ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Vitalité Health Network

Bathurst, NB

On-site survey dates: June 18, 2017 - June 23, 2017

Report issued: September 22, 2017

About the Accreditation Report

Vitalité Health Network (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in June 2017. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

Table of Contents

Executive Summary

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

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

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

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

Accreditation Decision

Vitalité Health Network's accreditation decision is:

Accredited

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

About the On-site Survey

- **On-site survey dates: June 18, 2017 to June 23, 2017**

- **Locations**

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

1. Centre de santé mentale communautaire / Community Mental Health Centre (Edmundston)
2. Centre de santé communautaire de Saint-Isidore Community Health Centre
3. Centre de santé communautaire St.Joseph Community Health Centre
4. Centre de santé mentale communautaire / Community Mental Health Centre (Moncton)
5. Centre Hospitalier Restigouche Hospital Centre
6. Centre hospitalier universitaire Dr-Georges-L.-Dumont Univesity Hospital Centre
7. Clinique pédiatrique (Dieppe)
8. Hôpital de l'Enfant-Jésus RHSJ† Hospital
9. Hôpital de Tracadie-Sheila Hospital
10. Hôpital et Centre de santé communautaire de Lamèque Hospital and Community Health Centre
11. Hôpital général de Grand-Sault / Grand Falls General Hospital
12. Hôpital régional Chaleur Regional Hospital
13. Hôpital régional d'Edmundston Regional Hospital
14. Hôpital régional de Campbellton Regional Hospital
15. Hôpital Stella-Maris-de-Kent Hospital
16. Hôtel-Dieu St-Joseph de Saint-Quentin
17. Programme extra-mural / Extra Mural Program (Dalhousie)
18. Programme extra-mural / Extra Mural Program (Dieppe)
19. Programme extra-mural / Extra Mural Program (Edmundston)
20. Santé publique (Moncton) Public Health
21. Services de traitement des dépendances / Addiction Services (Edmundston)
22. Services régionaux de traitement des dépendances (Campbellton)
23. Unité des anciens combattants / Veteran's Unit (Campbellton)

- **Standards**

  The following sets of standards were used to assess the organization's programs and services during the on-site survey.

  System-Wide Standards

  1. Governance
  2. Infection Prevention and Control Standards
  3. Leadership
  4. Medication Management Standards

  Population-specific Standards

  5. Population Health and Wellness

  Service Excellence Standards

  6. Ambulatory Care Services - Service Excellence Standards
  7. Biomedical Laboratory Services - Service Excellence Standards
  8. Cancer Care - Service Excellence Standards
  9. Community-Based Mental Health Services and Supports - Service Excellence Standards
  10. Critical Care - Service Excellence Standards
  11. Diagnostic Imaging Services - Service Excellence Standards
  12. Emergency Department - Service Excellence Standards
  13. Home Care Services - Service Excellence Standards
  14. Long-Term Care Services - Service Excellence Standards
  15. Medicine Services - Service Excellence Standards
  16. Mental Health Services - Service Excellence Standards
  17. Obstetrics Services - Service Excellence Standards
  18. Perioperative Services and Invasive Procedures - Service Excellence Standards
  19. Point-of-Care Testing - Service Excellence Standards
  20. Primary Care Services - Service Excellence Standards
  21. Public Health Services - Service Excellence Standards
  22. Rehabilitation Services - Service Excellence Standards
  23. Reprocessing of Reusable Medical Devices - Service Excellence Standards
  24. Substance Abuse and Problem Gambling - Service Excellence Standards
  25. Telehealth - Service Excellence Standards
  26. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Work with my community to anticipate and meet our needs)	112	3	2	117
Accessibility (Give me timely and equitable services)	151	9	5	165
Safety (Keep me safe)	674	84	109	867
Worklife (Take care of those who take care of me)	195	7	2	204
Client-centred Services (Partner with me and my family in our care)	583	53	22	658
Continuity (Coordinate my care across the continuum)	136	2	6	144
Appropriateness (Do the right thing to achieve the best results)	1057	153	231	1441
Efficiency (Make the best use of resources)	73	3	5	81
Total	**2981**	**314**	**382**	**3677**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	35 (97.2%)	1 (2.8%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	87 (90.6%)	9 (9.4%)	0	136 (93.2%)	10 (6.8%)	0
Infection Prevention and Control Standards	37 (92.5%)	3 (7.5%)	0	27 (87.1%)	4 (12.9%)	0	64 (90.1%)	7 (9.9%)	0
Medication Management Standards	66 (90.4%)	7 (9.6%)	5	55 (94.8%)	3 (5.2%)	6	121 (92.4%)	10 (7.6%)	11
Population Health and Wellness	4 (100.0%)	0 (0.0%)	0	35 (100.0%)	0 (0.0%)	0	39 (100.0%)	0 (0.0%)	0
Ambulatory Care Services	40 (90.9%)	4 (9.1%)	2	72 (92.3%)	6 (7.7%)	0	112 (91.8%)	10 (8.2%)	2
Biomedical Laboratory Services	11 (91.7%)	1 (8.3%)	59	13 (92.9%)	1 (7.1%)	91	24 (92.3%)	2 (7.7%)	150
Cancer Care	93 (92.1%)	8 (7.9%)	0	122 (95.3%)	6 (4.7%)	0	215 (93.9%)	14 (6.1%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Community-Based Mental Health Services and Supports	39 (88.6%)	5 (11.4%)	0	92 (98.9%)	1 (1.1%)	1	131 (95.6%)	6 (4.4%)	1
Critical Care	38 (76.0%)	12 (24.0%)	0	102 (88.7%)	13 (11.3%)	0	140 (84.8%)	25 (15.2%)	0
Diagnostic Imaging Services	61 (91.0%)	6 (9.0%)	0	67 (97.1%)	2 (2.9%)	0	128 (94.1%)	8 (5.9%)	0
Emergency Department	53 (75.7%)	17 (24.3%)	1	94 (88.7%)	12 (11.3%)	1	147 (83.5%)	29 (16.5%)	2
Home Care Services	40 (83.3%)	8 (16.7%)	0	67 (89.3%)	8 (10.7%)	0	107 (87.0%)	16 (13.0%)	0
Long-Term Care Services	47 (85.5%)	8 (14.5%)	0	87 (88.8%)	11 (11.2%)	1	134 (87.6%)	19 (12.4%)	1
Medicine Services	40 (88.9%)	5 (11.1%)	0	63 (82.9%)	13 (17.1%)	1	103 (85.1%)	18 (14.9%)	1
Mental Health Services	38 (76.0%)	12 (24.0%)	0	82 (90.1%)	9 (9.9%)	1	120 (85.1%)	21 (14.9%)	1
Obstetrics Services	61 (87.1%)	9 (12.9%)	3	82 (94.3%)	5 (5.7%)	1	143 (91.1%)	14 (8.9%)	4
Perioperative Services and Invasive Procedures	100 (87.0%)	15 (13.0%)	0	105 (96.3%)	4 (3.7%)	0	205 (91.5%)	19 (8.5%)	0
Point-of-Care Testing	11 (100.0%)	0 (0.0%)	27	18 (100.0%)	0 (0.0%)	30	29 (100.0%)	0 (0.0%)	57
Primary Care Services	42 (73.7%)	15 (26.3%)	1	82 (91.1%)	8 (8.9%)	1	124 (84.4%)	23 (15.6%)	2
Public Health Services	43 (97.7%)	1 (2.3%)	3	67 (98.5%)	1 (1.5%)	1	110 (98.2%)	2 (1.8%)	4
Rehabilitation Services	37 (82.2%)	8 (17.8%)	0	73 (92.4%)	6 (7.6%)	1	110 (88.7%)	14 (11.3%)	1
Reprocessing of Reusable Medical Devices	82 (93.2%)	6 (6.8%)	0	40 (100.0%)	0 (0.0%)	0	122 (95.3%)	6 (4.7%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Substance Abuse and Problem Gambling	43 (95.6%)	2 (4.4%)	0	81 (100.0%)	0 (0.0%)	1	124 (98.4%)	2 (1.6%)	1
Telehealth	39 (86.7%)	6 (13.3%)	7	70 (92.1%)	6 (7.9%)	13	109 (90.1%)	12 (9.9%)	20
Transfusion Services	8 (100.0%)	0 (0.0%)	67	10 (83.3%)	2 (16.7%)	57	18 (90.0%)	2 (10.0%)	124
Total	**1172 (88.1%)**	159 (11.9%)	175	1728 (93.0%)	131 (7.0%)	207	2900 (90.9%)	290 (9.1%)	382

