony. Staff are comfortable with the clinical support received from partners and see the greatest challenge as resources (ie: vendors for beds) access (to senior housing) and lack of storage for equipment. As some communities are aging the need will only continue to grow for housing and supports and the organization is encouraged to analyze once the planned community health assessment is complete.

Priority Process: Decision Support

Technology and information systems continue to develop and evolve in Community Health. Accurate and complete records are maintained and standardized health information is collected across the health authority. Privacy and confidentiality is key. It is suggested that input from clients and families be formalized.

Priority Process: Impact on Outcomes

Home Care Services are provided based on evidence. Much of the work is standardized across the region and are province wide initiatives utilizing standardized tools and assessments. While the client and family feel they are a partner in care there is opportunity to engage clients and families for input on strategies, safety, guidelines and outcomes.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
2.7	Input is gathered from the IPC, and the OHS teams to maintain optimal environmental conditions within the organization.	
2.8	Environmental services and the IPC team are involved in maintaining processes for laundry services and waste management.	!
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
7.5	Policies, procedures, and legal requirements are followed when handling bio-hazardous materials.	!
8.4	Team members, and volunteers have access to dedicated hand-washing sinks.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

There are resources allocated to Infection Prevention & Control (IPC) throughout Labrador-Grenfell Health. The IPC committee meets monthly and there is Regional staff and representation from the Public Health. The Medical Officer of Health provides ongoing support to the IPC team. At each IPC meeting a number of policies are reviewed and revised. The policies are also revised ad hoc.

Healthcare Associated infections are tracked throughout the Region. The data is analyzed to identify outbreaks and trends. This information is shared with front line management and staff, and flows to the Quality Assurance Committee and the Board. Flow charts and audit reports can be located on the communication boards in the Clinical areas The "Safer Healthcare Now Surgical Site Infection" bundle is used to monitor Caesarean Sections and joint surgery. The results from this data analysis goes directly back to the surgeon and staff involved in the surgical case(s). Clinical practice changes do occur based on the analysis and trending information.

A great deal of effort and work has gone into the development and implementation of the hand hygiene program and education. Labrador-Grenfell is encouraged to continue its' work on hand hygiene monitoring and continue to increase awareness and compliance.

All Infection Control policies, algorithm flow charts and protocols are available to staff on the hospital intranet. There is always supervisory or administrative support in the evening and nights shifts, and on

weekends, so that staff have support should a IPC situation arise. The IPC members are commended for the work they have completed in the above areas.

The Strait of Belle Isle Health Centre is a new facility that was designed and furnished with attention to IPC
requirements. Facilities are well laid out, bright and clean and furnishings are non porous and suitable for a healthcare setting. Hand hygiene products are readily available and signage is visible throughout the organization.

The IPC committee is considering the possibility of having a patient and family representation on this committee and the role this person would provide to the IPC service. The organization is in the process of developing a Patient Advisory Council.

It is recommended that the Infection Control Practitioners in the Region complete spot audits in areas such as e.g. Medical Device Reprocessing Department to ensure reprocessing standards are consistently met. There needs to be auditing for compliance in the sharp and waste holding areas to ensure doors are locked, garbage lids are secure and holding bins are not overflowing. IPC & OHS needs to monitor the laundry environment and ensure temperature and humidity control and ergonomically correct practices and equipment are available to staff.

It is important from an IPC and risk perspective to LEAN the organization and de-clutter rooms and halls.

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.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.6	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
8.15	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
9.4	The assessment process is designed with input from clients and families.	
9.7	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
9.7.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.7.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
11.9	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		
12.8	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.	!
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.	!
15.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
15.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
15.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
15.4	Safety improvement strategies are evaluated with input from clients and families.	!
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
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

Inpatient care at the health centres within the Health Authority is provided on a combination of general inpatient units with dedicated areas and services for obstetrical and surgical care.

While there are patient specific goals and objectives for an episode of care, there are no unit or facility specific goals and objectives to guide the overall development of local programs and evaluation of the effectiveness of care. The organization is encouraged to develop a framework for facility and unit specific establishment of SMART (specific, measurable, achievable, realistic / relevant, time sensitive) goals and objectives on a periodic basis.

As the health authority develops its strategy for involving clients and families in its planning and evaluation processes, these voices can help ensure that the goals and objectives developed for inpatient care are patient centric.

Priority Process: Competency

Clinical staff on the inpatient units are well trained, competent and subject to ongoing assessment of these competencies. There is an active training program with a full complement of learners from various clinical discipines.

Although the health authority has developed a comprehensive ethics framework, not all staff interviewed were familiar with it. The organization is encouraged to ensure that all staff are provided with education and training on the ethics framework and tools for ethical decision making, both as part of an orientation package and on an ongoing basis.

Priority Process: Episode of Care

The inpatient units have implemented a range of standardized patient safety initiatives, including the universal use of the Braden scale for assessment of risk of developing pressure ulcers, the Morse scale for assessment of the risk of falls, and the need for venous thromboembolism prophylaxis and standardized protocols for it. The use of these safety tools is audited on a regular basis and there is a high degree of reported compliance.

