ACCREDITATION
AGRÉMENT
CANADA
Better Quality. Better Health.
Meilleure qualité. Meilleure santé.

ACCREDITATION HANDBOOK

Pembroke Regional Hospital 2023

The Pembroke Regional Hospitals Quardruple Aim- True North

The organizational direction we continuously strive towards- led by our Mission, Vision and Values.

True North Metrics

Measures used to determine where we are and where we would like to be.

Provider Experience
- Employee Workplace Incidents
- Staff Engagement & Satisfaction Survey

Patient and Family Experience
- Emergency Department Length of Stay
- Overall Hospital Ranking

Best Possible Health Outcomes
- 30 Day Readmission Rate
- Never Event Occurrences
- Patient Safety Audit Scores

Value and Efficiency
- Overtime Paid
- # of Improvement tickets completed
- Monthly Cash Balance

Mission: We are a regional community hospital committed to delivering a wide range of quality health services. Following Catholic tradition, we will meet the physical, emotional and spiritual needs of all.

Vision: Delivering the safest and highest quality of care to every person, every encounter, every day.

Values:
- Compassion and Caring
- Excellence and Innovation
- Social and Fiscal Responsibility
- Sacredness of Life
- Mutual Respect
- Community Spirit

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Accreditation Overview

Accreditation Canada

Accreditation Canada is an independent, not-for-profit organization that manages accreditation for many diverse health sectors across Canada and internationally. Accreditation Canada is a leader in raising the bar for quality in health and improved patient safety. It guides participant health-care organizations such as PRH in the assessment of the care and services they provide, giving them a clear picture of their strengths and areas to be improved.

What is Accreditation?

Accreditation is a process whereby the systems and services of a health care organization are evaluated and rated based on standards that reflect best practices. Accreditation Canada is the organization that conducts these types of surveys in health care institutions throughout Canada.

How often does it occur?

Accreditation Canada's Qmentum program follows a cycle with an onsite visit every four years to review service and standards and determine whether criteria have been met. At the completion of the onsite visit, PRH will receive a decision or accreditation status. Being accredited demonstrates the organization's commitment to continuous quality improvement as well as patient and workplace safety.

What will the accreditation visit look like?

Accreditation Canada Surveyors will be visiting several areas of the Hospital. During the visit, surveyors follow both clinical and administrative processes from beginning to end – this is called a tracer. During the tracer, the surveyors review charts or documents, ask questions of staff, patients or visitors, observe processes, and record their findings.

Accreditation is our opportunity to showcase the many improvements you and your team have made in the past few years.

Things to do to Prepare You and Your Teams for the Survey

Accreditation is our opportunity to shine! This is the opportunity to show the Surveyor(s) about the work that you and your team do in service to PRH's vision – ***Delivering the safest and highest quality of care to every person, every encounter, every day***. Be sure to refresh your teams on our vision and our 6 core values:

- ***Compassion and Caring***
- ***Excellence and Innovation***
- ***Social and Fiscal Responsibility***
- ***Sacredness of Life***
- ***Mutual Respect***
- ***Community Spirit***

Remember that PRH's focus on quality and safety is embedded throughout our strategy, ongoing plans and projects, and in the work we do every day for patients and their families.

In the time leading up to the onsite survey, take the time with your teams to:

- Reflect on the quality improvement initiatives taken and/or involving your area – discuss this at your team meetings
- Ensure there is visible information of the current metrics, your area/unit performance, and improvement initiatives specific to your area posted (this could be on a Huddle Board)
- Refresh on the specific policies and procedures governing the work in your area, specifically relating to medication safety and infection prevention and control practices
- Keep work areas as organized, clutter free and up-to-date as possible
- Always remember privacy protocols

The time a Surveyor will have in your specific area will likely be brief and they will want to speak with staff, patients and/or families. Think about what you hope to share with the Surveyor(s) that demonstrated the great quality and safety work done in your area! Be proud of the work you do every day and the amazing care or support you provide for patients and families at PRH.

Accreditation Week Checklist for Leaders

Physical Environment

- ☐ Medication Room, Cabinets, Drawers and Carts secured (doors closed and locked)
- ☐ Patient charts properly stored
- ☐ Check hand sanitizer dispensers are in good working order and are filled. (Hallways, point of care, patient bedside and/or table)
- ☐ De-clutter hallways:
    - Limit the amount of:
        - Personal mobility equipment
        - Linen carts
        - Soiled linen bins
    - Ensure that one side of the hallway is clear so that ambulating patients can walk freely down the hall
- ☐ Ensure that all patients' equipment (loaner or personal) is labeled with the patient's name (walkers, wheelchairs, commodes)
- ☐ Do a walk-through and remove unnecessary signage. If signage is necessary, ensure it is laminated and in good form

Information Boards

- ☐ Ensure current data and reports are posted on huddle boards
- ☐ Ensure Hand Hygiene Audits are posted on Health and Safety Board
- ☐ Ensure PPE audits are posted on Health and Safety Boards
- ☐ Remove all outdated posters/notices from all communication boards
- ☐ Ensure Emergency Preparedness Stations are up-to-date and reflective of current code of the month

Staff

- ☐ All Staff wearing ID badges
- ☐ Staff know when surveyors will be on their units and/or when they could encounter them during survey week
- ☐ Staff comfortable with ROPs and standards for their areas
- ☐ Staff ready with "good news stories", achievements, awards, quality improvement
- ☐ Casual staff know when Accreditation is and are given necessary just-in-time education

Patients

- ☐ 3-5 potential patient charts selected and audited for completion – patients asked if they are agreeable to speaking with a member of the survey team
- ☐ All patients/families notified during rounding that surveyors will be on the unit and may ask to speak with them – accreditation pamphlets provided

Accreditation Frequently-Asked Questions (FAQs)

What is the schedule for the on-site survey?

The onsite survey will occur April 3-6, 2023. The schedule for the current year has been provided as an insert to this handbook.

What happens during an onsite survey?

The week of the onsite survey, surveyors will come onsite to PRH to review both clinical and administrative activities; these are called 'tracers. During a tracer, a surveyor follows the path of either a patient or an administrative process through the continuum of care from beginning to end. For example, they may trace the path of hiring a new staff member through looking at orientation materials, speaking with staff about their new hire experience and training, safety concerns, ongoing performance reviews, etc. The information gathered during a tracer will be used to evaluate PRH's compliance to the national standards.

Who are the surveyors?

The surveyors are trained reviewers who usually work as health care professionals in other hospitals or health care settings in a leadership role. The names and biographies of the surveyors coming to PRH this year are included as inserts of this handbook.

What should I expect during a tracer?

Expect that you may be asked to show paper or electronic documentation in relation to clinical practices (i.e. medication safety policies). Don't worry, the survey team signs a privacy and confidentiality agreement so that they may review sensitive patient and administrative documents.

Expect that you may be approached and asked questions about your job role or work life. Don't worry, the surveyor is not there to assess you personally and your name or position will not be linked to the report. Be polite and helpful in answering their questions.

Expect that your work environment will be observed. Again, don't worry, they aren't assessing you personally. The surveyor needs to observe how people work on the unit to ensure that patient and work safety practices are being observed (e.g. hand hygiene, patient privacy, medication storage, wet floor signs).

Accreditation Frequently-Asked Questions (FAQs)

What do I do if I don't know the answer to a surveyor's question?

Let them know that you aren't sure and direct them to the person (or resource) that you would go to for an answer. For example, if you refer to a policy on an as needed basis, offer to show them how you would access policies and procedures on Policy Medical Procedure Manual on the intranet and search for the document.