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Patient safety incident disclosure (Leadership)	Met	4 of 4	2 of 2
Patient safety incident management (Leadership)	Met	6 of 6	1 of 1
Patient safety quarterly reports (Leadership)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Communication			
Client Identification (Ambulatory Care Services)	Met	1 of 1	0 of 0
Client Identification (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Client Identification (Cancer Care)	Met	1 of 1	0 of 0
Client Identification (Critical Care)	Met	1 of 1	0 of 0
Client Identification (Diagnostic Imaging Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Medicine Services)	Unmet	0 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Unmet	0 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Cancer Care)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Long-Term Care Services)	Unmet	2 of 4	0 of 1
Information transfer at care transitions (Medicine Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Unmet	1 of 4	0 of 1
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Unmet	0 of 7	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Unmet	5 of 12	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Unmet	2 of 4	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Long-Term Care Services)	Unmet	0 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Unmet	2 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Mental Health Services)	Unmet	0 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Unmet	6 of 8	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
The “Do Not Use” list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Unmet	1 of 5	1 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Home Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Medicine Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Infusion Pumps Training (Rehabilitation Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Unmet	1 of 7	0 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Unmet	3 of 5	0 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Ambulatory Care Services)	Unmet	0 of 3	0 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Critical Care)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Medicine Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Unmet	4 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Unmet	3 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Unmet	4 of 5	0 of 0
Suicide Prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0
Venous Thromboembolism Prophylaxis (Cancer Care)	Unmet	2 of 3	1 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Venous Thromboembolism Prophylaxis (Critical Care)	Met	3 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Medicine Services)	Unmet	2 of 3	2 of 2
Venous Thromboembolism Prophylaxis (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Summary of Surveyor Team Observations

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

The Vitalité Health Network is one of the two regional health authorities in the province of New Brunswick. It was created in 2008 and bears the dual responsibility of the provision and administration of health services for the territory covering the entire north and south-east of New Brunswick. The Vitalité Health Network has the distinction of being an authority under Francophone governance which must offer services to the population in both official languages. The Network has almost 70 points of care in its territory: eleven hospitals, including five regional and six community hospitals, nine health centres, five clinics, ten community mental health centres, four addiction treatment centres, two centres for veterans, eleven public and sexual health offices and twelve Extra-Mural Program offices. The Network has about 7,400 employees, more than 570 doctors (including 269 specialists) and just over 1,000 volunteers. The annual budget was 689 million Dollars in 2016-2017.

The Vitalité Health Network's Board of Directors demonstrates strong leadership and a high level of commitment. Its permanent committees are active and fulfill their mandate. The Directors are well equipped to support their decision making. The recent 2017-2020 strategic planning exercise was the occasion to renew the organization's mission statements, vision and values. The strategic planning takes into account the varied needs and realities of the population, government guidelines and health trends. The Board displays a desire for modernization and transformation. A global operational plan focused on the user has been produced to ensure its implementation. The Board was invited to clarify the terms permitting it to ensure the expected results were achieved. A Regional Health and Business Plan also contributes to the strategic alignment in respect of planning and priorities in the health system.

The organization has established stable relations with multiple community, institutional, governmental and university partners. The partners we met testify to a rich history of collaboration and appreciate the transformational leadership shown by the Vitalité Health Network's management. The management team is committed to informing, consulting and involving partners in the achievement of its mission and the implementation of the services, demonstrating a commitment to transparency.

The organizational structure of the senior management reflects a desire to manage the various clinical programs and administrative functions of the Vitalité Health Network transversely. In a spirit of dynamism and an impetus for renewal, the management has reviewed its organizational identity and has developed a brand image, as "Francophone leader serving its communities". The management team possesses a clear vision of its key challenges, consistent with the organization's seven main strategic orientations. The commitment to performance is ever present and combines financial, quality and safety concerns. The Administration has established a healthy collaboration with the medical team with a view to achieving the organizational objectives. The medical teams will gain from being organized into regional practice communities so as to increase their involvement.

A Human Resources Development Plan has been produced for the entire Vitalité Health Network. Several training and education activities are offered to staff and the prioritizing criteria take account of the strategic alignments and requirements in terms of safety. Various initiatives contribute to the improvement of the quality of working life and to expressing recognition of employees. Work has been undertaken with regard to the prevention of violence in the workplace. The organization is encouraged to follow this program through to its conclusion. A performance appraisal program has been implemented. However, practices vary from one sector to another. It would be desirable for the implementation of this to be extended and systematized. The organization is facing serious challenges with regard to staffing. There is a significant shortfall in the workforce in several activity sectors and this represents a threat for the continuity of services, the stability of the teams and the safety of the practices. The organization is encouraged to intensify and diversify its recruitment strategies and to optimize the staffing process.

The Vitalité Health Network is committed to adapting the care and health services to the needs of the population. Accessibility is a recognized issue given the dispersed territory and the practice facility to implement various solutions promoting proximity of service. The organization recognizes the need to strengthen the care continuum and to emphasize the ambulatory shift. It is encouraged to intensify its efforts in this direction by continuing to reallocate resources and by clarifying the roles and responsibilities of care partners. The vulnerable areas at a clinical level are known, in particular with regard to mental health services and efforts have been agreed to rectify the situation. Various obstacles are, however, hindering the progress of users and among other things, contributing to the overspill of emergencies. The organization is invited to implement a systematic and coordinated approach enabling the congestion and overspilling of emergency services to be prevented, by sharing the internal teams and the external network.

The organization officially endorses a care approach centred on the user and their family. A guidance document called "Care centred on the user and the family" formalizes this commitment. Several client satisfaction surveys have been administered over the last two years (care in the home, the user's experience in hospital, mental health and addiction program, chronic care program). The information gathered through these surveys is disseminated and used in decision-making at clinical and administrative level. Some initiatives undertaken already demonstrate a desire to improve the experience of the user through a closer partnership with users and families. Clinical teams are encouraged to work in closer partnership with users and families to offer care. It is also essential to generate greater involvement in partner patients in organizational decision-making.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Information transfer at care transitions Information relevant to the care of the resident is communicated effectively during care transitions.	· Cancer Care 22.9 · Home Care Services 9.10 · Mental Health Services 9.18 · Long-Term Care Services 9.19
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.	· Perioperative Services and Invasive Procedures 12.3 · Medicine Services 9.2
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.	· Emergency Department 10.5 · Perioperative Services and Invasive Procedures 11.6 · Cancer Care 15.6 · Ambulatory Care Services 8.5 · Long-Term Care Services 8.5 · Medicine Services 8.5 · Obstetrics Services 8.5 · Critical Care 8.6 · Mental Health Services 8.6
Patient Safety Goal Area: Medication Use	
High-Alert Medications A documented and coordinated approach to safely manage high-alert medications is implemented.	· Medication Management Standards 2.5
Patient Safety Goal Area: Worklife/Workforce	
Workplace Violence Prevention A documented and coordinated approach to prevent workplace violence is implemented.	· Leadership 2.12

Unmet Required Organizational Practice	Standards Set
Client Flow Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	· Leadership 13.4
Patient Safety Goal Area: Risk Assessment	
Falls Prevention Strategy To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.	· Ambulatory Care Services 8.6
Suicide Prevention Clients are assessed and monitored for risk of suicide.	· Emergency Department 10.7 · Long-Term Care Services 8.8 · Mental Health Services 8.8
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.NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	· Cancer Care 15.8 · Medicine Services 8.8

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
2.3 The governing body includes clients as members, where possible.	

Surveyor comments on the priority process(es)

The Board of Directors has well-defined administrative rules and policies. Several permanent committees are active and fulfill their mandate. The orientation program for new members is structured and training sessions are frequently offered to the directors. The members of the Board of Directors are well informed and equipped to support their decision-making. They demonstrate a marked sensitivity to ethical issues and ensure a culture of care centred on the user and the family is adopted. The Board of Directors has assumed strong leadership in strategic planning and it is encouraged to clarify the mechanisms enabling the realization of the global operational plan to be closely monitored.

Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
1.6	Input is sought from clients and families during the organization's key decision-making processes.	
4.11	The organization's progress toward achieving the strategic goals and objectives is reported to internal and external stakeholders and the governing body where applicable.	
4.12	Policies and procedures for all of the organization's primary functions, operations, and systems are documented, authorized, implemented, and up to date.	
6.2	When developing the operational plans, input is sought from team members, clients and families, and other stakeholders, and the plans are communicated throughout the organization.	
12.1	A structured process is used to identify and analyze actual and potential risks or challenges.	!

Surveyor comments on the priority process(es)

A 2017-2020 Strategic Plan has been developed over the last year, taking into account the varied needs and realities of the population, government guidelines and health trends. A global operational plan is resulting from this which clarifies the management responsibilities at implementation level. The mechanisms permitting the achievement of the expected results, in particular in respect of the role of the Board of Directors, to be monitored, must be clarified.