The standard route for admission to an inpatient bed is through the ER. While this standardizes the admission process, it can also create a bottle neck in patient flow and may create a barrier to admission for certain patients. Direct admissions to inpatient units are uncommon. Consequently, as observed on the survey, there is a potential for some of the standard admission safety processes (such as completion of VTE prophylaxis assessment) may be bypassed. While this may be uncommon, the health authority is encouraged to review admission processes to ensure that the route for admission is patient focussed and to ensure that all patients admitted undergo the same safety assessments.

The health authority has implemented a system of "intentional rounding" on an hourly basis for all inpatients. Both staff and patients interviewed indicate that this creates an effective means for identifying patient needs on a proactive basis.

The health authority has implemented medication reconciliation on admission to hospital and there is a standardized BPMH (best possible medication history) form that is used to facilitate this. However, by observation on the survey, it is apparent that while the BPMH form is standardized, there are varying interpretations of its use to generate ongoing medication orders, as well as its use for reconciliation at points of patient transfer, including discharge. There is a plan to further implement medication reconciliation at transfer and discharge and the health authority is encouraged to ensure that not only the tools for medication reconciliation (BPMH form, etc) but that the processes in which the BPMH is used by clinicians are also standardized.

There is standard designation of the care status of inpatients as either 'acute', 'alternate level of care', or 'medically discharged'. As with all inpatient care, there are bottlenecks in moving patients to the most appropriate venue of care depending on their care needs. There are a significant number of inpatients at any one time who may be clinically stable but are waiting transfer to a higher level of care for cardiac investigative procedures and interventions. The health authority is encouraged to continue to work with its partners in Eastern Health to streamline the process for managing cardiac wait lists and prioritisation to ensure that patients awaiting cardiac procedures are prioritized based on clinical status and urgency, not on admission status or location.

Priority Process: Decision Support

Inpatient client records are currently a hybrid of paper based and computerized (Meditech) records. There is a comprehensive patient record kept for each patient but its components may be in various places and formats at any one time. Information may be found in the Meditech system, in binders at the nursing station, and at the bedside. This can create the potential for information to be missed by clinicians.

The health authority is encouraged to develop an information management (IM) strategy, supported by its information technology (IT) strategy, to ensure that clinical information is available to clinicians at the point of care in a consistent, secure, and convenient manner. Current practices involve electronic transmission of lab data, which is then printed to be signed and stored in hard copy in patient charts. Similarly, decision support tools such as clinical order sets are completed electronically, then printed and sent to pharmacy, where they are re-entered into the pharmacy electronic record. This is not only inefficient, but introduces the potential for error when information is transferred from one system and format to another. While the health authority may not be ready to implement a fully computerized patient record, it is encouraged to develop an overall information management strategy to guide further investments in information technology.

Priority Process: Impact on Outcomes

The health authority has implemented a consistent process for patient follow up with standardized telephone calls following discharge. This is well received by patients and provides a valuable tool for assessing the effectiveness of care and of the discharge process.

The health authority has implemented a robust program of clinical audits and provides clinicians with a broad range of decision support tools (order sets, access to Up to Date Online, etc). However, in identifying clinical guidelines and in evaluating the impact of care plans and protocols, there has been no involvement of patient voices to ensure that all aspects of care are patient centric.

The organization is encouraged to fully develop its strategy for including patient voices in its evaluation processes and ongoing quality initiatives for inpatient services.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Service-specific goals and objectives are developed, with input from residents and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from residents and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from residents and families.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from residents and families where appropriate.	
Priority Process: Competency		
3.15	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
4.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
5.1	The workload of each team member is assigned and reviewed in a way that ensures resident and team safety and well-being.	
Priority Process: Episode of Care		
7.2	Residents and families are encouraged to be actively engaged in their care.	
7.14	Information and education about recognizing and reporting abuse is provided to residents and families.	
7.18	A process to investigate and respond to claims that residents' rights have been violated is developed and implemented with input from residents and families.	!
8.2	The assessment process is designed with input from residents and families.	
10.5	Residents are involved in menu planning.	

Priority Process: Decision Support		
13.8	There is a process to monitor and evaluate record-keeping practices, designed with input from residents and families, and the information is used to make improvements.	!
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from residents and families.	
Priority Process: Impact on Outcomes		
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from residents and families, teams, and partners.	
15.3	There is a standardized process, developed with input from residents 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 residents and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from residents and families.	!
15.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from residents and families.	!
16.1	A proactive, predictive approach is used to identify risks to resident and team safety, with input from residents and families.	!
16.2	Strategies are developed and implemented to address identified safety risks, with input from residents and families.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from residents and families.	!
16.5	Safety improvement strategies are evaluated 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		

There is strong clinical leadership across all sites. There are also very dedicated and supportive Clinical Educators who deliver a large variety of mandatory and optional educational in-services.

Leaders are encouraged to actively include residents and families in the review of the physical space and the roles and responsibilities of caregivers.

Priority Process: Competency

The organization has a clear focus on providing necessary education and training opportunities for all staff (mandatory and optional). Leaders and staff interviewed confirmed receiving education and training on numerous topic matters such as: workplace violence, managing responsive behaviours, safe equipment use, infusion pump training, lift and transfer of residents, restraint use, cultural sensitivity education.