Will my supervisor know what happened during my conversations with the surveyor?

No. Your name will not be linked to any surveyor comment or response in the report.

Will the surveyor want to speak with patients or families?

Yes! In patient care areas, you should speak to the patients/families a day or two before the surveyors arrive to let them know that they may be approached and asked questions about their experience. Reassure them that this is part of our accreditation process and provide them with the patient handout. If a patient does not want to participate, it's important to note that so that the surveyor will know not to approach them.

How long will the surveyors be in my area?

When surveyors visit an area, it could be for a defined amount of time, or it could be as part of a tour. When they visit as part of a tracer, we expect that they will be there for a few hours.

Who do I talk to if I have more questions?

Speak with your manager or director, review the information on the Accreditation portal, or contact PRH's Accreditation Coordinators, Kirsten Johnson kirsten.johnson@prh.email or Danielle Rae danielle.rae@prh.email

TIPS for Selecting Patient Charts for the Onsite Survey

- ☐ Select 3-5 current patient files for the surveyor to review
- ☐ Patients should be varied in nature where possible (age, diagnosis, length of stay, etc)
- ☐ Patients/families should be able to understand questions in English and answer to the best of their ability
- ☐ Think about nursing assignments when selecting patients (you don't want all selected patients with the same nurse – try to spread it out)
- ☐ Review the charts for thoroughness and accuracy in advance (are risk assessments complete?)
- ☐ Speak with the patient/family to ensure they are comfortable and willing to speak to the surveyor; provide them with the patient accreditation pamphlet
- ☐ Patients/families should be able to speak to:
  - Their care plan – why they are in hospital, next steps, medications, potential discharge date, etc
  - Teaching/Education/Information received (patient handouts, infection control/hand hygiene information, etc)
  - The information on their care board
  - Responsiveness of the care team
  - How they participate or provide input in care planning/decision making
  - Safety precautions (ie fall risk – have mats on the floor/sticker on care board etc)

Special notes:
If patient is on a self-admin pump – have they received training? Did they provide feedback on the training?

Patients/families who have requested Ethics consult or Patient Relations can absolutely be selected – it demonstrates that we have a process in place!

Questions Surveyors May Ask

Throughout the accreditation onsite survey, surveyors will be visiting various areas, and *talking to staff about their day-to-day work*. This is all part of a 'tracer' and its part of how they assess PRH's compliance to the standards for that area. Surveyors do not evaluate individuals and you can feel confident that your answers will not be identified. If you don't know an answer or it's not part of your role, be helpful and direct the surveyor to someone else who has expertise in that area. Also, if the surveyor asks a question using terms that you're not familiar with, please ask them to rephrase the question or provide you with more detail as to what they are asking about.

Here are some examples of the types of questions you may be asked:

Quality

1. What are your unit goals and objectives or what are you focused on improving right now?
2. What changes have been made to improve quality of care?
3. Have you had the opportunity to be involved in a Quality Improvement project?

Patient Safety

1. How do you report an incident, near miss, or safety concern?
2. Can you tell me about patient safety initiatives on your unit? What are the top (most common or most important) patient safety incidents on your unit?
3. What improvements have you made as a result?
4. What training and education have you received around patient safety?
5. How do you identify the patient before a treatment?
6. What is the process when a patient arrives on your unit/in your area?

Patient Engagement

1. In your daily work, how do you involve patients in their care planning?
2. How do you collect patient feedback? What do you do with the information?

Medication Management

1. Can you describe how you administer medications?
2. What practices are in place to reduce and prevent medication errors?

*continues on page 12

Ethics

1. How would you deal with or respond to an ethical issue?
2. What is your framework? (YODA)
3. What resources are available to help you?

Emergency Preparedness

1. What would you do in the case of a Code Red?
2. What do you do in the case of an evacuation?
3. Where can you find information on emergency codes?

Work life

1. Do you receive regular performance evaluations or feedback from your leader?
2. Do you feel comfortable reporting concerns?
3. Have you received training in workplace violence prevention?

Engaging with Patients and Families

What is engagement?

The participation of patients, caregivers, family members, community representatives, community groups and the public in how health services are planned, delivered and evaluated.

Pembroke Regional Hospital engages with patients and their families in a way that is respectful, compassionate, and culturally appropriate. The needs, values, beliefs, and preferences of patients and their family members are considered and incorporated into the provision of world class care, exceptional service and compassion we would want for our loved ones. We have several ways in which we engage patients and family across our organization, and we continue to seek new ways of increasing this engagement.

Patients and their families provide input through advisory committees, unit leadership teams, quality improvement working groups, surveys, focus groups and informal day-to-day feedback through:

- Patient and Family Advisory Council and Patient/ Family advisors on Unit Leadership Teams - to provide input and feedback into educational materials, policy and program development
- The sharing of patient and family experiences:
    - By email, letter, or telephone through Patient Relations
    - Patient experience surveys
    - Directly to departments / units / areas of care (ex: through satisfaction surveys, focus groups)
- Participation in various initiatives and improvement projects throughout PRH

Patients and their families partner with us in several ways in the delivery of their care:

- By working collaboratively with specific departments / units / areas of care in aspects of designing, planning, delivering and evaluating healthcare services.
- Participating in Bedside Rounds.
- Whiteboards in patient rooms to make sure there is clear, complete communication and shared goals regarding their plan of care.
- Confirm patient identity (e.g., “What is your name?”, “What is your date of birth?”).

Required Organizational Practices (ROPs)

Accreditation Canada defines a Required Organizational Practice (ROP) as an essential practice that organizations must have in place to enhance patient safety and minimize risk.

All ROPs (including each test for compliance) must be met in order to receive the highest Accreditation Decision Level. Below is a list of the 31 ROPs that will be evaluated during our onsite survey in2023. More details can be found for each ROP as you continue reading this handbook or on PRH's Accreditation Hub.

Safety Culture: Create a culture of safety within the organization

- Accountability for quality
- Patient safety incident disclosure
- Patient safety incident management
- Patient safety quarterly reports

Medication Use: Ensure the safe use of high-risk medications.

- Antimicrobial stewardship
- Concentrated electrolytes
- Heparin safety
- High-alert medications
- Infusion pump safety
- Narcotics safety

Infection Control: Reduce the risk of hospital-acquired infections and their impact.

- Hand-hygiene compliance
- Hand-hygiene education and training
- Infection rates
- Reprocessing

Communication: Improve the effectiveness and coordination of communication among care providers and with the recipients of care across the continuum.

- Client identification (2 patient identifiers)
- The "Do Not Use" list of abbreviations (dangerous abbreviations)
- Information transfer at care transitions
- Medication reconciliation as a strategic priority
- Medication reconciliation at care transitions
- Medication reconciliation in the Emergency Department
- Medication reconciliation in Ambulatory Care areas
- Safe surgery checklist

Work Life / Work Force: Create a work life and physical environment that supports the safe delivery of care.

- Client flow
- Patient safety education and training
- Patient safety plan
- Preventative maintenance program
- Workplace violence prevention

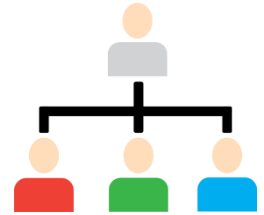
Risk Assessment: Identify safety risks inherent in the patient population.

- Falls prevention and Injury Reduction
- Pressure ulcer prevention
- Suicide prevention
- Venous thromboembolism prophylaxis

SAFETY CULTURE

ROP: Accountability for Quality

The governing body demonstrates accountability for the quality of care provided by the organization.