Within the context of the regionalization of the administrative services and clinical programs, many policies and procedures need to be developed to promote the standardization of practices.

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The allocation of financial resources for operations and assets is subject to a rigorous planning cycle. The allocation of resources takes into account strategic guidelines and the business plan. The Board of Directors, the leadership team and all management staff share in the preparation, approval and monitoring of the budget. The processes relating to the procurement of equipment, as well as renovation projects, are also well-structured. Resource management systems have been integrated for the entire Vitalité Health Network. These activity sectors are encouraged to review their policies and procedures with a view to the standardization of practices.

Priority Process: Human Capital

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

Unmet Criteria			High Priority Criteria
Standards Set: Leadership			
2.12	A documented and coordinated approach to prevent workplace violence is implemented.		ROP
	2.12.4	Risk assessments are conducted to ascertain the risk of workplace violence.	**MAJOR**
	2.12.5	There are procedures for team members to confidentially report incidents of workplace violence.	**MINOR**
	2.12.6	There are procedures to investigate and respond to incidents of workplace violence.	**MAJOR**
	2.12.7	The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy.	**MINOR**
	2.12.8	Information and training is provided to team members on the prevention of workplace violence.	**MINOR**
10.14	Human resource records are maintained for all team members.		

Surveyor comments on the priority process(es)

A Human Resources Development Plan (HRDP) has been produced for the entire Vitalité Health Network. Several training and education activities are offered to staff and the prioritizing criteria specifically take account of the strategic alignments and requirements in terms of safety.

Various initiatives contribute to the improvement of the quality of working life and to expressing recognition of employees. Work has been undertaken with regard to the prevention of violence in the workplace. The organization is encouraged to complete the processes to establish this program.

A performance appraisal program has been implemented. However, practices vary from one sector to another. It is desirable for the organization to extend and systematize implementation of this.

The organization is facing serious challenges with regard to staffing. There is a significant shortfall in the workforce in several activity sectors and this represents a threat for the continuity of services, the stability of the teams and the safety of the practices. The organization is encouraged to intensify its recruitment strategies and to optimize the staffing process.

The content of employee files varies from one file to another, likewise from one institution to another. It is essential to standardize practices, ensuring the information relating to recruitment, orientation, performance appraisals and issues in this respect, as well as dismissal or resignation, including the exit interview, are included.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has developed a Benchmark Framework in respect of quality and safety for users. It is encouraged to continue dissemination of this and to ensure it is put into operation. An annual action plan for the improvement of quality and safety is also developed. The drive demonstrated by the many quality improvement projects is highlighted. Several assessment and sampling tools are administered and the monitoring measures are integrated into the work plans in the sectors in question.

Complaint management and risk management are also well structured and regularly reported to the Board of Directors. The risk management program and a risk mitigation policy are available. There is also a documented and coordinated approach relative to the disclosure to users and families of incidents linked to safety. The organization is encouraged to unify the management system for the declaration of events, to reinforce the declaration habits, to intensify the feedback measures for teams on the ground and to continue the work concerning the mitigation measures for organizational and governance risks.

A regional plan for the roll-out of a medicinal reconciliation has been defined. The policy is, however, in the process of being drafted. The institution is encouraged to complete this formalization stage. Two sectors have been prioritized for the current year: intensive care and Extra-Mural services.

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A conceptual framework in respect of ethics has recently been developed and covers clinical, organizational and research ethics. The Vitalité Health Network's Code of Ethics, likewise the guidelines relative to the rights and responsibilities of users, has recently been revised. It is essential that the organization implements strategies ensuring this content is disseminated.

A Regional Clinical Ethics Committee has recently been created, as a replacement for the clinical ethics committees formerly present in each area of the network. The organization is encouraged to facilitate the use of ethical consultations by staff in all institutions. The organization rigorously regulates the ethical assessment of research projects. It is important to highlight the work undertaken during the last year to support introduction of physician-assisted dying.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.1 Information management systems selected for the organization meet the organization's current needs and take into consideration its future needs.	
Surveyor comments on the priority process(es)	
The organization demonstrates a dynamic and strategic approach to communication. It has adopted a communications plan which is used as a general reference framework. The annual action plan for the communications management is well in line with the strategic guidelines. Many communications tools have been developed for internal and external use. These tools showcase the organization's renewed vision and leadership. Relations with the media are detailed and structured. The communications team is encouraged in its desire to get closer to communities and in its desire to have increased presence on social media.	

Priority Process: Physical Environment

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
9.2 There are mechanisms to gather input from clients and families in co-designing new space and determining optimal use of current space to best support comfort and recovery.	

Surveyor comments on the priority process(es)

It is not current practice to involve users and families in projects concerning the development of spaces. The organization is encouraged to do this, to promote decision-making focused on the experience received by the user.

The implementation of computerized management for the maintenance of the facilities is greatly contributing to the speed of intervention and reliability of operations. Timescales for the completion of minor works remain irritants. The organization is encouraged to prioritize the allocation of resources for this purpose. The organization is to be congratulated for the achievement of several energy economy projects.

The cleaning services are committed to adhering to good practices in respect of the prevention of infections and audit processes enabling compliance to be assured.

The standardization of practices for the entire region, both the cleaning service and the physical facilities, is recommended.

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A health emergency management plan and an operational continuity plan have been prepared. Emergency measures are managed in an integrated and collaborative manner with the partners in question. The standardization of emergency codes for the entire Vitalité Health Network is partially completed (70%). The organization is encouraged to complete this stage.

Several initiatives contribute to the dissemination of plans and codes, but it is essential to pursue these so as to promote successful adoption for all the individuals involved. Exercises and simulations of emergency situations take place regularly; it is recommended that these are systematized for all types of emergency and that their frequency is increased. When an emergency situation occurs, feedback is provided on the events and the plans are improved, if necessary.

Each area of the institution has a continuous administrative safeguarding system, twinned with a regionalized system for safeguarding of emergency measures. Training has been offered to all the administrators in question and the tools to support procedures are easily accessible.

Priority Process: Patient Flow

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

Unmet Criteria		High Priority Criteria
Standards Set: Emergency Department		
3.1	Client flow throughout the organization is addressed and managed in collaboration with organizational leaders, and with input from clients and families.	!
3.2	A proactive approach is taken to prevent and manage overcrowding in the emergency department, in collaboration with organizational leaders, and with input from clients and families.	!
3.10	There are established protocols to identify and manage overcrowding and surges in the emergency department.	!
3.11	Protocols to move clients elsewhere within the organization during times of overcrowding are followed by the team.	!
Standards Set: Leadership		
13.1	Client flow information is collected and analyzed in order to identify barriers to optimal client flow, their causes, and the impact on client experience and safety.	
13.2	Information about barriers to client flow is used to develop a strategy to build the organization's capacity to meet the demand for service and improve client flow throughout the organization.	
13.4	Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors. NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	ROP
13.4.1	The organization's leaders, including physicians, are held accountable for working proactively to improve client flow and mitigate emergency department overcrowding.	**MAJOR**

13.4.2	Client flow data (e.g., length of stay, turnaround times for labs or imaging, community placement times, consultant response times) is used to identify variations in demand and barriers to delivering timely emergency department services.	**MAJOR**
13.4.3	There is a documented and coordinated approach to improve client flow and address emergency department overcrowding.	**MAJOR**
13.4.4	The approach specifies the role of teams within the hospital and other sectors of the health system to improve client flow.	**MAJOR**
13.4.5	The approach specifies targets for improving client flow (e.g., time to transfer clients to an inpatient bed following a decision to admit, emergency department length of stay for non-admitted clients, transfer of care times from emergency medical services to the emergency department).	**MAJOR**
13.4.7	When needed, short-term actions to manage overcrowding, that mitigate risks to client and team members (e.g., over-capacity protocols), are implemented.	**MAJOR**
13.4.8	Client flow data is used to measure whether the interventions prevent or reduce overcrowding in the emergency department, and improvements are made when needed.	**MINOR**

Surveyor comments on the priority process(es)

Various obstacles are hindering the progress of users and contributing, among other things, to the overspill of emergencies. Although the organization has an overspill policy and various initiatives to intervene upstream and downstream, there is no evidence of a systematic, coordinated and documented approach enabling congestion of the emergency departments and overspills to the hospital units to be prevented. Certain procedures have been implemented in primary care, in home care and in the community as well as within the hospital, but the overall effort is insufficient and poorly coordinated.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
Standards Set: Reprocessing of Reusable Medical Devices		
3.2	The MDR department is designed to prevent cross-contamination of medical devices, isolate incompatible activities, and clearly separate work areas.	!
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
5.4	The team involved in reprocessing medical devices is prepared for the functions it performs through education and training in a formal medical device reprocessing training program recognized by the health care setting.	!
7.1	Clear and concise policies are developed and maintained for reprocessing services.	!
8.1	The reprocessing area is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	!
9.7	For each cleaner and disinfectant, manufacturers' instructions for use are followed including ventilation requirements, contact time, shelf life, storage, appropriate dilution, testing for appropriate concentration and effectiveness, and required PPE.	!