The organizations leaders are encouraged to develop a plan to ensure the annual provision of performance reviews for all employees can be completed.

Leaders are encouraged to ensure that formal Resident and Family Councils are actively in place and supported at all Long Term Care sites. These Councils can serve as one forum to gather the necessary resident and family input that is required to support resident-centred care and meet accreditation standards.

Priority Process: Episode of Care

A skilled team of multidisciplinary care providers offer care and service to the residents in Long Term Care at the three sites that were visited during this survey. Centre leaders speak very highly of the dedicated staff who strive to provide individualized and loving care to the residents under their charge each and every day. Although it was clear to the survey team that direct care staff (nurses and patient care aides) carry a very heavy resident case load, they do so with an intentioned focus to ensure individual resident needs can be met.

The nursing team is commended for it's clear focus on providing exemplary pressure ulcer and wound care. There are many nurses who have completed the wound care course and there are notable low numbers of pressure ulcers at all three LTC sites. Leaders also attribute these low pressure ulcer numbers to the new Patient Rounding Initiative that was recently introduced.

With four LTC sites in the region there is an opportunity for more collaboration between sites to share best practices, learnings and ideas that will serve to enhance the resident care experience.

Priority Process: Decision Support

The organization has a mix of electronic and paper record keeping processes that are relatively well interfaced.

Resident records are currently stored for an indefinite period and the organization is encouraged to review their provincial privacy and health information protection laws to guide decision making in record storage/destruction.

Although the organization has a well defined Ethics Framework, it is not well known or utilized within the long term care setting. There is opportunity for staff development in recognizing ethical circumstances and addressing them through the Ethics Framework.

Priority Process: Impact on Outcomes

Good work has been done in developing a number of relevant and meaningful quality improvement audits that are regularly completed and subsequently reported to Senior Management and the Board. Written updates are also provided on various "quality boards" to inform staff. The organization is further encouraged to share these results formally at departmental staff meetings to seek additional direct feedback from staff and/or "close the loop" on the outcome of the various quality initiatives. They are further encouraged to include residents and families in their quality improvement activities.

A large number of the criteria within this standard set also require the direct inclusion of clients and family members in order to be rated as met. The organization is encouraged to consider adding client/family members to their Quality Improvement Committees as an avenue to seeking client perspective on their quality improvement activities.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
1.3	The roles and responsibilities of the interdisciplinary committee are regularly evaluated and improvements are made as needed.	
2.3	There is an antimicrobial stewardship program to optimize antimicrobial use. NOTE: This ROP applies to organizations providing the following services: inpatient acute care, inpatient cancer, inpatient rehabilitation, and complex continuing care.	ROP
2.3.5	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	**MINOR**
3.1	The interdisciplinary committee sets criteria for adding and removing medications to the formulary.	
3.3	The interdisciplinary committee regularly reviews and updates the formulary.	
3.4	The interdisciplinary committee ensures that teams are informed about any changes to the formulary.	!
4.4	The effectiveness of training activities for medication management is regularly evaluated and improvements are made as needed.	
11.2	A policy that specifies when and how to override smart infusion pump alerts is developed and implemented.	!
12.6	Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas.	!
27.4	The interdisciplinary committee regularly and comprehensively evaluates its medication management system.	
27.6	The interdisciplinary committee prioritizes and completes medication use evaluations.	
27.8	The interdisciplinary committee shares evaluation results with teams.	

Surveyor comments on the priority process(es)

Priority Process: Medication Management

The health authority has recently reinstituted a Pharmacy and Therapeutics Committee, with multidisciplinary representation, reporting to the regional Medical Advisory Committee. The Terms of Reference of this committee give it responsibility and accountability for most of the medication management processes, particularly the programmatic components and quality assurance. As a newly reconstituted committee, the P&T committee has had to prioritize its work plans and focus on areas it has identified as high priority.

In the absence of established P&T processes for system oversight, most of the processes are overseen directly by the local head pharmacist. The actual processes employed for quality assurance and quality improvement in pharmacy services vary across the region based on the local leadership of these individuals. The P&T committee is encouraged to establish standardized quality indicators (KPI's) and monitoring systems for the medication management processes it has accountability for.

There is a well developed Antibiotic Stewardship program that has been implemented across the region under the accountability of its own oversight committee. The program is robust and comprehensive and there is evidence that it is beginning to change prescribing behaviours with respect to antibiotics. The health authority is encouraged to evaluate the Antibiotic Stewardship Program for effectiveness as well as to leverage the change management process it has used. The process used to implement this program could be used as a template for other medication management processes.

Currently, there is no single formulary across the health authority. Facility formularies are largely harmonized but the processes by which these formularies are managed varied from site to site. Similarly, the processes for ensuring adherence to the formulary, and approving exceptional variances are not well established. The P&T committee is encouraged to prioritize the development of a single, health authority wide formulary, with accompanying policies for managing additions to, compliance with, and review of the formulary.

Medication related errors and incidents are reported through the computerized incident reporting system. This is a rich source of data for identifying areas for improvement. The P&T committee is encouraged to use the data from the incident reporting system to identify trends in medication management that could signal the need for enhanced quality assurance or opportunities for quality improvement.