Governing bodies are accountable for the quality of care provided by their organizations. When governing bodies are engaged in overseeing quality, their organizations have better quality performance (better care, better client outcomes, better work life, and reduced costs). PRH's Board of Governors demonstrate accountability for quality through:

Knowledge and Expertise

- Governors are selected based on their specific skills and expertise to ensure that the Board achieves a balance to fulfill its governance roles and responsibilities and to genuinely reflect the community it serves. Governors are provided regular learning opportunities about quality of care issues.

Commitment to Discussing Quality Regularly

- The Board Quality and Patient Safety Committee, which is a subcommittee of the Board of Governors, meets a minimum of five times per year and is dedicated to monitoring quality. Areas of review include quality issues and the overall quality of services provided at the Hospital, reviewing performance indicators, publicly reported patient safety indicators, oversight of critical incident disclosure and review, aggregate critical incident data and patient relations data.

Monitoring Quality Performance

- PRH has an organizational scorecard which is heavily weighted towards quality and the quadruple aim. The scorecard aligns actions of front-line staff with our strategic goals. The board regularly monitors performance on the organizational scorecard.
- The Board Quality and Patient Safety Committee receives progress reports on quality and safety metrics

Decisions and Priorities

- In reviewing quarterly and semi-annual quality plan progress updates, the Board Quality and Patient Safety Committee has the opportunity to direct or redirect resources based on performance observed. In addition, any serious quality concerns arising are raised to the Board Quality and Patient Safety Committee for their awareness and oversight of effective resource allocation necessary to address the issue.

Senior Leadership Accountability

- As part of their performance evaluation, a proportion of executive compensation is tied to the achievement of quality indicator targets as mandated through *the Excellent Care for All Act* (ECFAA). The process of determining which indicators and respective targets occurs on an annual basis aligned to the Ministry Quality Improvement Plan cycle.

SAFETY CULTURE

ROP: Patient Safety Incident Disclosure

A documented and coordinated approach to disclosing patient safety incidents to client and families, that promotes communication and a supportive response, is implemented.

PRH has a documented and coordinated process to disclose patient safety incidents to clients and families which includes:

A Documented Disclosure Process (Policy: *Disclosure of a Patient Related Critical/ Adverse Event*)

- It provides clear direction on requirements to disclose, who is responsible for guiding and supporting the disclosure process, what can be communicated and to whom about the incident, when and how to disclose and where to document the disclosure.
- This policy has been revised and approved with input from patient advisors.

Guiding and Supporting the Disclosure Process

- The Disclosure Policy includes process steps, direction on disclosure conversation and requirements to document.
- Consultation and guidance is also available from the Patient Relations Delegate. Can also seek support through your manager.

A Communication Tracking Process

- Patient Relations tracks disclosure of critical incidents.
- Disclosure conversation is documented by the most responsible physician directly in the patient's health care record.

Patient and Family Support & Feedback

- Patients and families are offered the support of Social Work, Spiritual Care, and Patient Relations. A Patient Relations Delegate is involved in the communication with patients and family members for serious and critical incidents to assess satisfaction with the disclosure process and to close the loop.

Questions the surveyor may ask about this ROP:

Have you ever been involved in a serious or critical patient safety incident?

What was the process to report it?

How was the patient or family informed?

On our unit, we comply by:

Reporting

- Critical Incidents are reported to Medical Advisory Committee and Board Quality and Patient Safety
- The Board Quality and Patient Safety Committee and Organizational Quality & Patient Safety Committee review aggregate data on patient incidents, concerns and compliments

Supporting Policies:

Management and Reporting of Patient Related Critical/ Adverse Event

SAFETY CULTURE

ROP: Patient Safety Incident Management

A patient safety incident management system that supports reporting and learning is implemented.

PRH has implemented the following patient safety incident management initiatives:

Policies

- Policies and procedures are available on Policy Medical which address reporting of adverse events and near misses – *Management and Reporting of Patient Related Critical/ Adverse Events* and *Risk Incident Management System.*

Incident Management Software

- The Risk Incident Management System (RIMS) software is regularly enhanced based on software upgrades and PRH user requests.
- All programs at PRH use the RIMS system to report incidents, conduct reviews and identify areas for improvement.

Staff Training

- Training for RIMS has been added to our eLearning system and is a requirement of corporate orientation for all new staff.

Review, Analysis, Actions & Improvements

- There is a process for screening events for immediate corrective action and directing events to the appropriate review group depending on event severity.
- All incidents are routed to the Quality and Patient Safety Manager to be classified and trending reports are generated and analyzed.
- Automated notifications of new reports, multi person reviews and clear accountability structure
- Actions are entered into RIMS.

Sharing of Information, Evaluation and Getting Feedback

- Recommended actions and improvements are shared with appropriate team members, patients and/or family members.
- Critical incidents are reported at Medical Advisory Committee (MAC) to the Board Quality and Patient Safety Committee and the CEO

Questions the surveyor may ask about this ROP:

How do you report a patient safety incident?

What happens after you report the event?

If you discover an error or adverse event, how are patient and families involved?

On our unit…:

SAFETY CULTURE

ROP: Patient Safety Quarterly Reports

The governing body is provided with quarterly reports on patient safety that include recommended actions arising out of patient safety incident analysis, as well as improvements that were made.

Patient safety initiatives are followed quarterly by the Quality Committee of the Board and include:

Patient Safety Reports

- PRH has a Board Quality and Patient Safety Committee that meets regularly. The committee operates under the authority of the Board and is the designated Quality Committee for purposes of the Excellent Care for All Act 2010. Items on the agenda include: Story Telling (Quality Themes), Quality and Safety Measures (PRH Balanced Scorecard – Key Indicators for Patient Care/Services), Aggregated Critical Incident Report, QIP Report on Progress, Quality Improvement Projects – Update on Key Organizational Projects, Accreditation, Lean updates on increasing efficiency, minimizing waste and increasing quality. The Board supports the organization in learning from results, both positive and negative, making decisions that are informed by research and evidence. Recognition is provided through various celebrations and demonstrates a commitment to staff and volunteers for their quality improvement work.
- The Board Quality and Patient Safety Committee receive a report related to any critical incident and quality improvement recommendations.
- Summary trending reports on all patient related incidents are presented at least twice per year.
- For all critical incident reviews the detailed case and actions being taken to mitigate risks is presented to the patient and to the Board Quality and Patient Safety Committee.
- Staff and supervisors discuss patient safety issues during LEAN Huddles as they arise.
- All levels of *Status Updates* discuss patient safety issues and initiatives to deal with the issues.
- All action items supporting the patient safety activities and accomplishments remain on the agenda until they are complete and reported upon.
- Patient Safety updates and information is shared with all staff in the Pulse Newsletter

COMMUNICATION

ROP: Client Identification

Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.

Using person-specific identifiers to confirm that clients receive the service or procedure intended for them can avoid harmful incidents such as privacy breaches, allergic reactions, discharge of clients to the wrong families, medication errors, and wrong-person procedures.

Two Person-Specific Identifiers

- At PRH, two unique patient identifiers are confirmed at entry to the Hospital and prior to staff or physician providing care or service.

  Examples of Person-Specific Identifiers include:
  - Client's full name
  - Date of Birth
  - Personal Identification Number
  - Home address (when confirmed by the client or family)
  - Accurate photograph

- Staff are never to use the patient's room or bed number, as this is not person-specific and cannot be used as an identifier.
- **When clients and families are not able to provide this information, other sources of identification can include:**
  - Wristbands
  - Health records
  - Government issued identidication
- All Medication Administration Records (MAR) are stamped with addressograph including name/ DOB/ CPI

Policies

- Instructions for performing patient identification are contained in the following policies:
  - Patient Identification and Same Name Alert
  - Newborn Identification

Questions the surveyor may ask about this ROP:

What steps do you take to ensure you are treating the right patient?