Surveyor comments on the priority process(es)

Many efficient processes are in place in the reprocessing units in the four areas and comply with Accreditation Canada's standards and the standardized operational procedures (SOP). The reprocessing facilities at Dr. Georges-L.-Dumont University Hospital Centre have been fitted out in relation to the level of use of the range of reprocessing services and the elimination of all cross-contamination. The working

areas are well designated. Access to the equipment and contaminated instruments receiving facility is located in another corridor, thus avoiding coming and going in sterile areas. Collaboration between sites is in place and everyone is seeking best practice.

Employees are very engaged, competent and committed to performing their tasks with excellent, being very aware of the importance of accuracy in their work. A training plan is underway which aims to certify the employees in the reprocessing centres with the aid of a specialist program in the reprocessing of medical devices recognized in healthcare by 2019. To date, more than a quarter of employees are certified and are very proud.

The organization is encouraged to pursue its certification approach.

We suggest that the computerization of the content of the many handbooks used to assemble the plates is continued, so as to facilitate the employee's work.

The clinical engineering department covers the four areas of the Vitalité Health Network and works in close collaboration with the Horizon Health Network. A provincial equipment management committee determines, among other things, the annual performance targets for preventative maintenance: 100% for life-critical equipment and 80% for high-risk equipment. This last year, the performance targets were achieved and even exceeded.

The provincial coordination in clinical engineering presents several benefits, including the standardization of procedures and the sharing of technicians with specific skills.

The employees are proud of their resource management system (RMS), of achieving the performance targets and of the collaboration with the Horizon Health Network and the provincial committee, of the standardization of the preventative maintenance procedures (provincial initiative), of the system for the weighting of the level of risk for each item of equipment and of the inventory of all the medical devices (request from the Ministry).

The challenges for this department lie in the implementation of the health alerts monitoring process (provincial initiative), the monitoring of the development of the new RMS module on the life-cycle of devices (supporting the projection of equipment requirements) and the exceeding of the current performance targets concerning the preventative maintenance of average and low risk devices.

The reprocessing services at the Edmundston Regional Hospital.

The reprocessing unit is clean and organized. The first phase of cleaning and washing takes place in the operating room. The instruments are then taken in a closed metal cart covered with a sheet.

The reprocessing area for endoscopes is adequate, with good separation between soiled equipment and the clean area. The endoscopes are hung in a cabinet. The only non-compliant place is in diagnostic imaging, where there is cross-contamination with the transvaginal probes.

About 25% of the staff have received training under a specialized program for the reprocessing of medical devices. There is, however, a plan to ensure that everyone is certified by 2019, as provided for by law.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

- Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Standards Set: Population Health and Wellness - Horizontal Integration of Care

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness

On reading the 2017-2020 Strategic Plan, about the Vitalité Health Network's mission and vision, one quickly understands that for the organization, the health and well-being of its population are the priority. The profile of the population and the priority populations are well known and prioritized. The collaboration between the services and numerous partners is remarkable. The team offers several activities for disease prevention and the promotion of healthy lifestyle habits in the community.

In collaboration with the public health department and partner organizations in the sector (municipal, educational, community organizations), different health projects and programs protect and promote health, taking the health determinants into account. Staff commitment in this sector is exemplary. Hypertension Canada has selected St. Joseph Community Health Centre to receive a Certificate of Excellence 2017 for its exceptional contribution to the prevention and control of hypertension.

So as to respond appropriately to the needs of vulnerable populations, we are citing two major projects implemented for the heavy consumers of the service (user who visits the emergency five or more times a year, user hospitalized more than three times a year).

The team is encouraged to involve users and families in the improvement projects. In this sector, the accessibility and commitment of the population remain a challenge to be met.

Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Clinical Leadership

- Providing leadership and direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Public Health

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

Point-of-care Testing Services

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.5	Resources and infrastructure needed to clean and reprocess reusable devices are accessible in the service area, as required.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
6.3	When scheduling services, same-day scheduling of multiple services for individual clients is coordinated with other service areas in the organization in partnership with the client and family.	
6.4	Clients are provided with information on eligibility for insured services.	
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications at ambulatory care visits where the client is at risk of potential adverse drug events. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and how often medication reconciliation is repeated.	ROP

	8.5.1	The type of ambulatory care visits where medication reconciliation is required are identified and documented.	**MAJOR**
	8.5.2	For ambulatory care visits where medication reconciliation is required, the frequency at which medication reconciliation should occur is identified and documented.	**MAJOR**
	8.5.3	During or prior to the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers, and others, as appropriate.	**MAJOR**
	8.5.4	During or prior to subsequent ambulatory care visits, the BPMH is compared with the current medication list and any medication discrepancies are identified and documented. This is done as per the frequency documented by the organization.	**MAJOR**
	8.5.5	Medication discrepancies are resolved in partnership with clients and families OR medication discrepancies are communicated to the client's most responsible prescriber and actions taken to resolve medication discrepancies are documented.	**MAJOR**
	8.5.6	When medication discrepancies are resolved, the current medication list is updated and retained in the client record.	**MAJOR**
	8.5.7	The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with a complete list of medications the client should be taking following the end of service.	**MAJOR**
8.6	To minimize injury from falls, a documented and coordinated approach for falls prevention is implemented and evaluated.		ROP
	8.6.1	A documented and coordinated approach to falls prevention is implemented.	**MAJOR**
	8.6.2	The approach identifies the populations at risk for falls.	**MAJOR**
	8.6.3	The approach addresses the specific needs of the populations at risk for falls.	**MAJOR**
	8.6.4	The effectiveness of the approach is evaluated regularly.	**MINOR**
	8.6.5	Results from the evaluation are used to make improvements to the approach when needed.	**MINOR**
10.3	Clients are empowered to self-manage conditions by receiving education, tools, and resources, where applicable.		
Priority Process: Decision Support			

The organization has met all criteria for this priority process.

Priority Process: Impact on Outcomes		
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
14.6	Safety improvement strategies are evaluated with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Improvements could be made in respect of information technology in a standardized way so as to optimize the services offered and to facilitate the work of the staff and managers (e.g. a one-stop shop for planning meetings). This would also aid the standardization of how things are done between the different clinics.

A redevelopment of the working areas is already planned, including a major redevelopment at the Chaleur Regional Hospital. In summary, we can only encourage the organization to continue its quest for excellence.

Priority Process: Competency

The roles of each of the team members are clearly defined, which makes the actions to be taken simpler: orientation, training, evaluation, etc. We should highlight their commitment at many levels, such as the monitoring of the quality management charts, indicators, audits and the lists of expectations.

Priority Process: Episode of Care

The medicinal reconciliation and falls prevention remain the processes to be prioritized and to be defined. Which users will profit the most from this?

Priority Process: Decision Support

Ambulatory care takes place in several areas, with one or more facilities in each area. Even if they work with the internal and primary care, some ambulatory services are managed by Extra-Mural organizations and even by certain clinical teams themselves, which does not facilitate the standardization of practices. They are also working to standardize the services with the other hospitals in the centre and north regions.

The members of the management team work together as much as possible and this also reflects the general situation of some other teams we visited. They comply with the recommendations according to the evidence. What is more, they have chosen to take administrative decisions and to offer services in relation to the best practices and the evidence.

Priority Process: Impact on Outcomes

The contribution of users and families forms another process to be considered so as to determine what their contribution may provide to the various ambulatory services teams.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Laboratory		
20.2	The laboratory follows an SOP for maintaining the integrity of samples handled after hours, if applicable.	!
29.16	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Laboratory		

Various laboratories are equipped with high-tech equipment in the majority of the activity sectors. The facilities are clean, illuminated and relatively large. The laboratory regularly carries out surveys with its clients and gathers comments from its users. This data is analyzed and, if required, enables changes to be made to the service offering. All contracts are checked annually. Meetings are held with service providers for which significant deviations in the compliance with requirements have been noted. Laws and regulations are checked and staff are informed of any changes. A member of staff is responsible for ensuring the updating of the "Clinical and Laboratory Standards Institute" (CLSI).

Client relationships are transparent and any impediment to access to the service is analyzed and documented. So as to maintain the quality and safety standards, quality agents have been appointed. Their role consists, for example, of carrying out different quality audits and of ensuring the mandatory training for the laboratory is followed as well as that requested by the Network. Every year, a review by the Services Management is produced. All elements of the quality system are reviewed.

