



ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

Prepared for:

Haro Park Centre Society

Vancouver, BC

On-site Survey Dates:

February 23, 2011 - February 25, 2011

March 9, 2011



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Accreditation Report

About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of Haro Park Centre Society.

This report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Haro Park Centre Society only. Accreditation Canada does not release the Report to any other parties.

In the interests of transparency, Accreditation Canada encourages the dissemination of the information in this Report to staff, board members, clients, the community, and other stakeholders.

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About the Accreditation Report

The accreditation report describes the findings of the organization's accreditation survey. It is Accreditation Canada's intention that the comments and identified areas for improvement in this report will support the organization to continue to improve quality of care and services it provides to its clients and community.

Legend

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

-  Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.
-  Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.
-  Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.
-  Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.
-  Items marked with an arrow indicate a high risk criterion.

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Haro Park Centre is a not for profit organization, housing 154 complex care residents as well as 64 people in the assisted and independent living component. In 2010 the Centre marked its 30th year. It was founded as a collaborative endeavour between the B'nai Brith Building Society and the Netherlands Association for Seniors Care.

There are many overall strengths in this well run Centre. There is a strong emphasis on education and research as evidenced by the many collaborative community partnerships, student involvement and research initiatives. The ethics committee is well established and there is an ethical framework in place, with access to ethicist resources.

Residents and families speak highly of the care received and are appreciative of staff. The Board is an active, involved group who are forward-thinking and dedicated to the evolution of the Haro Park campus of care concept. To this end, they have identified five strategic directions: resident and family safety and satisfaction; staff safety and succession planning; fiscal accountability and sustainability; physical plant; and community outreach.

By implementing "green" initiatives such as re-commissioning the building, upgrading lighting and adjusting maintenance to fit the climate, significant improvements have been made. Reductions in gas, water and electricity usage which equate to considerable savings annually are noteworthy. Challenges are being experienced as the building is now over 30 years old. The lack of a capital budget from the Health Authority adds to the challenge of maintaining an aging facility.

Another challenge is to combat the high incidence of staff absenteeism and rate of workplace compensation claims.

The community partners describe the communication between themselves and Haro Park as timely, collaborative and sensitive. They are appreciative of the willingness of the Haro Park team to participate in pilot studies, to try new things and to generally be in the forefront of changes happening in the long term care sector. Examples cited are the palliative care program, electronic chart and medication system, disability management committee, new program development and educational programming.

Organization's Commentary

The organization has no comment at this time.

Overview by Quality Dimension

The following table provides an overview of the organization's results by quality dimension. The first column lists the quality dimensions used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for each quality dimension.

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	26	0	0	26
Accessibility (Providing timely and equitable services)	14	0	0	14
Safety (Keeping people safe)	94	3	21	118
Worklife (Supporting wellness in the work environment)	30	0	1	31
Client-centred Services (Putting clients and families first)	41	0	0	41
Continuity of Services (Experiencing coordinated and seamless services)	8	0	0	8
Effectiveness (Doing the right thing to achieve the best possible results)	153	0	15	168
Efficiency (Making the best use of resources)	17	0	0	17
Total	383	3	37	423

Overview by Standard Section

The following table provides an overview of the organization by standard section. The first column lists the standard section used. The second, third and fourth columns indicate the number of criteria rated as met, unmet or not applicable. The final column lists the total number of criteria for that standard section.

Standard Section	Met	Unmet	N/A	Total
Sustainable Governance	91	0	0	91
Customized Effective Organization	60	1	0	61
Infection Prevention and Control	70	0	33	103
Customized Managing Medications	43	1	3	47
Long Term Care Services	119	1	1	121
Total	383	3	37	423

Overview by Required Organizational Practices (ROPs)

Based on the accreditation review, the table highlights each ROP that requires attention and its location in the standards.

All Required Organizational Practices (ROPs) have been met by the organization. There is no follow-up required.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

This part of the report speaks to the processes and infrastructure needed to support service delivery. In the regional context, this part of the report also highlights the consistency of the implementation and coordination of these processes across the entire system. Some specific areas that are evaluated include: integrated quality management, planning and service design, resource allocation, and communication across the organization.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Planning and Service Design

Developing and implementing the infrastructure, programs and service to meet the needs of the community and populations served.