How do you verify the identity of patients? Ie.registration, before medication administration or administration of blood or blood products?

On our unit, we comply by:

COMMUNICATION

ROP: The "Do Not Use" List of Abbreviations

A list of abbreviations, symbols, and dose designations that are not to be used have been identified and implemented.

Medication incidents are the largest source of preventable adverse effects. Misinterpreted abbreviations can result in omission incidents, extra or improper doses, administering the wrong drug, or giving a drug in the wrong manner. To reduce the risks associated with the misinterpretation of abbreviations, PRH has the following in in place:

A Do-Not-Use List of Abbreviations

- PRH's policy on *Abbreviations- NOT acceptable* includes the Institute of Safe Medication Practices (ISMP) Canada's "Do-Not-Use List". This policy is available to all staff in Policy Medical

Application of the Do-Not-Use List

- The Do-Not-Use List of Abbreviations is applicable to all clinical documentation, whether it is handwritten or as free text within PRH electronic systems.

Pre-Printed Forms

- Pre-printed Orders are reviewed by Stakeholders including Pharmacy to ensure adherence to the Do-Not-Use list.

Pharmacy

- All Pharmacy-generated labels and forms are compliant with the ISMP Do-Not-Use List.

Education and Informing

- Education on the Do-Not-Use List is done as part of the Nursing Orientation Checklists
- The ISMP 'Do Not Use' abbreviation list is at the front of each admitted patient chart and is available at each nursing station and near physician stations
- The ISMP 'Do Not Use' abbreviation list is included in onboarding packages for new physicians

Audits for Compliance

- Monthly patient chart audits are completed to ensure compliance with the ISMP 'Do Not Use' abbreviation list

Questions the surveyor may ask about this ROP:

***Compliance to this ROP will be assessed through review of patient health records**

What are some examples of abbreviations that have been identified as unacceptable in your organization?

Where can you access this information?

COMMUNICATION

ROP: Information Transfer at Care Transitions

Information relevant to the care of the client is communicated effectively during care transitions.

The information that is required to be shared at care transitions is defined and standardized for care transitions where patients (clients) experience a change in team membership or location: admission, handover, transfer, and discharge.

Policy and Process:

- Transfer of Accountability Interdepartmental Patient Transfers
- Transfer of Accountability Communication Tool- SBAR
- External Patient Transfer Policy
- Emergency Transfer Form
- Patient Tranfer Records completed for emergent and non-emergent tranfers
- Transfer form for LTC/ RH transfers
- Transfer protocols for health care partners- Carefor, University of Ottawa Heart Institute, Renfrew Victoria Dialysis
- Up-to-date Program to print pertinent information to share with patients/ families
- Mosby's Clinical Skills or Policy medical for patient education materials
- Discharge checklists

PRH has several strategies and clinical tactics in place to ensure that information is relayed effectively with involvement from the patient or family members:

- Nursing transfer of accountability occurs at every patient transfer from one inpatient unit to the next within PRH between the transferring nurse and the receiving nurse. Transfer of Accountability includes SBAR verbal report (situation, background, assessment and recommendation).
- At the time of patient transfer, the transferring nurse and the receiving nurse utilize the Interdepartmental Transfer Communication Tool to assist in the provision of verbal face to face report. In exceptional circumstances when the transferring nurse and the receiving nurse are not able to do a verbal face to face patient report the transferring nurse calls the receiving nurse and gives telephone verbal report using the SBAR tool and signs the SBAR tool. The receiving nurse signs the SBAR tool when the patient arrives to the unit.
- Nursing transfer of accountability shift report occurs at every shift change between the oncoming and off-going nurses.
- It is expected that all care provided is to be captured in the permanent legal health record. It is the nursing staff responsibility to complete the appropriate core elements of documentation and communicate to other members of the interprofessional team

Questions the surveyor may ask about this ROP:

Can you tell me how you transfer a patient to another unit?

Describe your processes for transferring patient information on admission? At shift change? When a patient is transferred to another service? At discharge?

On our unit, we comply by:

ROP: 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.

Policy and Process:

- Medication Reconciliation Policy
- Pharmacy Generated BPMH or Medication Order Form and Best Possible Medication History
- The policy outlines who is responsible for collecting the best possible medication history (BPMH) and for the med rec itself

Sustainability:

- An interdisciplinary team, Medication Management Committee provides oversight on implementation and monitors compliance with med rec.
- Medical Quality Improvement Committee monitors compliance with med rec at discharge and reports to Medical Quality Improvement Committee sharing data or concerns.
- Medication Reconciliation will be included as a strategic priority within PRH's 2023-2024 Quality Improvement Plan (QIP)

Training and Education:

- An electronic education module is mandatory for all new physicians and residents before they are able to use the electronic med rec application.
- Coaching and education is also provided by clinical pharmacists to support medical staff in the process when reconciliation occurs.

Monitoring Compliance:

- Monthly chart audits are completed to monitor ongoing compliance with the following
    - Percentage of Pharmacist Preliminary Med Rec (discharge)
    - Percentage of Physician Electronic Medication Reconciliation
    - Percentage of Med Rec Prepared
    - Percentage of Med Rec on Admission
- Monthly chart audits are available to all clinical managers and directors within the Common Folder- under "Clinical Chart Audit"
- Med Rec compliance is shared at various committees inlucding Medication Management, Medical Quality Improvement Committee and Medical Advisory Committee (MAC) for ongoing monitoring and discussion improvements to the process.

COMMUNICATION

ROP: 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.

Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.

- All admitted patients at PRH (with the exception of neonates) have a BPMH initiated and completed in the health record.
- The BPMH lists all the medications the patient is taking including prescription, non-prescription, holistic, herbal, vitamins and supplements.
- Creating a BPMH involves interviewing the patient, family or caregivers and consulting at least one other source of information.

The BPMH is used to generate admission medication orders, or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.

- At PRH, all patients admitted to the hospital, including admission through the Emergency Department, Pre-Operative Assessment Clinic or direct transfer in from another institution, all have medications reconciled.
- Medication reconciliation by our BPMH pharmacy technicians or health care professional at admission is achieved using one of two models:
    - In the proactive model, the BPMH is used to generate admission medication orders. The admitting physician or most responsible physician (MRP) completes the medication reconciliation and physician orders within 48 hours- using the BPMH to create admission orders.
    - In the retroactive model, the BPMH is generated after admission medication orders have been written; a timely comparison of the BPMH and admission medication orders is then made.
- Regardless of the model used, it is important to identify, resolve and document medication discrepancies. When discrepancies are identified between the BPMH and admission orders, the pharmacy department notifies the clinical pharmacist or MRP.
- All physicians have access to the electronic medication list which include BPMH and current medication list to generate discharge prescription.
- The physicians use the BPMH and the current hospital medication list to generate discharge medication orders. Pharmacists prepare the transfer prescriptions and some discharge orders as well as using both the BPMH and current hospital orders.
- The BPMH is kept on the patient's chart.
- Patient always gets a copy.
- Provided to Home and Community Care when referred.
- Upon discharge, the patient is given a copy of their discharge prescription,

ROP: Safe Surgery Checklist

A safe surgery checklist is used to confirm that safety steps are completed for a surgical procedure performed in the operating room.