We encourage the managers to update the quality charts with the various sections where the results of the surveys and audits, the quality projects and the improvement opportunities will be found.

The laboratories are currently separated by area and are autonomous. The organization has adopted a regionalization and a modernization of its methods and the stock of equipment. The next few months are looking to be difficult, as choices must be made to maintain the service offering throughout the territory with significant staff shortages. The planned restructuring will certainly enable opportunities to be created to remedy the lack of resources.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
Priority Process: Competency		
8.1	Required training and education are defined for all team members with input from clients and families.	!
8.10	Education and training are provided on how to identify palliative and end-of-life care needs.	!
8.11	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
8.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
15.6	Outpatient services only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications at ambulatory care visits where the client is at risk of potential adverse drug events. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and how often medication reconciliation is repeated.	ROP
15.6.1	The type of ambulatory care visits that require medication reconciliation are identified and documented.	**MAJOR**
15.6.2	For ambulatory care visits that require medication reconciliation, the frequency at which medication reconciliation should occur is identified and documented.	**MAJOR**
15.6.3	During or prior to the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers, and others, as appropriate.	**MAJOR**

	15.6.4	During or prior to subsequent ambulatory care visits, the BPMH is compared with the current medication list and any medication discrepancies are identified and documented. This is done as per the frequency required by the organization.	**MAJOR**
	15.6.5	Medication discrepancies are resolved in partnership with clients and families OR medication discrepancies are communicated to the client's most responsible prescriber and actions taken to resolve medication discrepancies are documented.	**MAJOR**
	15.6.6	When medication discrepancies are resolved, the current medication list is updated and retained in the client record.	**MAJOR**
	15.6.7	The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with a complete list of medications the client should be taking following the end of service.	**MAJOR**
15.8	Inpatient care only: Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.		ROP
	15.8.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.	**MINOR**
	15.8.4	Major orthopedic surgery clients (i.e., those having hip and knee replacements or hip fracture surgery) who require post-discharge prophylaxis are identified and there is a process to provide them with appropriate post-discharge prophylaxis.	**MAJOR**
21.2	Outpatient systemic therapy only: Follow-up processes are established with clients who are receiving oral therapies.		
22.9	Information relevant to the care of the client is communicated effectively during care transitions.		ROP

22.9.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
25.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
25.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
25.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
25.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
25.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
27.17	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Medication Management		
	The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Dr. Georges-L.-Dumont University Hospital Centre and the Chaleur Regional Hospital have been visited for this priority process. The sites at Campbellton, Caraquet and Edmundston are also satellites of the Moncton Regional Centre and require specific attention from the point of view of quality improvement. The hospitalization unit at the Dr. Georges-L.-Dumont University Hospital Centre has 22 beds. The regional structure of committees set up to standardize the oncology services is applauded. We highlight the setting up of the Breast Health Centre the implementation of which was supported by users and survivors. Consultations were also held with users for the creation of the future chemotherapy room on the first floor. The organization is encouraged to continue proactive monitoring of the work of its services and the waiting times so as to plan the expansion of these in relation to the needs of the population being served.

Priority Process: Competency

The organization is encouraged to involve users and families in defining the training and education required by members of the team. The organization is encouraged to implement an education program for all employees in palliative and end of life care. Performance appraisals are held for problem employees and action plans put in place. The manager is encouraged to implement a regular and systematic cycle of performance appraisals for all members of the team. The multidisciplinary and collaborative approach is favourable to the provision of optimum care for users. The organization is encouraged to continue assessing the roles of the nursing, auxiliary and clerical staff to arrive at an optimum model.

Priority Process: Episode of Care

Continuation of the optimization of the use of chairs in the external chemotherapy services is encouraged. The deficient infrastructure in the external clinical oncology clinic at Moncton presents a risk for safety and confidentiality of users. The relationship with each user of the oncology services is open, transparent and respectful. The team is encouraged to implement a medicinal reconciliation process for the ambulatory oncology services, both in Moncton and in the satellite sites. The evaluation of the risk of venous thromboembolism not being recorded on the form for this purpose in all files, it is impossible to confirm compliance with this required organizational practice. A new procedure has recently been implemented in collaboration with the Cardiology Department so as to identify users wearing a heart pacemaker presenting a risk with radiotherapy. The organization is encouraged to systematize the mental health assessment of users of the oncology services. Standardization processes are underway so as to standardize the treatment protocols within the Vitalité Health Network. The implementation on a regional scale of the MOSAIQ system will ensure full dissemination of clinical information to all participants in the Network. The team is encouraged to implement a systematic process for monitoring users receiving oral anti-cancer treatments.

Priority Process: Decision Support

All criteria in this priority process are compliant. The organization is encouraged to continue its roll-out of the MOSAIQ system to the entire Network.

Priority Process: Impact on Outcomes

On encourage l'implication des usagers et des familles dans ce processus de choix des lignes directrices éclairées par des données probantes et l'élaboration des procédures et protocoles. On incite l'organisme à impliquer les usagers et les familles dans l'élaboration de plans d'action en soutien à l'amélioration de la qualité. Des revues par les pairs sont régulièrement effectuées au sein de l'équipe d'oncologie. On incite l'équipe à maintenir à jour son plan d'amélioration de la qualité, à le rendre disponible et à en faire le suivi avec tous ses membres. Le pilotage du projet de redéfinition des rôles du personnel sur l'étage 4D est particulièrement pertinent dans le contexte de la surcharge de travail présentement vécue.

Priority Process: Medication Management

The organization is encouraged to continue its processes for the complete computerization of the chemotherapy drugs prescription process so as to reduce the risk of error and variance. The Oncology Department at Dr. Georges-L.-Dumont University Hospital Centre is encouraged to restructure the Pharmacy Department counter for chemotherapy drugs; this is cluttered and presents an increased risk of error and accidental spillage. Likewise, the proximity of users and the lack of space set aside for the preparation of chemotherapy solutions present risks for user safety. The re-evaluation of the drug distribution process on the first floor is encouraged so as to reduce risks and to reduce unnecessary staff movements.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
3.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
8.9	The client's informed consent is obtained and documented before providing services.	!
12.1	Clients and families are actively engaged in planning and preparing for transitions in care.	!
Priority Process: Decision Support		
13.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The management leadership is stable and managers display plenty of enthusiasm for improving the quality of services and collaboration. The management encourages a culture of participation within the teams and demonstrates openness to invite users to be involved in each stage.

Priority Process: Competency

The program for the reduction of risks associated with the safety of users and members of the team is very successful.

Priority Process: Episode of Care

The program offers a well-integrated service provision supported by partners in the community, including the Royal Canadian Mounted Police (RCMP) and schools. The youth program is well aligned with the adult program. The teams are motivated, empathetic and committed. The organization offers an environment favourable to recovery. The organization is encouraged to capitalize on opportunities for partnership with users and families.

Priority Process: Decision Support

One of the great strengths of this program is the support it receives from the community. For example, the organization is very active in the dissemination of campaigns aimed at informing the public about mental health. Among others, the YouTube video "the male life" is a good example of success. The organization has made a good effort to reduce the stigmatization of men and the video shows very good examples of men discussing their vulnerability. There are still a few possibilities to include the contribution of users in association with certain criteria.

Priority Process: Impact on Outcomes

Users and families are involved in the quality committees. The models recognized as best practice, such as the FACT team, have been implemented.

Standards Set: Critical Care - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.		
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.		
Priority Process: Competency			
3.1	Required training and education are defined for all team members with input from clients and families.		!
3.3	A comprehensive orientation is provided to new team members and client and family representatives.		
3.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.		
Priority Process: Episode of Care			
8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.6.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
9.11	A delirium screening tool is used to assess clients for delirium in partnership with the client and family.		
Priority Process: Decision Support			
13.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.		!
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.		
Priority Process: Impact on Outcomes			
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.		

15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
16.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
16.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
16.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
16.4	Safety improvement strategies are evaluated with input from clients and families.	!
16.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		
12.3	There is a policy on neurological determination of death (NDD).	
12.4	A written protocol is followed for NDD that includes accessing the people qualified to determine neurological death.	
12.15	There are written protocols for donor management.	
12.19	Data gathered on all ICU deaths is accessible and there is a process for reviewing that data to identify lost opportunities for donation.	
Surveyor comments on the priority process(es)		

Priority Process: Clinical Leadership

The Critical Care Program has been regionalized since 2015. The four units meet regularly by video-conference to develop plans for the improvement of quality, to discuss progress and the challenges to be met. There is good collaboration in respect of the standardization of practices. However, the approval and implementation process are cumbersome and inefficient. There could be more than 20 channels of approval. Protocols may take more than two years before being applied and when they are applied, they should then already have been revised. The organization is encouraged to review its approval process so as to improve the implementation of best practice and to support the commitment of its staff in the preparation of these improvement plans.