Surveyor Comments

The Management team has provided leadership in bringing together staff, residents, families and the community to create an operation plan on the strategic directives developed by the Board. A review of the vision, mission and values statements was included as a necessary guide for all strategic directions and operations. Retreats held on site for staff to complete projects linked to the operation plan were well received by those involved and generated creative ideas and suggestions.

As part of the survey visit, a Community Partners Focus group took place. The 13 participants included educators, contracted providers such as pharmacy and physiotherapy, as well as pastoral services, the local health authority, a University of British Columbia research student and a mental health team representative. The community partners spoke very well of Haro Park and its provision of care and services.

Overall strengths cited were as follows: excellent communication with the leadership team; the team is interested in research and is forward looking, willing to participate in pilot programs and to be at the forefront of innovative ideas and programs; the Board is active and engaged; welcoming to students, friendly and open environment; the palliative program and steps are being taken to improve the physical environment, as evidenced by the improvements to the special care unit.

Overall areas for Improvement were noted by the partners as follows: more volunteers are needed to support the programs, in particular for accompanying residents; improvements to the physical environment as the building is aging; more and improved recreational services and programs and a need to encourage interaction and participation, particularly given the changing nature of clients who have more mental health needs. Many partners commented on front line staff resistance to change. The philosophical approach and commitment by management staff has not trickled down to the front line. Front line staff often say they are too busy to help or deal with a contracted provider.

No Unmet Criteria for this Priority Process.

Resource Management

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

Surveyor Comments

There is no capital funding available from the provincial funding agency. The organization has thus been challenged to find creative ways of accessing and utilizing resources. Although the funding restrictions are in effect, certain special needs have been granted, as in the case of the recent purchase of a new generator.

Sharing resources with other organizations has been one method of maximizing resources. An example is the disability management consultant. Fifty per cent of the funding is being provided by Worksafe BC as a two year pilot project. The organization's plan to share an attendance promotion strategy with seven other long term care facilities is a good direction and this kind of program and sharing of resources is encouraged. Other initiatives such as the establishment of a Board fundraising committee and accessing grants for specialized programs are noted.

On a very positive note, residents continue to benefit from the programming offered at no charge by the Haro Park Centre, such as horticulture, yoga, art and music.

No Unmet Criteria for this Priority Process.

Human Capital

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

Surveyor Comments

The organization is led by a diverse group of Board members who are dedicated, knowledgeable and resourceful community leaders. The leadership team identifies opportunities for quality improvement and makes progress in achieving its strategic goals and objectives. The Board receives timely reports on balanced score cards and uses the data to monitor outcomes.

The Governance Functioning Tool was completed and used for evaluation of the Board. The Board evaluates its performance makes improvements based on the tool.

The Board of Directors provides timely feedback and annual performance reviews for the Executive Director in alignment with the organization's goals and objectives. In addition, the Executive Director implements the 360 degree performance tool to ask staff for feedback. About 75 % of the staff who were asked for feedback responded to the request.

The organization has a very low staff turn over rate and many staff have been working with the organization for over 10 years. It is noted that the longevity of the staff create challenges in changing the culture of the organization. The theorists driving the change management strategies such as Watson and Kanter are a good place to start. It is suggested that the leadership team continue with this particular quality journey of moving from one of entitlement to one of achievement.

Staff are encouraged to share the responsibility in keeping track of their own educational and professional development. They successfully maintain their educational passport. It is noted that both staff and clients come from diverse backgrounds and there is good understanding and acceptance of different cultures.

The organization observes "anti-bullying day" and encourages staff to report and discuss issues. A survey on harassment in the workplace has been done and educational sessions were provided to staff regarding expected behaviour.

Personnel files include appropriate elements and are stored in a confidential area with restricted access.

No Unmet Criteria for this Priority Process.

Integrated Quality Management

Continuous, proactive and systematic process to understand, manage and communicate quality from a system-wide perspective to achieve goals and objectives.

Surveyor Comments

There is a Quality and Risk Management Committee which is a subcommittee of the Board of Directors. This demonstrates the Leadership and the Board's priority for quality.

The organization has used indicators to identify improvement opportunities and is also able to demonstrate the positive effect of changes made through the use of those indicators.

Performance indicators and measures are developed, monitored and reviewed within the organization at the Board, leadership and departmental/team levels. These include measures required by the Regional Health Authority and those developed as organization specific indicators.