Surgical checklists play an important role in providing safe and effective surgery. The purpose of the checklist is to initiate, guide, and formalize communication among team members to integrate these steps into daily work flow.

Use in the Operation Room:

- A three-phase checklist involving the Brief, Time-Out and De-Brief is followed for all procedures.
- The Surgical Checklist Documentation tool is to remain as a record as part of the patient chart.

Monitoring Compliance

- Completion of the checklist is documented on the patient's perioperative record
- Compliance reporting is to be completed in the Operating Room Benchmarking Collaborative (ORBC) data program.
- As mandated, compliance reporting is posted on the PRH website.
- Compliance and auditing accountabilities pertaining to the Surgical Checklist is overseen by the department Clinical Manager.

Questions the surveyor may ask about this ROP:

***This ROP will be assessed by observing the process in action. The surveyor may request to attend the start of a surgical procedure.**

The surveyor may also ask to see how the Safe Surgery Checklist is documented.

MEDICATION USE

ROP: Antimicrobial Stewardship

There is an antimicrobial stewardship program to optimize antimicrobial use.

Antimicrobial stewardship is a process to ensure that patients are treated with the optimal drug, dose and route of antibiotic, antiviral or antifungal.

PRH's Antimicrobial Stewardship Program (ASP)

- The Antimicrobial Stewardship Program (ASP) Committee is multi disciplinary and consists of Physicians, Pharmacists, Infection Prevention and Control Practioners, Information Technology and Lab.
- ASP priority interventions are decided by the committee based on monitoring and tracking of antimicrobial prescribing, and other important outcomes like C. difficile and resistance patterns.

Accountability for Implementing the ASP

- The ASP Committee makes recommendations for ASP activities to the Organizational Patient Care, Quality and Risk Committee and through the Medical Quality Improvement Committee to the Medical Advisory Committee (MAC).

Interventions to Optimize Antimicrobial Use

  - **Prospective audit and feedback:** The interventions done via prospective audit and feedback include discontinuing therapy, changing the antimicrobial agent, optimizing duration/route/dose, manage or prevent adverse reaction/event, monitoring parameters, etc.
  - **Antimicrobial Tools:** The ASP team develops or adapts and promotes tools to help optimize antimicrobial use, e.g. guidelines for empiric antibiotic therapy (updated yearly), PRH-specific antibiogram (updated yearly), treatment algorithms, clinical pathways, etc.
- Case reviews completed for all hospital acquired CDI cases. Shared with Chief of Staff and Pharmacy. IPAC maintains a monthly HAI CDI scorecard. Rates are reported at Medication Management Committee, Organizational Quality and Patient Safety and Medical Quality Improvement Committee.

MEDICATION USE

ROP: Concentrated Electrolytes

The availability of concentrated electrolytes is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

High concentration electrolytes are considered high-alert medications that have the potential to cause serious harm and should not be stocked at all (or strictly controlled) for patient safety reasons.

The following concentrated electrolyes are ONLY stored in pharmacy department and not stored in patient care areas:

- Potassium Chloride Inj. (concentrations greater than or equal to 2mEq/mL)
- Phosphate Potassium Inj.
- Sodium Chloride Inj. (concentrations greater than 0.9%)
- Calcium Chloride Inj. (concentrations greater than or equal to 10%)
- Calcium Gluconate Inj. (concentrations greater than or equal to 10%)
- Magnesium Inj. (concentrations greater than or equal to 20%)

The following exceptions apply:

- Calcium Chloride pre-filled syringes on crash cart trays
- Calcium Gluconate in OR, ED, ICU and LDRP
- Magnesium Sulphate in LDRP

At PRH, we limit the availability of concentrated electrolytes through:

Limitation of Stocking Concentrated Electrolytes

- Concentrated electrolytes have been removed from patient care areas.

Exception Review and Approval

- The Medication Management Committee reviews rationale and approves the stocking of concentrated electrolytes in select areas only, e.g. ICU, Emergency Department, OR, LDRP.

Monitoring Compliance

- Audits are completed by the pharmacy department at least annually.

Questions the surveyor may ask about this ROP:

The surveyor will usually look for any medication discrepencies as part of their observations on the unit. If they find concentrated electrolytes, they may ask about the rationale for having them, how/where there are stored?

On our unit, we comply by:

MEDICATION USE

ROP: Heparin Safety

The availability of heparin products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

Heparin is a high-alert medication that can result in patient harm if prepared or administered incorrectly to a patient. Limiting access and removing heparin from patient care areas minimizes the risk of patient injury and death. PRH's Heparin Safety Program includes:

- Avoiding high conentrations of unfractionated heparin at PRH
- Unfractionated heparin (high dose): greater than or equal to 10,000 units is provided on a patient specific basis when required and is stocked in the pharmacy department
- Limiting the quantities of low molecular weight heparin stocked in patient care areas
- Restricting the patient care areas where low molecular weight heparins are stocked
- Standardizing medication options by having one low molecular weight heparin on our drug formulary- Enoxaparin
- Labelling all low molecular weight heparin products in patient care areas with visible warning and auxillary labels that identify it as a high-alert medication
- Using pre-filled syringes for low molecular weight heparin (i.e. Enoxaparin) instead of multi-dose vials
- Providing training about high-alert medications such as heparin
- Requiring an independent double check for unfractionated heparin prior to administration
- Pharmacy completes routine audits of heparin on clinical units

Review and Approval of Exceptions

- The Medication Management Committee reviews requests for stocking heparin products and approves based on rationale.

Questions the surveyor may ask about this ROP:

The surveyor will usually look for any medication discrepencies as part of their observations on the unit. If they find high-dose heparin, they may ask about the rationale for having it, how/where it is stored, and/or about administration process?

MEDICATION USE

ROP: High Alert Medications

A documented and coordinated approach to safely manage high-alert medications is implemented.

High-alert medications are drugs that bear a heightened risk of causing significant harm when used in error. PRH's approach to manage high-alert medication includes:

Policy/ Process

- We have a policy on High-Alert Medications available to all staff in Policy Medical- *High Alert Medications and Independent Double Check*
- Pharmacy completes routine audits of high alert medication on clinical units

List of High-Alert Medications

- A list of High Alert Medications is available to all staff on the Policy Procedure Manual. The list of High Alert Medications is reviewed and approved by the Medical Quality Improvement Committee and Medical Advisory Committee (MAC)

Procedures for Storing, Prescribing, Preparing, Administering, Dispensing and Documenting

- The policy includes procedures for all aspects of handling high-alert medications.

Limitation and Standardization

- The Pharmacy Department limits concentrations and volumes of high-alert medications.

Independent Double Check

- PRH has a standardized process called an Independent Double Check for high alert medications where a second practioner conducts verification without any prior knowledge of the preparatory steps or calculations performed by the first practioner. This process is then documented on the Medication Administration Record (MAR), or hospital approved flow sheet.

Questions the surveyor may ask about this ROP:

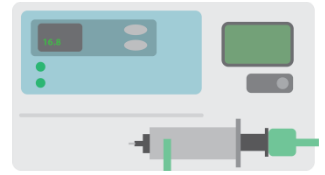
What is the process for administering a high-alert medication?

What medications are considered high-alert? Where would you find a list of all available at PRH?

On our unit, we comply by:

MEDICATION USE

ROP: Infusion Pump Safety



A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.

Effective and ongoing infusion pump training helps to enable safe delivery of intravenous medications by using standardized medication infusions, prove user confidence and patient safety awareness. PRH's Infusion Pump Safety Program includes:

Accessibility of Instructions and User Guides

- All infusion pump manuals and Quick Reference Guides are available on the Clinical Skills program.
- Staff can access eLearning modules for extra learning on the PRH eLearning platform.
- Policy and procedures for use of infusions pumps is found on the Clinical Skills program.