Patients are provided with information on their role in ensuring medication safety. This is primarily through posters placed strategically in patient rooms advising patients of the pertinent questions to ask about their medications. However, patient interviews suggest that this is not a particularly effective means of informing patients as none of the patients interviewed were aware of this information until it was pointed out to them. It is recommended that the health authority evaluate the effectiveness of the processes used to inform patients of their role in medication safety with a focus on active, rather than passive patient education on this important aspect of patient safety.

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.		
Priority Process: Competency			
3.1	Required training and education are defined for all team members with input from clients and families.		!
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			
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.5.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	8.5.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
11.9	Established policies on handling, storing, labelling, and disposing of medications and breast milk safely and securely are followed.		!
Priority Process: Decision Support			
14.8	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.		!
15.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.		
Priority Process: Impact on Outcomes			
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.		
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.		!

16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
16.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
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

There are approximately 250 to 300 births at the Labrador Health Centre. The birthing rooms are spacious and have essential equipment for both the delivery and the care of the newborn. A new manager and educator are revamping the training for staff orienting to the OB program. This appears to be well received by the staff. This program currently has no paediatricians.

Charles S. Curtis Memorial Hospital delivers approximately 40-60 births per year. Staffing L&D 24/7 is an issue for the Leader of this location. There are currently only 3 L&D trained staff who are also required to take on-call. Staff burnout and retention may become an issue which will affect the service. This location currently has two paediatricians.

There is intent to become Baby Friendly Initiative (BFI) credentialed in the summer/fall of 2018 and the organization and staff are commended for the work that has gone into the development and implementation of the BFI.

There are no midwives associated with the OB program.

Labrador-Grenfell Health has a standard practice of a patient follow up with a telephone call within 30 days of discharge from the hospital. During the phone call, the patient is asked to identify staff who they would like to recognize. As a result, an "Exception Team, Exceptional Card" is sent out by management to the staffs' home.

Priority Process: Competency

Performance appraisals are completed annually. In speaking with staff, they noted that they appreciate the feedback and identified areas for improvement that occur during the performance appraisal.

The MOREOb program has been used to support education for the Obstetrical program for the last 6 years. The organization is in the process of deciding if the MOREOB contract should be renewed this fall. Staff and physicians feel the MOREOB program has made staff work better together as a team and use standard approaches in the provisions of patient care.

Priority Process: Episode of Care

The Obstetrical Unit at the Labrador Health Centre and Charles S Curtis Memorial Hospital were visited by the surveyor team. There are approximately 250-300 births per year at HVGB and approximately 40-60 births at the Charles S. Curtis Memorial Hospital. There are 2 locum Obstetrical Gynaecologist Specialists at Labrador Health Centre and 2 permanent Obstetrical Gynaecologist at the Charles S. Curtis Memorial Hospital. There are 2 paediatricians at the Charles S. Curtis Memorial Hospital where deliveries are low and no paediatricians at Labrador Health Centre where delivery numbers are higher. The organization is encouraged to review service needs and volumes, and put the resources where the demands and needs are required.

The organization is culture sensitive in that it respects the birthing plan desires of the patient and family. Families of First Nation patients' (as identified by the patient) are permitted to attend the birth of the baby. Staff are also familiar with the birthing practices of Philippine patients and include these into the birthing plan.

High risk pre term cases, critically ill infants/ babies and children are transferred via medivac to Janeway Hospital in St Johns Newfoundland. When necessary, the team from Jane Way arrives with all essential equipment and supplies, stabilizes the infant/child and transports it to the Jane Way hospital. Parents may accompany the baby if there is room on the plane/helicopter, otherwise arrangements are made with the assistance of social services for the parents to follow the baby on another flight. This practice has been identified as an issue as the parents who provide consent for the babies' treatments may not be physically present to provide informed consent. The organization is encouraged to work on this issues from a People Centred Care Approach and with the Eastern Health system.

Both hospital sites have 24/7 on call and Csections are performed in the Operating Room. Labouring moms are registered in the Emergency Department, assessed and sent to the Obstetrical Unit if actively labouring and dilating. The Emergency Physicians do deliver the baby at Labrador Health Centre and the locum provides on call support. This practice may cause concern and risk for patients in the ER who arrive as a CTAS 1 or 2 and the ER physician is delivering a baby and unable to provide immediate treatment to the ER patient OR visa versa. The organization is encouraged to review this practice.

At both hospital sites, all babies room in with their mothers and skin to skin contact commences at birth. Labrador-Grenfell Health has been working diligently on the 10 steps required to obtain the Baby Friendly Initiative (BFI) designation. They are hoping to receive this award in the summer or fall of 2018. The organization is commended for its commitment and ongoing investment to obtain the BFI designation.

The Managing Obstetrical Risk Efficiently Program (MORE OB) is in its 6th year of implementation in Labrador-Grenfell Health. Management, Staff and Physicians feel the program has benefited the OB program in that the team learns and works together to create standard practices and protocols that are based on evidence based research and best practices. Staff noted they feel more confident and competent in their OB skill sets because of the knowledge and training they obtained through this learning module.