A positive worklife culture is encouraged by the organization with staff appreciation events and health and wellness activities provided and promoted for staff and volunteers.

The organization used the worklife pulse and patient safety culture instruments to address issues including stress management and working as a team.

When asked, frontline staff were not aware of the high WCB rates or the types of injuries involved in claims. The organization has a plan to communicate this information as well as the current trends to staff. Having this information may help prevent future injuries.

The organization receives information regarding its care and services as well as suggestions for improvements through ongoing dialogue with client groups, family council, resident council, satisfaction surveys, team meetings and daily team huddles.

No Unmet Criteria for this Priority Process.

Principle Based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

Surveyor Comments

Research projects are conducted according to protocols which include informed consents and reporting relationships.

There are a number of research projects which have been completed in partnership with local post secondary institutions, on such topics as Person Centred Care, Environmental Design in Long Term Care and Clean Energy Analysis.

An ethics framework is in place. The ethics committee is well established, with appropriate membership, quarterly meetings and additional meetings as required. The committee reports to the Quality and Risk Management committee, a subcommittee of the Board.

The organization is fortunate to have the services of an ethicist available through the Regional Health Authority who provides guidance, education and problem solving as requested.

Staff have access to the internet should they wish to search for any information on ethics, or other matters. However, front line staff say they likely would not do this as they have no time. They may read print materials related to ethics if it was readily available.

The organization demonstrates that it uses the ethics decision making framework regularly, citing a number of ethical dilemmas experienced over the past few years which required the total team involvement.

No Unmet Criteria for this Priority Process.

Communication

Communication among various layers of the organization, and with external stakeholders.

Surveyor Comments

Board activities are structured in accordance with their bylaws. There is documented evidence of ongoing and regular communication with the management team.

A communication plan is in place which includes reporting structures, an updated critical incident process and policy related to disclosure, an increased emphasis on the use of technology and learning/training for staff.

The community linkages are noted with the neighbourhood stores, schools, library and professional services. In addition, community outreach initiatives such as supporting foster children, students and various charitable projects are ways that the staff and residents give back to their community.

An improvement in communication has been the introduction of brief team meetings daily to highlight any changes or concerns. These team meetings include all staff.

No Unmet Criteria for this Priority Process.

Physical Environment

Providing appropriate and safe structures and facilities to successfully carry out the mission, vision, and goals.

Surveyor Comments

Haro Park Centre was built over 30 years ago and it presents many challenges to up keep especially when there is no capital funding available. The building is secure with automatic doors and timers, closed circuit cameras and other safety devices including the Wander Guard system.

The Board has led a "facility committee" to oversee the physical environment needs. There is a new generator installed on site.

Regardless of the age of the building, maintenance and housekeeping staff are to be commended on the cleanliness and the condition of the facility.

The special care unit has a newly renovated dining area which provides space for the residents to socialize and do recreational activities.

Haro Park Centre has initiated many innovative energy conservation projects such as changing to low flow toilets and recycling of hot water to be used for the hot water boilers. These projects have proven to be effective and reduced energy consumption and costs. Comparable facilities with the same square footage spend approximately \$100,000 more annually on utilities. The energy intensity of Haro Park in a study of seven facilities had the most efficient rating.

The organization is strongly encouraged to keep the tub room areas closed and secured when not in use. Similarly, more attention should be paid to keeping all cleaning materials and solutions secured and not accessible to residents.

The home needs to consider improving the smoking room ventilation to stop smoke from infiltrating out of the room.

Haro Park Centre is in need of renovation and painting to become more home like. Management have identified that they are waiting for capital funding to proceed with renovation plans. Since the building has limitations with long corridors and has no space in the neighbourhoods for dining areas, except for the special care neighbourhood, residents must go to the main floor dining room for meal services. The set up poses challenges.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
Customized Effective Organization		
The organization restricts access to high-risk areas and labels these areas.	7.4	↑

Emergency Preparedness

Dealing with emergencies and other aspects of public safety.

Surveyor Comments

The organization has an emergency preparedness plan. Elements include responses to codes red, white, blue, brown, black, green and yellow. Code green has been tested in October, 2010 with more than 40 high school students participating in the drill and acting as residents. Learning outcomes of the drills have been integrated into practice.