Training to Team Members

- All newly hired staff and those returning from extended leave are required to have training on all routinely used infusion pumps in their area
- All nursing staff are required to complete eLearning regarding infusion pumps every 2 years (evaluation of competence with pass/ fail quiz).
- Nurse Educators are available on every unit to provide training when a new pump is introduced, an existing pump is upgraded or when re-training is required.
- Just-in-Time training is provided for infrequently-used pumps and documentation is completed.
- Training records can be accessed through the electronic eLearning program.
- The RIMS System is used to record, investigate and evaluate infusion pump incidents.
- Formal education and roll out for any new pumps

Training to Patients and/or their Families on the Use of Patient-Operated Pumps

- Patient Teaching is provided to patients and/or families for any patient-operated infusion pump.
- Hourly Rounding completed by all nurses to ensure patient safety, assessment of patient's pain level, and understanding.
- Shift Report completed at hand-over assesses patient's current/future teaching needs, assess patient-operated infusion pump during safety check, and to assess patient understanding of teaching goals and the plan of care.
- Patient information brochure available on Mosby's Clinical Skills Manual for CADD PCA pumps
- Information is provided to patients and/or their families in written format to aid in teaching and training. Teaching is documented.

Questions the surveyor may ask about this ROP:

Have you received appropriate training on Infusion Pumps?

How often is Infusion Pump training provided? How is this done?

On our unit, we comply by:

ROP: Narcotics Safety

The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in client service areas.

Narcotics are a high-alert medication and errors involving them can cause serious harm or even death.

At PRH, we limit the narcotics available on the floor and provide staff education and training in known narcotic safety issues. Our Narcotics Safety Program includes:

Audits and Monitoring

- Narcotic counts occur in each patient area at shift changes when authority is transferred from outgoing shift to the incoming shift and in Pharmacy weekly.
- All staff responsible for narcotic administration will not leave their shift until any discrepancies in counts are reconciled. If error is not reconciled, staff are to notify the unit manager/ delegate and a RIMS report is to be completed.
- Any discrepancies in counts are reported to Health Canada within 10 days
- Random Audits are conducted every 6 months for narcotic administration, ordering and receiving.

Narcotic Storage

- All narcotic and controlled drugs are stored in a designated locked storage cabinet in all patient care areas.
- High dose narcotics (e.g. fentanyl ampoules or vials with total dose greater than 100 mcg per container, hydromorphone ampoules or vials with total dose greater than 2 mg, and morphine ampoules or vials with total dose greater than 15 mg) are not stocked in patient care areas.
- Naloxone is available in the crash cart trays in all patient care areas which stock narcotic substances.

Standardized Documentation and Administration

- Patient care areas with narcotics use a Daily Narcotic and Controlled Drug Record (DNCDR) to track received, returned, administered, and wasted narcotics.

Questions the surveyor may ask about this ROP:

The surveyor will usually look for any medication discrepancies as part of their observations on the unit. They may ask about how/where narcotics are stored, and/or about administration process.

On our unit, we comply by:

WORKLIFE/WORKFORCE

ROP: Client Flow

Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.

Patients need to receive the right care, in the right place, and at the right time. PRH has a strategy to meet variations in demand, reduce barriers to client flow and prevent overcrowding.

Patient flow strategies at PRH deal with 5 key areas every day:

1. Optimizing bed capacity
2. Improving emergency department and inpatient flow
3. Reducing Alternate Level of Care (ALC) patient days
4. Meeting requirements to repatriate PRH patients through external partners
5. Optimizing OR utilization and surgical throughput

Accountability

Clinical Managers and Physicians have defined accountabilities for managing patient flow. Measurements of success include:

- Length of stay as available through the Daily DART
- ED admission rate as available through the Daily DART
- Attendance by clinical resource/ discharge planner/ or delegates at daily patient flow meetings
- Time to inpatient bed
- Bed capacity

Client flow data is used to identify variations and barriers

- PRH utilizes the Daily DART dashboard to measure and monitor several indicators relating to key client flow indicators which affect the ED. Examples of key client flow items on these reports include:
    - Length of stay per encounter
    - ED visits admitted
    - ALC patients (#)
    - Time to inpatient bed
- ED volume and key metrics are monitored on the ED dashboard.

Improving Client Flow

- There is a daily bed meeting in which Clinical Resource/ Discharge Planners (or delegates) discuss hospital occupancy and anticipated patient flow challenges for the day. Anticipated discharges and potential discharge barriers/ solutions are also discussed
- PRH inpatient units perform daily discharge rounds with a focus on planning for and predicting estimated date of discharge .
- A Capacity Protocol for Patient Flow can be found in the “Patient Flow” policy
- Joint Discharge Rounds are performed every two weeks with representation from home and community care, Marianhill CCC, PRH discharge planners and patient flow manager and behavioural support.
- Regional patient flow call daily as well as a regional repatriation guideline

WORKLIFE/WORKFORCE

ROP: Patient Safety: Education and Training

Patient safety training and education that addresses specific patient safety focus areas are provided at least annually to leaders, team members, and volunteers.

A key component of patient safety culture is regular patient safety training and education. Our employee orientation and training sessions ensure that staff are aware of safety measures and adopt these into their day-to-day work habits.

At PRH, patient safety training and education is provided at/through:

- Corporate Orientation for new hires and volunteers
- Annual eLearning module focused on specific patient safety areas and how these concepts are integrated into everyday activities to contribute to safe patient care
- Other eLearning modules include: Cobas Academy, Bloody Easy, Delirium
- Department or unit-level orientation
- Nursing orientation
- Occupational Health and Safety training (including fit testing, lift and transfer training, accessibility awareness training)
- Patient safety handout available in all clinical areas
- Standard infection control education training
- Nursing Skills Days
- Workplace Violence Prevention training (eLearning)
- NVCI and GPA training
- Patient Safety and Incident Reporting (eLearning)
- Patient Welcome Guide offers safety information for in-patients
- Education during Patient Safety Week annually (Octoner-Novemeber)

Questions the surveyor may ask about this ROP:

Can you tell me about any safety training you have received?

How often do you have mandatory training? What types of mandatory training are you expected to complete?

On our unit, we comply by:

WORKLIFE/WORKFORCE

ROP: Patient Safety Plan

A patient safety plan is developed and implemented for the organization

Plan and Process

Pembroke Regional Hospital continues to maintain a focus on providing the highest quality of care and patient/family experience, in order to achieve the quadruple aim.
At PRH, the patient safety plan is rooted in our everyday work:

- Patient Safety measures are hospital drivers in our Quality Improvement Plans
- PRH continually measures and monitors safety indicators.
- PRH publicly reports on several patient safety indicators to the Ministry of Health and Long-Term Care:
  - Hand Hygiene compliance of health care providers
  - Clostridium difficile infection rates
  - Methicillin-Resistant Staphylococcus Aureus infection rates
  - Vancomycin-Resistant Enterococcus infection rates
  - Ventilator-Associated Pneumonia occurrence
  - Surgical Site Infection Rates
  - Surgical safety checklist compliance
  - Hospital Standardized Mortality Ratio
  - Other Audits done include:
    - Pressure Ulcer prevalence
    - Fall Risk assessment completion
    - Restraint use
    - VTE prophylaxis use
    - SBAR
    - Do Not Use Abbreviations
- Critical and Serious Adverse events are reviewed at the Board Quality and Patient Safety Committee and Medical Quality Improvement Committee
- PRH also uses the RIMS system to capture all patient safety related events. Summary reports are presented at various committees including Board Quality and Patient Safety Committee.
- Quality Improvement Plans and Balanced Scorecards highlight patient safety and quality initiatives
- LEAN is supported throughout hospital and supports quality and safety improvement initatives

WORKLIFE/WORKFORCE

ROP: Preventive Maintenance Program

A preventive maintenance program for medical devices, medical equipment, and medical technology is implemented.