There is a Kit available for staff to use should a stillbirth or infant death occur. It includes items such as the hand /footprint of the infant, picture of baby, literature, contact numbers for support and other memorable items that may comfort the parents.

Priority Process: Decision Support

Each patient, including mom and baby has an individual compiled health record. There are processes in place so that the patient may have access to their health record.

The organization is encouraged to continue their work toward a computerized chart and move away from a hard copy health record.

Priority Process: Impact on Outcomes

The OB program team is encouraged to include patients and families on committees to assist in the development of goals, objectives, quality improvement initiatives and evaluation, evidence based practices etcetera.
The organization is in the process of creating a Patient Advisory Council and defining roles for the patient and family members.

Standards Set: Perioperative Services and Invasive Procedures - 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	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.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
8.2	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		
6.1	Required training and education are defined for all team members with input from clients and families.	!
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.	!
7.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
8.1	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		
11.2	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		
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.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
25.1	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.	
25.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, 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.	
25.11	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

The organization collects input from patients and families through satisfaction surveys. They are encouraged to identify additional specific goals and objectives from end-of-service planning reports, wait list data, and community needs assessments. Given the unique population needs, identifying trends that could have an impact on the community and its health service needs will benefit the organization. They

are encouraged to formalize this process through the patient advisory committee.
The team is encouraged to look at the root causes of resource issues in the peri-operative services using data, cost analysis of OT and workload associated with peri-operative services in order to address them.

Priority Process: Competency

The organization has established policies and guidelines for managing workflow and overtime throughout the hospital, however in the peri-operative area (GHC) the team is encouraged to provide more stringent mechanisms in order to support staff with working through collaborative decision-making regarding management of add-on cases.

Priority Process: Episode of Care

The organization has implemented the post discharge call as a standard of practice for all discharges. This enables the organization to evaluate the effectiveness of transitions and use the information to improve transition planning. As a follow-up to the information gathered from this process, staff, managers and leadership is made aware of compliments and positive feedback.

Priority Process: Decision Support

The organization has revised documentation forms in the peri-operative area and staff acknowledge that these new forms support accurate and timely communication of client information at all transition points. The organization is encouraged to ensure implementation of the standardize the forms to all the peri-operative services. This will facilitate data collection and measurement for managers and leaders.

Priority Process: Impact on Outcomes

The organization is encouraged to formalize processes with input from clients and families through the patient advisory committee.

Priority Process: Medication Management

Medications are well managed in the perioperative services area.

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

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	
9.8 When completing the POCT report and filing it in the client record, the health care professional delivering POCT clearly labels the results as "POCT".	

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

The Point of Care Testing program has been in place since 2014 with a dedicated POCT coordinator responsible for the overall program across all of the regions' sites. The regional Medical Advisory Committee has been officially designated as the inter-disciplinary oversight committee with responsibility for the POCT program.

The majority of the POCT accreditation standards overlap with OLA standards so the scope of standards review undertaken as part of the accreditation survey is limited to the unique Accreditation Canada standards.

The regional POCT program participates at the provincial level in an inter-health authority purchasing program to tender contracts for POCT supplies. This tendering process also is described as defining the scope of the POCT test menu available in the health authority's sites. There has not been an independent, health authority driven, strategic evaluation of the POCT program to determine whether an expanded menu of POCT tests may be cost effective relative to the cost of transporting samples or patients, or the avoidable costs associated with not obtaining a test result. POCT program leaders are aware that there may be opportunities to expand the POCT program menu locally based on business and clinical case submission but have not done so. Similarly, not all sites have the full range of POCT tests on the current menu available to them. Specifically, troponin analysis is only available in select sites. The health authority is encouraged to evaluate both the clinical and business case for expansion of the availability of troponin as a POCT at all sites.

At the time of the survey, no chart audits have been done to monitor documentation of POCT test results as required by policy.

The organization is encouraged to standardize the process for recording of POC tests done at each site, independent of the recording of the test result in the patient record, with reference to the reagent or test strip lot numbers used as well as the quality reference test reagent lot numbers in order to facilitate 'trace back' processes in the event of a quality audit or product alert.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
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		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.2	The assessment process is designed with input from clients and families.	
Priority Process: Decision Support		
12.8	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		
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.	!
15.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
15.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
15.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!

15.4	Safety improvement strategies are evaluated with input from clients and families.	!
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.11	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

Primary Care Services include 17 sites; 14 community clinics and 3 health centres. Service specific goals are client/patient focused and individualized based on input from client/patients/families.

Information is collected from clients/patients and each has a profile on the chart and the chart is set up in a consistent and standardized format. Chart audits are conducted and results in some areas are 100%.

2017 was a focus year for policies and over 50 were updated and approved by a standardized approval process. There is strong collaboration with FNIHB especially as their policies/guidelines are referenced or used for Primary Care Services Clinical Practice Guidelines.