The organization is working with community partners to find a new place to be used as temporary shelter for the residents in case of emergency. The organization should put a timeline on finding an emergency shelter.

Education on the codes is offered to staff. Education should be extended to all volunteers.

External partners such as the fire marshal are involved with the drills.

There are regular scheduled fire drills on a monthly basis for all shifts.

Emergency boxes are readily available in the neighbourhoods to handle the codes.

No Unmet Criteria for this Priority Process.

Medical Devices and Equipment

Machinery and technologies designed to aid in the diagnosis and treatment of healthcare problems.

Surveyor Comments

The home has developed software to track and process their preventive maintenance program. The software helps track the online maintenance requests and the maintenance staff responses to each request by letting the staff know the progress of the repair.

All lifts are well maintained and are being checked at least once per year by the maintenance staff according to the policy and procedures.

There is a computerized generated schedule for all preventive maintenance.

Staff education and orientation are provided for every piece of new equipment.

Management seeks staff input in making decisions about buying new equipment.

No sterilization of reusable medical devices occurs on the premises.

No Unmet Criteria for this Priority Process.

Direct Service Provision

This part of the report provides information on the delivery of high quality, safe services. Some specific areas that are evaluated include: the episode of care, medication management, infection control, and medical devices and equipment.

Findings

Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Customized Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

A comprehensive quality control program is in place, as administered by the contracted pharmacy provider. This includes audits, medication utilization reviews, educational sessions for staff and families/clients as appropriate.

An electronic medication administration record system has been in place for the past year and a half.

Staff are encouraged to review safety guidelines for keeping medications secure and to ensure that medication carts are kept locked while unattended. Unlocked and unattended carts with medications and supplies fully accessible to residents were noted by the surveyors on two different occasions in different neighbourhoods.

The pharmacist and the Centre are in the process of updating and reviewing the existing pharmacy manual. The small pharmacy manual is in paper-only format and the organization's policies are accessed through the intranet.

Simplifying and combining the system, making it more comprehensive, user friendly and easier to access, will be helpful for staff who currently say they don't bother looking; they call and ask someone if they have a question related to medication management. The speedy updating of this essential staff resource is strongly encouraged.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team stores medications in a safe, secure and appropriate environment that is consistent with organizational policy and legislated requirements for controlled substances.	1.3	↑

Infection Prevention and Control

Infection Prevention and Control

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents.

Surveyor Comments

Hand hygiene audits are being conducted and results circulated.

Cleaning and disinfecting is done according to a schedule. Resident care areas are notably clean, bright and tidy.

Cleaning mobility equipment is done according to a schedule and protocol.

The basement laundry area has a single entry/exit door as well as a large chute for soiled bags to come down to the area. Staff have the areas organized so as to avoid cross contamination but the Centre is encouraged to look at updating this area in the future as funds become available. Currently all linens and personal clothing are laundered on site.

As an improvement, it is suggested to increase signage on hand hygiene protocols in washrooms and work areas throughout the organization.

While there are policies/procedures in place to give influenza vaccines to residents and staff, the rate of vaccination for staff is down markedly over the past two years, to less than 50% of staff being vaccinated. This has been a concern for the organization and will be addressed with the Regional Health Authority looking for suggestions on improving vaccination rates.

No Unmet Criteria for this Priority Process.

Long Term Care Services

Clinical Leadership

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

Surveyor Comments

The team uses information it collects about the residents to define the scope of their services. There is a strong emphasis on "elder centred care" and evidence of this is observed throughout the home.

The Management team has provided strong leadership and support to the care team. The team meets regularly for huddles. The care teams meet regularly to discuss the care plan and to identify the approach and interventions to best meet the residents' needs.

The home has recently made an adjustment to its staffing ratio by adding extra LPNs to the night shift in response to the care needs of the residents.

Physiotherapy and Occupational therapy are contracted services. Recreational therapy staff provide activities during days and evenings to promote quality of life.

Residents are offered a variety of programs to participate in throughout the day and are able to engage in various activities including music therapy, yoga classes, art therapy and outings.

There is a focus on fall prevention and wound care and the home enjoys success in these areas. Wound care data is sent to Vancouver Coastal Health for benchmarking and the home has a lower rate of wounds compared to the regional statistics.