Keeping our medical devices, equipment and technology in good working order is essential to keeping our patients and staff safe.

- Pembroke Regional Hospital has a Contract Agreement with the Children's Hospital of Eastern Ontario (CHEO) to provide maintenance and preventative maintenance on of the medical equipment at PRH
- CHEO has a preventative maintenance schedule for medical equipment
- Pembroke Regional Hospital (PRH) has a service contracts for each unit of Diagnostic Imaging equipment. This process is monitored by the Ministry of Health and Long-Term Care X-Ray Inspection Service's X-Ray Compliance Inventory as per the Healing Arts Radiation Protection (HARP) Act. Copies of all service and maintenance reports are stored within the Diagnostic Imaging Department.
- Pembroke Regional Hospital maintains copies of all preventive maintenance reports from our outside suppliers and as well our own work order system.
- There are established policies and processed for recalls and alerts

Questions the surveyor may ask about this ROP:

What is the process if you notice a piece of equipment is broken or defective?

On our unit, we comply by:

WORKLIFE/WORKFORCE

ROP: Workplace Violence Prevention

A documented and coordinated approach to prevent workplace violence is implemented.

Violence in the workplace is more common in health care settings than in many other occupations. Workplace violence can take many forms and can originate from patients or from co-workers.

At PRH:

- We have the "Prevention of Violence in the Workplace" policy and "Identification of Patients/ Persons at Risk for Violence" Policy and flagging system. Patients flagged receive a purple wristband upon admission and additional room signage to indicate violence precautions. Room signage is also posted when there are visitors who are a risk of violence.
- The Manager of Occupational Health and Safety performs violence risk assessments in collaboration with the Violence in the Workplace Committee, Departmental Managers/ Supervisors and staff, Joint Health and Safety Committee representatives and other stakeholders as appropriate.
- There is a procedure for staff to confidentially report incidents of workplace violence through RIMS.
- In accordance with the Prevention of Violence in the Workplace policy, there is a procedure for investigation and follow-up on reported incidents of violence and harassment against staff by another staff.
- Specific incidents are reviewed at the Violence in the Workplace Committee.
- The Violence in the Workplace Committee is accountable to the Senior Leadership Team (SLT) through the Committee chair:
    - The committee provides timely progress reports of any recommendations to the SLT and JHSC
- There is a training program that includes:
    - Mandatory Violence in the Workplace training for all staff through the eLearning system.
    - Non-Violent Crisis Intervention (NVCI) or Gentle Persuasive Approach (GPA) training for specified units/ roles.
- Risk assessments are conducted to a certain the risk of workplace violence
- Workplace violence reported at Monthly Management Team meeting

Questions the surveyor may ask about this ROP:

Do you feel that you have the tools and resources to keep you safe from potential incidents of violence at work?

Have you received any training on violence in the workplace?

Can you show me the policy on Workplace Violence?

On our unit, we comply by:

INFECTION CONTROL

ROP: Hand-hygiene Compliance

Compliance with accepted hand-hygiene practices is measured.

Proper hand hygiene is the single most important means of reducing hospital-acquired infections.

At PRH, we audit hand hygiene compliance to determine how we are doing with our hand hygiene practices. We do this by:

Tracking and Teaching

- Hand Hygiene (HH) performance is tracked on all inpatient units and within the Emergency Department by dedicated Hand Hygiene auditors.
- All 4 moments of HH are monitored, with a focus on moment 1.
- A minimum of 200 HH observations are audited each month in compliance with Public Health Ontario's "Just Clean Your Hands Campaign"
- The Infection Control Team has implemented random peer audits of hand hygiene compliance.
- Captive audience displays and reminders
- IPAC attendance at Lean and Safety Huddles

Sharing Compliance Results

- Performance on HH is provided through just-in-time education and point of care reminders
- Organizational HH audit results are shared electronically each month and posted on departmental Health and Safety Boards. Departmental hand hygiene results are also available.
- HH compliance rates are posted on the PRH website and are reported annually to Health Quality Ontario (HQO)

Reporting Compliance Results

- HH rates are reviewed and discussed at the Infection Control Committee, Organizational Quality and Patient Safety Committee, Medical Quality Improvement Committee, JHSC, and Board Quality and Safety.

Questions the surveyor may ask about this ROP:

Hand Hygiene is observed in all areas of the hospital.

How does the hospital measure compliance with hand cleaning? Do you know the compliance rate in your area?

How do you know what is expected of you regarding hand hygiene and that you are meeting expectations?

On our unit, we comply by:

INFECTION CONTROL

ROP: Hand-hygiene Education and Training

Hand-hygiene education is provided to team members and volunteers.

In a hospital setting, hand hygiene is a vital element of infection prevention and control.

At PRH,

Hand Hygiene (HH) education and training is provided to:

- All new employees at corporate/nursing orientation
- All new physicians during on-boarding
- All new volunteers and students during on-boarding
- Annual eLearning module for all staff

Hand hygiene education is provided by the Infection Control Team either in-person or via eLearning module.

Ongoing Hand Hygiene (HH) Education and Available Resources:

- HH education is provided by the HH auditor "on the spot" when required
- HH posters are available for units
- HH education and reminders are provided at departmental safety huddles or Lean huddles
- Standard Work for hand hygiene using alcohol based hand rub and soap and water
- Hand Hygiene Policy
- HH product is available at point of care

Questions the surveyor may ask about this ROP:

Hand Hygiene is observed in all areas of the hospital.

What are considered appropriate hand washing techniques?

What education about hand hygiene / infection control is available to you?

On our unit, we comply by:

INFECTION CONTROL

ROP: Infection Rates

Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.

Teams that are well informed about health care-associated infection rates are better equipped to prevent and manage them.

Tracking Infection Rates

PRH tracks the following health-care associated infections:

- *Clostridium difficile* infection (CDI)
- Methicillin-Resistant *Staphylococcus aureus (*MRSA)
- Vancomycin-Resistant Enterococci (VRE)
- Surgical site infections
- ventilator-associated pneumonia in the Intensive Care Unit
- Hospital-acquired influenza
- Others as needed (e.g. specific outbreaks or clusters of infection)

Analysis and Recommendations to Prevent Recurrences

- Each outbreak is analyzed by the outbreak management team. Recommendations are actioned and reported to JHSC, Board Quality and Patient Safety, and Organizational Quality and Patient Safety Committee
- Examples of recommendations are:
    - Addition of air scrubbers
    - Enhanced environmental cleaning audits
    - Environmental controls
    - Enhanced PPE
- Consultation with Renfrew County and District Health Unit (RCDHU) or Regional Infection Control Network (RICN) for guidance and recommendations

Questions the surveyor may ask about this ROP:

The surveyor may ask about outbreak protocols.

The surveyors will look for outbreak or caution signs as well as PPE use.

Does your team educate clients and families about preventing infections?