Community Liaison Committees are present in some communities who provide input and suggestions for service. Feedback is also gathered from the Client Experience Surveys (paper and on line). Standardized appointment cards encourage clients/patients to respond. Leaders and staff wear buttons to promote the Client Experience Survey.
The organization might consider formalizing input from clients/patients and families. If appropriate the organization might consider increasing the number of Community Liaison Committees

Priority Process: Competency

Training and education is a priority. Implementation of a general orientation the first week of every month was seen as positive. Dedicated clinical nurse education has been in place for 2 years. Cultural sensitivity training is available. Every effort is made to accomodate specific cultural care and belief needs.

There is a 1 888 number available to access translations services and some communities have translaters. The organization might consider ensuring that supports for some cultures such as Innu are available at larger provincial centers such as St. John's. Leaders described the two year Mentorship Program for new grads located in Goose Bay as a success. Good work on this recruitment and retention and competency strategy.

Priority Process: Episode of Care

Ethics-related issues have occurred and leaders described the role of the committee and gave examples of the process followed, including ultimately consulting with a provincial ethicist. It is understood that staff will often go to their supervisor first for consultation regarding ethics. Ongoing education to staff regarding ethics and the Labrador-Grenfell Health framework might be considered.

Medications for clinics are in the process of review and revamp. It is recognized the current doesn't meet pharmacy standards. Good luck with the initiative.

Priority Process: Decision Support

Paper based records are maintained and follow a standardized format. Audits are conducted at the 17 sites. The organization plans to move to an electronic medical record and Mania Ashini will be the first community/area for implementation. Great work on the chart audits!

The organization might consider reviewing record retention including storage to maximize space and review provinicial standards/recommedations.

Priority Process: Impact on Outcomes

The organization went live with Nursing Information Management System (NIMS) two years ago and is possibly the only health authority to electronically track memos, clinical practice, policy and resources. This "yes I have read and confirmation" tracking is helpful for staff and leaders. Other tracking and trending tools include complaints, client experience and post discharge calls. Scorecards for health centres is a good next step.

Information and feedback from clients and communities has informed care and changed practice such as hours of service and clinic appointment type. Continue the good community communication and collaboration.

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		
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Public Health		
6.4	There is a documented strategy to engage partners in implementing the population health improvement plan.	!
8.3	Health impact assessments for proposed public policies, programs, and projects are conducted in collaboration with partners and with input from the community.	
14.5	The data system, i.e., hardware and software, is evaluated annually and upgrades to improve the access, quality and use of health data are planned and implemented.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Public health services are provided across the region and standardized in areas such as immunization. The work and job design is tailored to meet the needs of clients and staff regularly, though informally solicit and include feedback from clients in their planning.

Priority Process: Competency

There are differing staff levels from community to community and to fit with the values of efficiency and effectiveness the organization might consider reviewing workload and assigning relevant tasks to the team. These areas could include vaccine management, clerical functions such as booking appointments and managing supplies.

Priority Process: Impact on Outcomes

Clients feedback suggested that there is comfort providing feedback about the quality of services such as at home visits

Feedback and input from families is gathered informally and formally.

Priority Process: Public Health

A Community Heath Needs Assessment was conducted in 2005, 2010 and now in 2018. The assessment is well underway and includes a mixed method approach. There has been extensive collaboration and data collection and analysis. The health status data has been collected from Stats Canada, CIHI, Newfoundland and Labrador government and in house. A report has been drafted and an action plan is in progress to share findings and engage stakeholders. A sustainability plan is the fifth step in the community health needs process. A PHAC epidemiologist is working with LGH and is in her first of a two year project. The organization may want to assign to a portfolio Community Health Assessment.

Public health has multiple partners and partnerships in the community.The team is creative and resourceful. There is a great sense pride in the work and dedication to the community. Keep it up!

Staff and leaders have developed excellent resources such as your Child's health bookmark so that a parent can have the printed material or have one bookmark with the link to the website. The team might want to consider an inventory of approved health information and messaging. While there is a community needs assessment process in place there is no evidence of an overall documented strategy to engage partners in implementing the population health improvement plan.

Documentation is public health is very important and a close partnership exists with the province regarding surveillance and communicable disease control and immunization. Multiple duplication for documentation such as for tuberculin skin testing which maybe necessary but the organization is encouraged to review for opportunities for improvement or efficiency. Internet speed can be compromised because of the geography and has been improved over time in areas such as Port Hope Simpson. Good luck to the organization in the development of an EMR.

Fantastic childhood immunization rates with the highest coverage rates in the province. Congratulations and keep up the good work.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Transfusion Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Transfusion Services

Transfusion services was included in the recent IQMH ISO 15189 Plus accreditation. The organization has done well to challenge themselves with complying successfully with these rigorous standards. Labrador-Grenfell has done well in capitalizing on the provincial partners and leveraging the resources and personnel outside the region to direct evidence based care and to determining appropriate benchmarks.

There is a clear process for Blood Transfusions. The Transfusion Safety Office for Labrador-Grenfell Health is located at Labrador Health Centre and is accessible to staff. A good working relationship with Regional Leaders, Eastern Health and St. Johns staff has been established. All blood units are transported by medevac from St. Johns. A daily report entitled “Daily Red Cell Stem & Product Inventory” is accessible to each hospital so blood type volumes and expiry dates are readily available.