No Unmet Criteria for this Priority Process.

Competency

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.

Surveyor Comments

At Haro Park Centre, interdisciplinary conferences are held four to six weeks after admission and then on an annual basis. The resident and/or family are invited to attend. The team assists the resident to set goals, develops interventions and evaluates outcomes. The interdisciplinary team collaborates with each other to achieve positive outcomes through their interventions.

Ongoing education/training is being provided for staff. Staff are invited to attend retreats which focus on team building, communication and initiatives to make Haro Park Centre more home-like.

Staff are asked to pick up a special project and set goals to enhance resident care.

No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

The Centre utilizes MDS and a software planning system. The care team meets on a regular basis to discuss the care plan. There is an admission conference where the family meets with the care team to discuss the care plan. Daily team huddles have proven to be an effective way for timely communication for all team members. Neighbourhood meetings are held weekly, with monthly night meetings. The Leadership team meets weekly and there is a twice daily huddle to review “urgent issues or updates”.

The care in the dementia area appears to be calm and inviting. Meal times are kept flexible for residents on the dementia care neighbourhood. There have been improvements in promoting the dining experience for the residents. After the implementation and promotion of the fine dining experience, staff are seeing positive results with the residents gaining weight. The plans to expand this type of dining experience to the rest of the building are strongly encouraged.

No Unmet Criteria for this Priority Process.

Decision Support

Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments

There is an up to date record for each resident and it includes the care plan. Team members can access information from the MDS and electronic software program to monitor the resident’s progress. There are also the daily huddles which help staff complete a real time assessment of what is working and what is not working.

The team monitors the ADL, CHESS scores, health conditions, cognitive performance, depression score, aggressive behaviours and pain scales.

For managing aggressive behaviours, a red dot is posted on the elder’s door to alert staff.

No Unmet Criteria for this Priority Process.

Impact on Outcomes

The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.

Surveyor Comments

The team meets regularly to discuss safety issues and to update and keep current on clinical information.

There is a one day orientation for new staff and ongoing education for staff at all levels.

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Education services are offered to staff every week and the home may consider rotating the session on a different day of the week throughout the year to give more alternatives for staff to attend the education sessions.

There are many casual and part time staff, and many of those spoken to by the surveyors had not attended any educational events over the past year.

As an improvement, it is suggested to provide more education to staff at all levels about the importance of reporting and tracking near misses.

The table below indicates the specific criteria that require attention, based on the accreditation review.

Criteria	Location	Priority for Action
The team identifies, reports, records, and monitors in a timely way sentinel events, near misses, and adverse events.	16.6	↑

Performance Measure Results

The following section provides an overview of the performance measures collected for the entire organization. These measures consist of both instrument and indicator results, which are valuable components of evaluation and quality improvement.

Instrument Results

The instruments are questionnaires completed by a representative sample of clients, staff, leadership and/or other key stakeholders that provide important insight into critical aspects of the organization's services. The following tables summarize the organization's results and highlight each item that requires attention. Results are presented in three main areas: governance functioning, patient safety culture and worklife.

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Governance Functioning Tool

The Governance Functioning Tool is intended for members of the governing body to assess their own structures and processes and identify areas for improvement. The results reflect the perceptions and opinions of the governing body regarding the status of its internal structures and processes.

Summary of Results

Governance Structures and Processes	% Agree	% Neutral	% Disagree	Priority for Action
	Organization	Organization	Organization	
1 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	100	0	0	
2 We have explicit criteria to recruit and select new members.	90	0	10	
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	0	0	
4 The composition of our governing body allows us to meet stakeholder and community needs.	91	0	9	
5 Clear written policies define term lengths and limits for individual members, as well as compensation.	91	0	9	
6 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	91	0	9	
7 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	0	0	
8 We review our own structure, including size and sub-committee structure.	100	0	0	
9 We have sub-committees that have clearly-defined roles and responsibilities.	100	0	0	
10 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	0	0	
11 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	0	0	