On our unit, we comply by:

Sharing of Information

- Outbreaks are shared internally via memo and on the external PRH website
- Information is shared with team members, senior leadership and the Board through:
    - Infection Prevention and Control (IPAC) Committee meetings
    - Review of HAIs and other IPAC issues provided to The Board Quality Committee
    - The Organizational Quality and Patient Safety, JHSC, and Infection Control Committee receive reports and updates as requested
- Patient information sheets available on Policy Medical
- Media alerts/ releases as indicated

INFECTION CONTROL

ROP: Reprocessing

Processes for cleaning, disinfecting, and sterilizing medical devices and equipment are monitored and improvements are made when needed.

At PRH, reprocessing of surgical instruments is contracted out to Steripro, a fully accredited facility.

- Steripro maintains documentation of specific data regarding sterile load parameters, including temperature, duration of exposure and drying time. Any concerns regarding the process are discussed with Steripro via quality assurance meetings.
- Biological indicators are used according to CSA standards
- All endoscopic equipment is cleaned by high level disinfectant on site. All cleaning is logged and verified by staff.
- Infection Prevention and Control completes quarterly reprocessing audits, results are shared at the Infection Control Committee

RISK ASSESSMENT

ROP: Falls Prevention and Injury Reduction

To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.

Falls are one of the most frequently-reported types of patient safety events. PRH has fall risk reduction strategies which help to minimize patient injury from falls and help to provide a safer environment for our patients.

Universal Fall Precautions

- All inpatient Medical, Surgical, Intensive Care, Rehab and Acute Mental Health, patients undergo a fall risk assessment on admission using the Morse Fall Scale Screening Tool
- In the ED, a fall risk assessment is completed on all patients over the age of 65 and on patients deemed high risk on nursing assessment using the Morse Fall Scale Screening Tool
- All adult inpatients that are at risk of falling are identified and a plan of care is implemented to minimize risk
- Ambulatory programs and obstetrics also have specified protocols for managing fall risk and preventing injury
- Procedures and Guidelines are found in the following documents:
  - Falls Risk Assessment, Prevention and Intervention Policy
  - Morse Falls Scale- Assessment Form
- Identification of high risk patients includes a yellow patient identification band and bedside signage
- Mobility and transfer signage is posted at patient bedsides following physio assessment
- Patient Care Plan (Kardex) includes fall risk

Questions the surveyor may ask about this ROP:

Can you tell me about the standard assessments that are done with patients when they are admitted to the unit?

Have you received training on fall risk reduction?

What information do you provide to patients? How?

On our unit, we comply by:

Education and Information

- Orientation for new employees includes information/education about fall risk reduction
- Communication to patients and families to review fall/injury risk strategies are implemented on inpatient units.
- Educational resources available to staff on appropriate use of fall risk reduction equipment.

Evaluation and Improvement

- Falls are reported in the Risk Incident Management System (RIMS). Reports are reviewed by the Manager of Quality and Risk Management. Trends are analyzed to identify system improvements.
- Post fall huddles are conducted by teams

RISK ASSESSMENT

ROP: Pressure Ulcer Prevention

Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.

Pressure ulcers are a major health concern and are a recognized indicator of quality of care.

Policies and Guidelines:

- Wound Care Screening Tool Policy
- Pressure Ulcer Management Policy
- Braden Scale
- Skin Care protocol for Incontinent Patients
- Wound Assessment and Treatment Record

Education and Process:

- Education about risk factors and prevention strategies is part of orientation for all new PRH nurses.
- All inpatients have a head-to-toe skin inspection and assessment for risk of pressure ulcer development within the shift of admission
- Nurses receive training and use the validated Braden Risk Scale to determine a patient's risk for pressure ulcer development
- In accordance with best practice guidelines, a head-to-toe assessment is completed on admission and daily thereafter.
- Skin care teaching is provided as needed and at nursing skills day sessions
- Educational materials about pressure ulcer prevention are available for patients and family members.
    - Handout: A Patient's Guide to Awareness and Prevention of a Pressure Injury
- Audits are completed for high-risk units

Questions the surveyor may ask about this ROP:

Can you tell me about the standard assessments that are done with patients when they are admitted to the unit?

Where do you document these assessments?

What information do you provide to patients? How?

On our unit, we comply by:

RISK ASSESSMENT

ROP: Venous Thromboembolism Prophylaxis

Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.

Venous thromboembolism (VTE) is one of the most common and preventable complications for patients in hospital or having surgery. VTE consists of both deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE can be substantially reduced or prevented by identifying patients at risk and providing appropriate VTE prophylaxis. At PRH there are established processes and protocols to assess for and manage risk of VTE.

Policies and Guidelines

- Venous Thromboembolism VTE Prophylaxis Policy
- VTE Pre Printed Order

At-Risk Patients

- Every adult hospitalized patient is assessed for VTE risk within 48 hours of admission to hospital and at the time of a signficiant change in clinical status.
- Optimal, evidence-based thromboprophylaxis is provided to every hospitalized patient to whom it is indicated based on their of risk of thrombosis, their risk of bleeding, and available options.

Implementation, Audits and Improvements

- Manual audits are performed monthly and available in Common- Clinical Chart Audits
- Audit results are reported at various committees and recommendations are assessed
- Education is provided as needed based on audit results.

Information and Education:

- Patient information is available in the PRH Welcome Guide and is provided upon discharge to high risk patients
- As part of the care pathway for these patients, the importance of ambulation as appropriate is reinforced by the health care team.

Reporting:

- Reviewed at Medication Management Committee, Medical Quality Improvement Committee, and Medical Advisory Committee (through Medical Quality Improvement)

RISK ASSESSMENT

ROP: Suicide Prevention

Clients are assessed and monitored for risk of suicide.

Early recognition of the signs of suicidal thinking together with timely and appropriate intervention can help prevent suicide in identified patients.

Identification and Monitoring of Patients at Risk of Suicide

At PRH,

- All patients presenting to the Emergency Department with mental health complaints are screened for risk of suicide at triage using the Columbia Screening Tool.
- Reassessment is done by nursing as needs change or based on clinical judgement.
- Acute Mental Health and/ or Community Mental Health teams provide additional assessment and care.
- Patients assessed as at risk have close observation.
  - Personal safety plans are created and reviewed with the patient
  - Psychiatry/ MRP will assess for possible transfer to form 1 facility
  - Patient safety is closely monitored
- Personal belongings are secured, and items of risk removed if needed.

Policies and Guidelines:

- Columbia-Suicide Severity Rating Scale (C-SSR) for AMH/ ICU Shift Assessment
- Suicide Risk Assessment
- Suicide Severity Rating Scale for Triage Assessment
- Personal Safety Care Plan
- Search of Patient Property Policy

Questions the surveyor may ask about this ROP:

If a patient arrives to the ED as a result of a threat or attempted suicide, can you tell me what processes are in place?

On our unit, we comply by:

Quick Tips…

Keep the following tips in mind during the Accreditation Survey Week:

1. Be welcoming and friendly to surveyors; you can fully expect them to be respectful and appreciative of the time you can share with them.

2. Make time to talk with them; they will respect the flow and rhythm of the unit and will understand that patients' needs take precedence.

3. Be proud! The work done on the units every day is outstanding. Most of what the surveyors are assessing is what we do every day. Talk about it with pride.

4. Tell the great and exceptional stories. Share quality improvement initiatives, awards, leading practices, special accomplishments, etc.

5. If you don't know the answer, it's ok to say: "I'm not sure but I would go to …. ***… to find out." Remember, that's the point of having policies, standards, educators and managers and subject matter experts on staff is to support patient care; use those resources as you would in a real situation.

6. Be comfortable to join a conversation with a colleague. It's perfectly acceptable to support one another. "I can add to that…" is a great way to contribute additional information to an answer and to demonstrate teamwork.