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: February 26, 2018 to April 4, 2018**
- **Number of responses: 5**

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	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	20	80	N/A
3. Subcommittees need better defined roles and responsibilities.	0	20	80	N/A
4. As a governing body, we do not become directly involved in management issues.	0	20	80	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% 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.	20	20	60	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	40	60	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	0	20	80	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	20	0	80	N/A
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	N/A
12. Our ongoing education and professional development is encouraged.	0	0	100	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	0	100	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	0	0	100	N/A
17. Contributions of individual members are reviewed regularly.	0	50	50	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	20	40	40	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	0	50	50	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	0	40	60	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	0	40	60	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	0	40	60	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	40	60	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	0	60	40	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	40	60	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	100	0	0	N/A
27. We lack explicit criteria to recruit and select new members.	100	0	0	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	100	0	0	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	40	0	60	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	20	80	N/A
31. We review our own structure, including size and subcommittee structure.	20	20	60	N/A
32. We have a process to elect or appoint our chair.	100	0	0	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	20	40	40	N/A
34. Quality of care	20	40	40	N/A

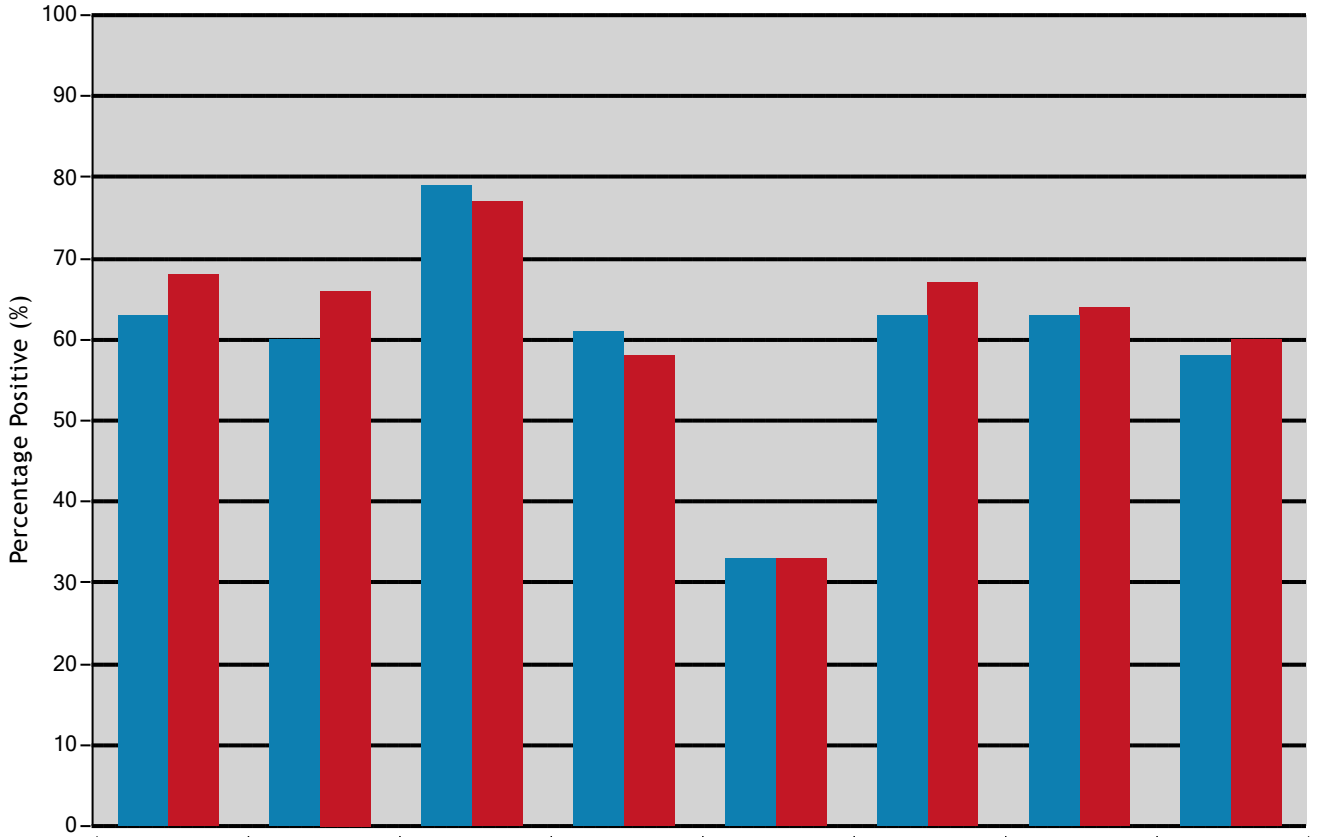
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: January 16, 2017 to March 17, 2017**
- **Minimum responses rate (based on the number of eligible employees): 268**
- **Number of responses: 268**

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
	63%	60%	79%	61%	33%	63%	63%	58%
	68%	66%	77%	58%	33%	67%	64%	60%

Legend

Labrador-Grenfell Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Worklife Pulse