12 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	0	0
13 Our meetings are held frequently enough to make sure we are able to make timely decisions.	100	0	0
14 Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	100	0	0
15 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	0	0
16 Our governance processes make sure that everyone participates in decision-making.	100	0	0
17 Individual members are actively involved in policy-making and strategic planning.	100	0	0
18 The composition of our governing body contributes to high governance and leadership performance.	100	0	0
19 Our governing body’s dynamics enable group dialogue and discussion. Individual members ask for and listen to one another’s ideas and input.	100	0	0
20 Our ongoing education and professional development is encouraged.	91	0	9
21 Working relationships among individual members and committees are positive.	100	0	0
22 We have a process to set bylaws and corporate policies.	100	0	0
23 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	0	0
24 We formally evaluate our own performance on a regular basis.	82	0	18
25 We benchmark our performance against other similar organizations and/or national standards.	82	0	18
26 Contributions of individual members are reviewed regularly.	91	0	9
27 As a team, we regularly review how we function together and how our governance processes could be improved.	91	0	9
28 There is a process for improving individual effectiveness when non-performance is an issue.	91	0	9

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29 We regularly identify areas for improvement and engage in our own quality improvement activities.	82	0	18
30 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	82	0	18
31 As individual members, we receive adequate feedback about our contribution to the governing body.	91	0	9
32 We have a process to elect or appoint our chair.	91	0	9
33 Our chair has clear roles and responsibilities and runs the governing body effectively.	100	0	0

Patient Safety Culture Survey

The patient safety culture survey results provide valuable insight into staff perceptions of patient safety, as well as an indication of areas of strength, areas of improvement, and a mechanism to monitor changes within the organization.













Summary of Results

Number of survey respondents = 45 respondents








A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 Patient safety decisions are made at the proper level by the most qualified people	4	4	91	
2 Good communication flow exists up the chain of command regarding patient safety issues	2	22	76	
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	73	16	11	⚠
4 Senior management has a clear picture of the risk associated with patient care	11	7	82	
5 My unit takes the time to identify and assess risks to patients	9	7	84	
6 My unit does a good job managing risks to ensure patient safety	0	11	89	
7 Senior management provides a climate that promotes patient safety	5	14	82	
8 Asking for help is a sign of incompetence	75	18	7	
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	98	2	0	
10 I am sure that if I report an incident to our reporting system, it will not be used against me	7	27	67	⚠
11 I am less effective at work when I am fatigued	14	14	73	⚠
12 Senior management considers patient safety when program changes are discussed	7	13	80	
13 Personal problems can adversely affect my performance	27	16	57	⚠
14 I will suffer negative consequences if I report a patient safety problem	77	11	11	

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15	If I report a patient safety incident, I know that management will act on it	4	16	80	
16	I am rewarded for taking quick action to identify a serious mistake	24	29	47	
17	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	33	23	44	
18	I have enough time to complete patient care tasks safely	16	19	65	
19	I am not sure about the value of completing incident reports	76	17	7	
20	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	26	15	59	
21	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	14	24	62	
22	I have made significant errors in my work that I attribute to my own fatigue	80	8	13	
23	I believe that health care error constitutes a real and significant risk to the patients that we treat	18	13	69	
24	I believe health care errors often go unreported	30	34	36	
25	My organization effectively balances the need for patient safety and the need for productivity	7	13	80	
26	I work in an environment where patient safety is a high priority	0	11	89	
27	Staff are given feedback about changes put into place based on incident reports	11	16	73	
28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	7	9	84	
29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	7	29	64	
30	My supervisor/manager seriously considers staff suggestions for improving patient safety	9	27	64	
31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	64	20	16	
32	My supervisor/manager overlooks patient safety problems that happen over and over	60	13	27	

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33	On this unit, when an incident occurs, we think about it carefully	9	7	84	
34	On this unit, when people make mistakes, they ask others about how they could have prevented it	15	34	51	
35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	5	18	77	
36	On this unit, when an incident occurs, we analyze it thoroughly	7	26	67	
37	On this unit, it is difficult to discuss errors	68	25	7	
38	On this unit, after an incident has occurred, we think long and hard about how to correct it	20	36	44	
B. These questions are about your perceptions of overall patient safety		% Good/Excellent	% Acceptable	% Poor/Failing	Priority for Action
		Organization	Organization	Organization	
39	Please give your unit an overall grade on patient safety	76	22	2	
40	Please give the organization an overall grade on patient safety	71	24	4	
C. These questions are about what happens after a Major Event		% Disagree	% Neutral	% Agree	Priority for Action
		Organization	Organization	Organization	
41	Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	7	23	70	
42	A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	7	17	76	
43	Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	17	26	57	
44	The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	7	17	76	

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45 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	2	21	76
46 Changes are made to reduce re-occurrence of major events	2	21	76

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Worklife Pulse




The concept of ‘quality of worklife’ is central to Accreditation Canada’s accreditation program. The Pulse Survey enables health service organizations to monitor key worklife areas. The survey takes the ‘pulse’ of quality of worklife, providing a quick and high level snapshot of key work environment factors, individual outcomes, and organizational outcomes. Organizations can then use the findings to identify strengths and gaps in their work environments, 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.