The organization is encouraged to include the contributions from users and families when assessing the efficiency of resources.

Priority Process: Competency

The critical care teams are multi-professional and all members have the required competences. The organization must be congratulated for a rigorous program of training and verification of the maintenance of the difference certifications. The online apprenticeship program is robust. Although apprentice management software is used, its use does not yet appear to be maximized. In some location, staff maintain a parallel documentation system. The organization is encouraged to establish a partnership with users and families.

Priority Process: Episode of Care

The organization has four sites which provide critical care. At Dr. Georges-L.-Dumont University Hospital Centre, there is a closed clinical and surgical intensive care unit. The coronary care unit and the Campbellton, Bathurst and Edmundston units are open units, covered outside normal hours by different specialists.

The organization is encouraged to review this operating method so as to aim for standardization favouring a closed unit model.

Criteria have been established for admission and discharge from the different units, but there is some variation in the implementation of the discharge criteria. The organization is encouraged to clarify the discharge criteria. Users and families collaborate in the development of care and transition plans.

The team listens to suggestions from users and families, as attested by the project for the improvement of the different visitor waiting rooms in the different departments. Support is available in challenging situations, such as for palliative care and end of treatment decisions.

The various safety protocols are well established, with the exception of medicinal reconciliation on transfer and on discharge, as well as screening for delirium. The team is encouraged to continue its pathway in the establishment of these safety practices.

Priority Process: Decision Support

The organization is at different stages of computerization of the medical files. However, in all sites, the files were up to date and contained all the information necessary to enable the team to provide quality and safe care. The organization is encouraged to assess the possibility of migration to a single computer file, so that all information is available in the same place. The organization is encouraged to include the contributions of users and patients when reviewing practices for reviewing files and on the use of technology and electronic communications.

Priority Process: Impact on Outcomes

The organization should be congratulated for the development of a regional quality improvement plan with specific objectives and documented deadlines. It monitors progress linked to the achievement of these targets. The organization is encouraged to include the participation of users and their families in the development of targets and the process for monitoring the achievement of these targets, as well as in the selection of evidence-based protocols.

Priority Process: Organ and Tissue Donation

The intensive care team is well aware of the possibilities of organ donation. The members of the team are in contact with the provincial program which coordinates the organ donation process. Training on the organ donation process has taken place recently. The head physician of the clinical-surgical critical care in Moncton provides clinical leadership, which wants to invest in this avenue and become a centre of expertise for the Province, or the maritime Provinces. The team is encouraged to formalize the policies and procedures linked to neurological deaths. It is also encouraged to assess deaths so as to define the opportunities to increase the identification of potential donors.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
3.6	The team's medical director and physicians are imaging specialists credentialed by the appropriate professional college or association.	!
4.4	The client service area includes a space for screening clients which respects confidentiality issues prior to their diagnostic imaging examination.	!
4.5	The client service area is equipped with a private and secure space for clients to change.	!
6.7	The team annually reviews and updates the Policy and Procedure Manual.	
10.4	The team understands their roles and responsibilities when clients are unable to make informed decisions, and involves a substitute decision maker when appropriate.	
10.6	For procedures involving radiation to the abdomen or pelvis on women, the team asks female clients of childbearing age whether they are or may be pregnant and documents the response.	!
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

Monitoring of waiting times takes place in each of the medical imaging sectors. We note an issue with delays in certain sectors, including ultrasound, arthrography and MRI. Measures have been taken so as to relieve waiting times which are higher than anticipated targets.

Various methods are used to learn of user satisfaction and comments, as well as those of their families and internal and external partners. So as to optimize the use of various technologies associated with research diagnostics, decision trees and the training of attending physicians are offered.

With the regional consolidation, a global analysis of the use and the succession plan in the event of equipment breakage has been produced. The team is committed to offering the service to the population at all times, wherever possible.

The team defines the resources needed to offer diagnostic imaging services effectively and in good time. The lack of technical resources and support in ultrasound is the most blatant.

New doctors will be joining the team in Summer 2017. We are encouraging the organization to complete the regionalization of the clinical section so as to ensure regional coverage responding to needs.

The team provides information about diagnostic imaging examinations to users and their families verbally when examinations are carried out and in writing in the various waiting rooms. Radiology examinations are interpreted locally daily or by the designated site. As required, on-call cover enables access. Reports are available thanks to Impax immediately for attending physicians. Voice recognition is established and very much appreciated.

The team is at the beginning of the regional standardization of procedures and protocols. The analysis of repetitions has been implemented since the last accreditation visit.

Chaleur Regional Hospital
When consent is given by an individual responsible for making decisions on behalf of the user, for example, the parent of a minor, we suggest that the name of this individual, their link with the user and the decision made are shown in the user's file.
For all examinations necessitating exposure of the abdomen or the pelvis, the team must ask female users of child-bearing age if it is possible they are pregnant, and their response must be noted in their file.

Edmundston Regional Hospital
The management team has undertaken a process for the improvement of day-to-day quality. Several strategies are used: quality audits, observations of procedures and client satisfaction surveys are a few examples. These strategies are in place at several levels in the various imaging sectors. The data is analyzed and disseminated on the quality chart to be viewed by users and staff. The users interviewed have shown themselves to be very satisfied with the services.
Despite a lack of radiologists, we highlight the work of the team which has rallied together in an exemplary manner to find other solutions and to avoid a breakdown in service for clients. A teleradiology service has been rolled out with the collaboration of external resources. Computer links have been adjusted so as to ensure the security of the images transmitted and the confidentiality of the digitized data transfers.

Enfant-Jésus RHSJ† Hospital in Caraquet
The MRI Department has recently been refurbished. The facilities and equipment respond to the needs of users. When an emergency requires a specialist examination, pathways are used quickly to respond to needs. Examinations are interpreted at Bathurst within the desired timescales. Urgent requests for examination at night are covered by an on-call service. Everything responds at the moment to the needs of emergency medicine.

Dr. Georges-L.-Dumont University Hospital Centre - Moncton
A tenth radiologist will probably be required during the course of the next few years due to the growth in the population in this region. The collaboration between the attending physicians and MRI needs to be consolidated.

Campbellton Regional Hospital
The client reception area is open, which does not ensure confidentiality of users' information before diagnostic examinations are carried out. We encourage the team to carry out employee performance appraisals. The place and the process for the decontamination of ultrasound transvaginal probes should also be reviewed.

Hôtel-Dieu Saint-Joseph hospital in Saint-Quentin
We note a cloakroom issue in the sector. The head physician must be a member of the required association.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	Resource requirements and gaps are identified and communicated to the organization's leaders.	
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
4.1	Required training and education are defined for all team members with input from clients and families.	!
4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
6.3	Workload is assessed and team members are reassigned as required during periods of high volume and surges in the emergency department.	
Priority Process: Episode of Care		
8.4	A triage assessment for each pediatric client is conducted within P-CTAS timelines, and in partnership with the client and family.	!
9.16	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
10.2	The assessment process is designed with input from clients and families.	
10.5	Medication reconciliation is initiated in partnership with clients, families, or caregivers for clients with a decision to admit and for a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).	ROP

10.5.1	Medication reconciliation is initiated for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers, and documented. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.	**MAJOR**
10.5.2	The criteria for a target group of non-admitted clients who are eligible for medication reconciliation are identified and the rationale for choosing those criteria is documented.	**MAJOR**
10.7	Clients are assessed and monitored for risk of suicide.	ROP
10.7.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
14.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!
17.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!

18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.5	Ambulance offload response times are measured and used to set target times for clients brought to the emergency department by EMS.	
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		
11.6	Training and education on how to support and provide information to families of potential organ and tissue donors is provided to the team, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

A regional management committee for emergencies has been established so as to standardize the various emergency services in the Network. Several processes are underway in support of this standardization effort.

A regional clinical structure has also been established with a view to obtaining a consensus concerning the clinical management associated with these new standardized approaches. Furthermore, committees for policies, procedures and continuous training have been created. Some of the smaller sites have slightly reduced their internal meetings in this context and they are encouraged to re-establish these so as to maintain transparency in communications and exchanges in this period of change.