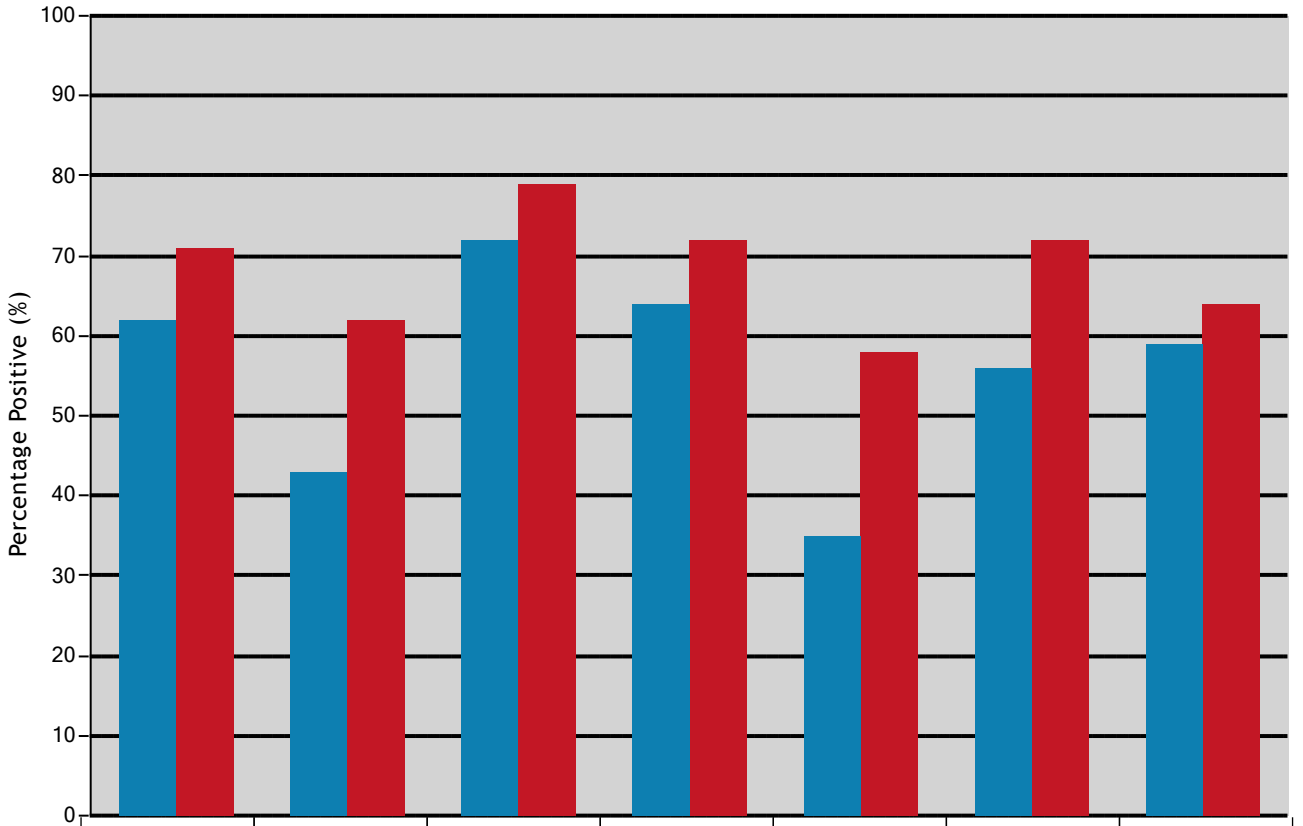
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: November 6, 2015 to December 11, 2015**
- **Minimum responses rate (based on the number of eligible employees): 303**
- **Number of responses: 327**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	62%	43%	72%	64%	35%	56%	59%
	71%	62%	79%	72%	58%	72%	64%

Legend

Labrador-Grenfell Regional Health Authority

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2017 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

After the on-site survey, the organization was invited provide comments to be included in this report about its experience with Qmentum and the accreditation process.

Labrador-Grenfell Health believes in quality improvement as an ongoing process that must be a primary function of every employee, service area and committee. Participation in the Accreditation Canada Qmentum Program illustrates the organization's commitment to quality improvement and the provision of safe, quality services.

The recent accreditation survey visit provided the opportunity to validate the good work being completed by health care teams in all program areas, and to also receive feedback regarding areas requiring improvement. The Labrador-Grenfell Health Board of Directors and Senior Executive would like to thank all employees, clients and community partners for their contribution to the accreditation process.

Labrador-Grenfell Health is proud of our accomplishments and will continue to make patient safety a priority and to involve patients and families in their care and decision making.

Appendix A - Qmentum

Health care accreditation contributes to quality improvement and patient safety by enabling a health organization to regularly and consistently assess and improve its services. Accreditation Canada's Qmentum accreditation program offers a customized process aligned with each client organization's needs and priorities.

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 15 business days.

An important adjunct to the Accreditation Report is the online Quality Performance Roadmap, available to client organizations through their portal. The organization uses the information in the Roadmap in conjunction with the Accreditation Report to ensure that it develops comprehensive action plans.

Throughout the four-year cycle, Accreditation Canada provides ongoing liaison and support to help the organization address issues, develop action plans, and monitor progress.

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
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.