Summary of Results

Number of survey respondents = 47 respondents

How would you rate your work environment	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
1 I am satisfied with communications in this organization.	19	13	68	⚠
2 I am satisfied with communications in my work area.	13	21	66	⚠
3 I am satisfied with my supervisor.	9	11	81	
4 I am satisfied with the amount of control I have over my job activities.	11	21	68	⚠
5 I am clear about what is expected of me to do my job.	9	6	85	
6 I am satisfied with my involvement in decision making processes in this organization.	15	28	57	⚠
7 I have enough time to do my job adequately.	26	23	51	⚠
8 I feel that I can trust this organization.	9	19	72	⚠
9 This organization supports my learning and development.	11	19	70	⚠
10 My work environment is safe.	6	17	77	
11 My job allows me to balance my work and family/personal life.	9	21	70	⚠

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Individual Outcomes	% Not Stressful	% A bit Stressful	% Quite or Extremely Stressful	Priority for Action
	Organization	Organization	Organization	
12 In the past 12 months, would you say that most days at work were...	19	49	32	
	% Very Good/ Excellent	% Good	% Fair/ Poor	Priority for Action
	Organization	Organization	Organization	
13 In general, would you say your health is...	64	32	4	
14 In general, would you say your mental health is...	77	17	6	
15 In general, would you say your physical health is...	62	36	2	
	% Very Satisfied	% Somewhat Satisfied	% Not Satisfied	Priority for Action
	Organization	Organization	Organization	
16 How satisfied are you with your job?	91	6	2	
	% < 10	% 10 - 15	% > 15	Priority for Action
	Organization	Organization	Organization	
17 In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)	79	17	4	
18 During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?	79	11	11	
	% Never/ Rarely	% Sometimes	% Often/ Always	Priority for Action
	Organization	Organization	Organization	
19 How often do you feel you can do your best quality work in your job?	2	6	91	

	% Disagree	% Neutral	% Agree	Priority for Action
	Organization	Organization	Organization	
20 Overall, I am satisfied with this organization.	9	17	74	
21 Working conditions in my area contribute to patient safety.	4	13	83	

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Indicator Results

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% Formal medication reconciliation at admission
RED	Haro Park Centre Society	Interdisciplinary LTC Team (Long Term Care Services)	01/04/2010 30/06/2010	55
RED	Haro Park Centre Society	Interdisciplinary LTC Team (Long Term Care Services)	01/07/2010 30/09/2010	45
GREEN	Haro Park Centre Society	Interdisciplinary LTC Team (Long Term Care Services)	01/10/2010 31/12/2010	100

Threshold for Flags

RED: < 75/100

YELLOW: >= 75/100 AND < 90/100

GREEN: >= 90/100

Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care-Associated MRSA & C. difficile - C. difficile				
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 10,000 patient days
GREEN	Haro Park Centre Society	Infection Control Committee (Infection Prevention and Control)	01/01/2010 31/03/2010	0.73
GREEN	Haro Park Centre Society	Infection Control Committee (Infection Prevention and Control)	01/04/2010 30/06/2010	0
GREEN	Haro Park Centre Society	Infection Control Committee (Infection Prevention and Control)	01/07/2010 30/09/2010	0
GREEN	Haro Park Centre Society	Infection Control Committee (Infection Prevention and Control)	01/01/2011 31/03/2011	0

Threshold for Flags

RED: > 80/10,000
 YELLOW: <= 80/10,000 AND > 60/10,000
 GREEN: <= 60/10,000

Next Steps

Congratulations! You have just completed your Qmentum on-site survey visit. Please note the following check list items that you need to attend to in the coming days and months.