The organization is encouraged to set up a more robust escalation system for minor network emergencies which are frequently exposed due to the large number of inter-institution transfers. The organization is encouraged to involve users and their families more in these decision-making and quality improvement processes. We encourage the continuation of discussions between the staff at Dr. Georges-L.-Dumont University Hospital Centre and the Moncton Hospital in the Horizon Health Network to facilitate the securing of services, collaboration and synergies. The emergency occupancy rates and the lack of staff in Moncton and in Edmundston are creating a care environment which presents a significant risk for the safety of users, given the physical congestion which results from this. This very worrying situation is contributing to the increase in the workload of the staff on-site and has a detrimental effect on staff retention. Although representations have been made concerning the lack of human resources at Moncton, they have not resulted in a concerted action plan at organizational level, unlike the emergency department at Edmundston, which appears to have been successful in a similar process. Systematic assessment is to be encouraged to target realistic and effective solutions to this shortfall. The

organization is to be congratulated for its initiatives aimed at reducing upstream the volume of users presenting at the emergency department (neurology clinic, iv antibiotic therapy clinic, personalized plan for large users, vulnerable clients, community approaches to reduce 4 and 5 priorities and to optimize support at home, use of nurse practitioners), likewise the processes aimed at accommodating this volume increase (aggressive internal redevelopment, reallocation of staff). We suggest that the analysis of the roles of the nursing, auxiliary and clerical staff is continued, mirroring the exercise underway on the oncology floor and the rationalization of the orientation process to the emergency department. The organization is encouraged to review its overspill code, as it is not systematically declared when it occurs, which contributes to the escalation of the congestion. A regional decongestion plan is on the point of being completed and implemented before the next Winter season; greater proactivity in the management of overspill situations in the emergency department is desirable. The organization is encouraged to define occupancy criteria for the emergency department as criteria for triggering the overspill code and to see congestion in the emergency department as a managerial symptom in respect of the entire user pathway. We encourage the organization to engage with users and families and to establish proactive management of its infrastructure projects to facilitate confidential and secure interactions for staff and users.

Priority Process: Competency

The organization is encouraged to involve users and families in defining the training and education required by members of the team. There is a robust process of staff orientation and continuous training in the emergency department, which is accompanied by support in the form of mentoring which is very much appreciated. Staff performance appraisals have just begun in certain areas and the organization is encouraged to continue its steps in this direction. The team is encouraged to consider greater participation from users and their families in respect of dealing with their satisfaction associated with their roles and responsibilities. The organization is encouraged to continue its review of the role of the different participants so as to increase its efficiency in the use of staff. The team is encouraged to establish a program of simulations of emergency situations and to practice these manoeuvres on a regular basis. The high rate of staff turnover in certain areas is resulting in a significant increase in the proportion of less-experienced staff. The organization is encouraged to continue its efforts to quantify the shortfall in human resources so as to provide safe care. There appears to be very little flexibility for the reallocation of staff to the emergency department in periods of high volumes of consultations; the organization is encouraged to invest in these resources.

Priority Process: Episode of Care

Delays in accessing certain specialist consultations are creating problems in some sites. The organization is encouraged to plan for options such as remote consultation, given the success experienced by the psychiatry consultants from Bathurst who offered support to Caraquet. In xc electronically and in the paper file, the information required can generally be easily found. The organization is encouraged to continue its efforts for the computerization of the user file with the aim of increasing access to medical information for all the professionals involved. Nursing staff have access to records, policies and procedures, as well as information on medication on Boulevard. The Health Portal in New Brunswick

provides access, using the medical insurance number, to information about users: laboratory and radiology examinations, visits to the emergency department and the drug profile can all be retrieved. The organization is encouraged to continue its work for the implementation and full use of the electronic form for declaring incidents.

Priority Process: Decision Support

Vitalité Health Network's hard-copy records are well maintained. Although some information is in both electronic and hard-copy formats, the necessary information is generally readily available. The Health Network is encouraged to continue its automation of user records to improve access to medical information for all health professionals involved. Nursing staff can access information documents, policies and procedures and medication information on the Boulevard intranet. User information, including lab and radiology tests, emergency department visits and drug profiles, is accessible on the Government of New Brunswick Health Portal with the patient's health insurance number. The Health Network is encouraged to continue its implementation and full use of the online incident reporting form.

Priority Process: Impact on Outcomes

The organization is encouraged to develop and implement a process to involve users and families in the choice, development and implementation of guidelines. The organization is encouraged to involve users and families in the development and implementation of strategies enabling safety risks to be defined. The organization is encouraged to assess the delays in the transfer of users taken by ambulance with a view to continuous improvement. We suggest that teams keep their quality improvement action plans up to date, accompany them with specific and measurable objectives (SMART) and to make them available to all staff. The organization is encouraged to implement a more robust process for the evaluation of quality improvement projects with the involvement of users and families. Quality audits take place regularly and the results are shared with staff.

Priority Process: Organ and Tissue Donation

The organ donation program is managed at provincial level and the expertise lies principally at that level. The organization is encouraged to continue its efforts aimed at the awareness of the staff in respect of dealing with the program. The organization is also encouraged to involve users and families in this process

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.11	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
Priority Process: Episode of Care		
8.2	The assessment process is designed with input from clients and families.	
9.10	Information relevant to the care of the client is communicated effectively during care transitions. 9.10.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP **MINOR**
Priority Process: Decision Support		

11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
14.11	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team always appears ready to react to define the needs of users and families. The major strengths recorded are the partnership within the Chronic disease program and the program for the care of the elderly, and the collaboration with the acute care at the hospital. The team has access to tools, such as the guide for the care of the elderly and it is using their indicators appropriately to improve its services. There is a possibility of involving users and inviting partner patients onto the quality committees

Priority Process: Competency

The organization has a good, well-integrated team. The professionals work with and support their colleagues. There is also an opportunity to include user participation in this priority process and to recruit partner patients by standardizing their role.

Priority Process: Episode of Care

Feedback from users and their families concerning the program's services is very positive. Users and families very much appreciate the support and care offered by the team. For example, the spouse of a user said: "Extra-Mural, that is another word for solutions, because they always have immediate solutions for the rest of us".

Another strength of the service is the collaboration between professionals to find creative and personalized solutions for users so as to support them at home. We note that the employees work hard and have a feeling of fulfillment and pride in their work.

All the same, there are a few opportunities to be seized concerning the lack of information encountered from time to time when transferring users. Another opportunity which presents itself concerns the procurement of equipment for users not having the means to procure it for themselves.

Priority Process: Decision Support

Files are well-organized and it is easy to find the information needed. The policies for retaining user records are followed and users know how to access their records. The only thing that is missing is a process to promote the involvement of users in the evaluation and monitoring of documents. The team has already taken note of this challenge and a plan is being implemented to remedy this.

Priority Process: Impact on Outcomes

One of the key strengths is the clinical pathway, which is well-defined, clear and integrated. There are still opportunities to be seized to promote the involvement of users and families in respect of the improvement of services.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
1.1	IPC program components are regularly reviewed based on a risk assessment and organizational priorities.	!
2.10	Applicable standards for food safety are followed to prevent food-borne illnesses.	!
5.2	Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.	
14.1	There is a quality improvement plan for the IPC program.	!
14.3	Input is gathered from team members, volunteers, and clients and families on components of the IPC program.	
14.4	The information collected about the IPC program is used to identify successes and opportunities for improvement, and to make improvements in a timely way.	
14.5	Results of evaluations are shared with team members, volunteers, clients, and families.	

Surveyor comments on the priority process(es)

Priority Process: Infection Prevention and Control

The team responsible for the prevention of infections is dynamic, proactive and involved. In 2015, following the publication of the report by the Auditor General, a regional team was created to respond to the various deficiencies raised in the report from the Office of the Auditor General. This regional team has come to the end of its mandate and will shortly be replaced by a regional committee. The links with public health are well-integrated into the processes.

Decisions are taken at regional level, to the great satisfaction of the whole team, who only see the benefits of this.

All policies are standardized; procedures are to be implemented in each organization. Although the situation in respect of infections is under control, it is worrying to see that some infection prevention services fall on the shoulders of a single individual. The organization is encouraged to review this situation which may turn out to be problematic in the event of major outbreaks in the area.

One challenge which remains is clinical involvement in certain areas.

The team for the prevention and monitoring of infections is involved at all levels in the organization and it exercises its influence well.

The implementation of a visual method to warn carers and visitors that a room is in isolation must be highlighted. Posters on the doors of isolation rooms are clear and easy to follow for staff and families.