- We ask that you review this report within the next five days for errors in titles of names of services. This will help ensure the report and our records are accurate. Once you have reviewed, please send your requested changes to your Accreditation Specialist.
- In 10 business days, a letter outlining your accreditation decision and requirements will be e-mailed to your Chief Executive Officer. If revisions to the report were required, a copy of a revised report will be sent along with that letter.
- You are required to submit your quarterly reports on indicators on May 31st, every year. If you have any questions regarding this submission, please contact your Accreditation Specialist.

Appendix A - Accreditation Decision Guidelines

Quality improvement continues to be a key principle of Accreditation Canada's Qmentum program. Accreditation Canada's standards assess the quality of services provided by an organization and are constructed around eight dimensions of quality:

1. Population focus
2. Accessibility
3. Safety
4. Worklife
5. Client-centred services
6. Continuity of services
7. Effectiveness
8. Efficiency

Each standard criterion is related to a quality dimension. Organizations participating in Accreditation Canada's Qmentum program are eligible for the recognition awards: Accreditation; Accreditation with Condition (Report and/or Focused Visit) and Non-accreditation.

Under the Qmentum accreditation program, Accreditation Canada High Priority Criteria and Required Organization Practices (ROPs) are the two main factors that are considered in determining the appropriate recognition award.

Accreditation Canada High Priority Criteria

Accreditation Canada identifies high priority criteria by their alignment with several key areas:

- Quality Improvement
- Safety
- Risk
- Ethics

Required Organization Practices (ROPs)

A Required Organizational Practice is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. It is a specific requirement for healthcare organizations in the accreditation program.

Based on the above, the three accreditation decisions for 2010 Qmentum surveys are:

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Option 1: Accreditation

An organization is eligible for full accreditation (with a resurvey in three years) if all of the following criteria are met:

- (a) 90% or more of high priority criteria met per standard section, AND
- (b) Compliance with all of the Required Organizational Practices, AND
- (c) Compliance with collection of all the performance measures,

If the organization is a CSSS, participating in the Joint Program with Conseil québécois d'agrément (CQA) and Accreditation Canada, the following additional criteria are required, which are specific CQA indicators relating to customer service and worklife:

- (d) Compliance with $\geq 66.6\%$ of Client Satisfaction Indicators AND
- (e) Compliance with $\geq 66.6\%$ of Employees Mobilization Indicators

Option 2: Accreditation with Condition: Report and/or Focused Visit

An organization will receive Accreditation with Condition: Report and/or Focused Visit if any of the following criteria is met:

- (a) More than 10% and less than 30% of high priority criteria unmet in any standard section,
OR
- (b) Non-compliance with any one of the Required Organizational Practices
OR
- (c) Non-compliance with the collection of any one of the performance measures

If the organization is a CSSS, participating in the Joint Program with CQA and Accreditation Canada, the following addition criteria apply:

- (d) Compliance with less than 66.6% of Client Satisfaction Indicators,
OR
- (e) Compliance with less than 66.6% of Employees Mobilization Indicators

The condition, i.e. submission of a report or focused visit; and timeframe, i.e. 6 months or 12 months; is based upon the nature of the recommendations. If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.

Organizations are required to submit follow-up reports as a condition of maintaining accreditation status. If a satisfactory report is not submitted within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress, and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

For organizations that fail to complete a satisfactory focused visit within the required timeline, Accreditation Canada may grant a one-time extension of 6 months, based on surveyor input, proof of progress and a plan to meet the conditions. Failure to comply with these requirements within the maximum allotted time extension will result in removal of accreditation status, at the discretion of Accreditation Canada.

Option 3: Non-accreditation

An organization will NOT be accredited if the following conditions exist:

(a) One or more ROPs not in place

AND

(b) 30% or more high priority criteria unmet in one or more standards sections

AND

(c) 20% or more criteria unmet overall for all standards applied to the organization

Should an organization wish to have their non-accreditation status reviewed within 6 months post survey, they are required to complete a focused visit within 5 months. Organizations that fail to complete a satisfactory focused visit within the required timeframe will maintain a non-accreditation status.

If the organization is a CSSS, and their compliance with the Client Satisfaction Indicators OR Employees Mobilization Indicators is less than 66.6%, they must conduct the survey(s) again within 18 months following the onsite visit as a condition of accreditation.