The organization carried out audits on the different units in 2015. At the time of our visit, we recorded several deviations from the set procedures. We encourage the organization to regularly carry out audits and to apply rigorous monitoring of the action plans following audits.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with residents and families, partners, and the community.	!
2.3	An appropriate mix of skill level and experience within the team is determined, with input from residents and families.	
2.4	The physical space is designed with input from residents and families and is safe, comfortable, and reflects a home-like environment.	
2.5	The physical security of residents is protected.	
Priority Process: Competency		
3.9	Education and training on recognizing, preventing, and assessing risk of abuse are provided to the team.	!
3.16	Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
5.7	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
Priority Process: Episode of Care		
7.14	Information and education about recognizing and reporting abuse is provided to residents and families.	
7.15	The organization's strategy on preventing abuse is understood and followed by the team.	!
8.5	Medication reconciliation is conducted in partnership with the resident, family, or caregiver to communicate accurate and complete information about medications across care transitions.	ROP
8.5.1	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with the resident, family, health care providers, or caregivers (as appropriate).	**MAJOR**

	8.5.2	The BPMH is compared with the admission orders and any medication discrepancies are identified, resolved, and documented.	**MAJOR**
	8.5.3	The reconciled admission orders are used to generate a current medication list that is kept in the resident's record.	**MAJOR**
	8.5.4	Upon or prior to re-admission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented.	**MAJOR**
	8.5.5	Upon transfer out of long-term care, the resident and next care provider (e.g., another long-term care facility or community-based health care provider), as appropriate, are provided with a complete list of medications the resident is taking.	**MAJOR**
8.8	Clients are assessed and monitored for risk of suicide.		ROP
	8.8.1	Clients at risk of suicide are identified.	**MAJOR**
	8.8.2	The risk of suicide for each client is assessed at regular intervals or as needs change.	**MAJOR**
8.12	Each resident's oral health status and needs are regularly assessed in partnership with the resident and family.		
9.7	A procedure is followed to appropriately implement restraints, monitor a resident in restraint, and document the use in the resident's record.		!
9.10	Residents' access to dental services is facilitated by the team.		
9.19	Information relevant to the care of the resident is communicated effectively during care transitions.		ROP
	9.19.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where residents experience a change in team membership or location: admission, handover , transfer, and discharge.	**MAJOR**
	9.19.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**

9.19.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of resident records) to measure compliance with standardized processes and the quality of information transfer • Asking residents, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
10.1	Residents and families are provided with an environment that is flexible and meets their needs.	
10.3	A pleasant dining experience is facilitated for each resident.	
12.7	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from residents and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from residents and families, teams, and partners.	
15.3	There is a standardized process, developed with input from residents and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from residents and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from residents and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

There is strong clinical leadership in the long-term unit. The geriatric physician provides precious support to the inter-disciplinary team, a continuity of care and security during the transition period for users and families. The physician supports comfort care and the move with dignity towards the end of life. His support to the team is critical to the team's ability to help close relatives accept the accommodation.

The presentation of the week of assessment for long-term care is a good initiative by the team in the unit to highlight the care and services provided to these clients.

The organization is encouraged to develop the service offering of volunteers and to involve close relatives to provide support to the clinical team. Just the physical presence is often an effective method of healing with clients.

The interdisciplinary team meets every three weeks to discuss cases. The organization is encouraged to find a planning tool for interdisciplinary interventions to be produced in partnership with the user and the family. The early involvement of close relatives would facilitate continuity in the pathway process already well underway.

An important issue in long-term care is the wait for an interim bed. This multi-factorial delay, involving the Ministry of Health and the Ministry of Social Development for the Province, among others, and the lack of available resources to provide care in the beds available in the community, means that users often stay in long-term care for many years. In this context, the organization is encouraged to review what can be done to limit these delays, but above all to create an environment of well-being for an extended transitional stay.

Priority Process: Competency

The online training software is valuable and user-friendly tool for participants and enables improvement to be monitored by the manager. The integration in this specialist training software specific to long-term care may be an asset in the development and maintenance of skills.

The participants we met during the visit all spoke to us of the increase in disruptive behaviour in clients in long-term care. They expressed an increasing need for training and tools to help them with their actions to reassure. The physical premises represent an obstacle to isolating a user and ensuring that he does not disrupt the peace of the care unit. The organization offers specific training on the subject, but places seem to disappear quickly. The organization is encouraged to review essential training in long-term care and to improve staff skills. The interdisciplinary team is encouraged to pursue improvement initiatives such as training modules, lunchtime workshops and exchanges between peers, to maintain practice standards.

The organization is encouraged to address the issue of abuse in the training offered to clients and to close relatives. This can currently be found in the documentation in the care unit, but there is no formal training offered to the team.

The skills of the members of the interdisciplinary team are already being used. By way of an example, occupational therapy is involved for all users who are at risk of wounding themselves or of falling, or who require restraint.

The members of the team are encouraged to probe the interests and assess the competences of users and families for possible and voluntary use of these to benefit the quality of the care.The team is

experienced in offering assistance to close relatives during this transition period. The organization is encouraged to support this essential quality practice and to encourage the rapid involvement of close relatives in the interdisciplinary team.

Priority Process: Episode of Care

The care protocols for the prevention and management of wounds as well as for the prevention of falls are complete, known by everyone and aligned with an interdisciplinary approach. The identification of all users at risk of falling is a proactive approach in the management of risks. Within the unit, there are several compensatory strategies to limit the use of restraints. The organization is encouraged to roll-out the suicide prevention protocol.

The unit encourages close relatives to bring familiar objects and to personalize the user's environment. On the other hand, it is a challenge to create a living environment within a hospital unit. The organization is encouraged to study possible changes to improve the experience received by the user and to involve close relatives in the improvement initiatives.

The physical environment is a challenge in size for the long-term unit. Congestion, the lack of rest areas and the presence of overspill beds in the corridors limit the safety, confidentiality and dignity of users. During our visit, an extra user in the unit was accommodated in the corridor for 4 weeks. We counted 4 additional beds during the visit and access to a single bath for an occupancy of 25 users. Repairing the floor in the shower room would provide access to the shower. Staff adopt strategies to limit shortcomings which affect the user's privacy.

The organization is encouraged to review the process for managing beds to ensure the safety of users and quality of care. Consultation with users and close relatives may form part of the process to define solutions.

Several solutions are in place to ensure client safety. The organization is encouraged to continue in this direction and to adopt a proactive approach and team accountability regarding the management of risks to ensure a hazard-free environment for clients. Although visual rounds are made regularly, unlocked medication carts and open access to soiled and clean equipment were observed during the visit. Shared responsibility and team accountability in the management of risks would ensure constant safety within care units within a context where space is a challenge.

A few clinical initiatives should be highlighted in the upgrading of significant activities for users. The involvement of Recreation favours pet therapy and friendly visits and, thanks to the foundation, an outdoor area has been created. Users are involved in the upkeep of this recreation area where there is a vegetable garden.

The suicide prevention policy is in the process of being reviewed in the Network. It is not yet rolled out and known by participants. However, there is currently an assessment carried out by a geriatric physician on the prevention of depression and suicide. This assessment is used to establish strategies and thus ensure the safety of users in the care unit.

Priority Process: Decision Support

The recruitment process is complete. The practice of integration of new employees includes target activities associated with the Network's mission and values, as well as the philosophy of the care environment. A clinic mentor then ensures the integration of the required organizational practices. The welcome pack developed by the long-term department is a good initiative to provide information about the orientation of the care unit, the sequence of the stay and about the available resources. The organization is encouraged to roll-out this good practice.

The admissions process to the care unit is well-established and the tools aiming to ensure that full information about the use is available and up to date on his arrival are defined. Participants are familiar with the laws governing the content of files and the confidentiality associated with the transfer of information. The electronic file and the parallel medical file sometimes give a fragmented profile of the user. The organization is encouraged to pursue the computerization of all sectors. Audits on files are carried out regularly with several monitoring measures.

The policy on restraints is well defined. The organization is encouraged to ensure that the consent of close relatives and the record for monitoring the health and the integrity of the user under restraint are entered into the file and that the standardized monitoring tool is known and applied by all participants.

When the user is discharged from the care unit, the transfer of information to the monitoring partners within the continuum is standardized and efficient to ensure optimum monitoring of clients.

Ethical issues are defined and discussed in the interdisciplinary team. There is healthy resolution of disputes and the members of the team know how to find external support if required.

Priority Process: Impact on Outcomes

The visual rounds conducted in the care unit are a proactive approach in the management of risks. The organization is encouraged to include close relatives in this initiative to include another angle and to develop other strategies to optimize safety.

The organization is also invited to review its overspill management strategies to limit the noise level and congestion within the care unit. The overspill beds, added to the equipment in daily use, create a potentially hazardous environment for staff, users and families. There are several projects in the quality development plan for long-term care. The plans are developed in relation to the priorities defined by the participants. The organization is encouraged to include users and close relatives on the clinical committees. The quality development chart is newly installed in the units. You will find information on quality, development plans and monitoring indicators. The organization is encouraged to support these projects, to mobilize participants and users and to support the development of a culture for measuring results.

One initiative which must be mentioned is the roll-out of charts in users' rooms in the Veterans' unit in Campbellton. The simplification of the information by pictograms facilitates understanding by all individuals.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
2.5	A documented and coordinated approach to safely manage high-alert medications is implemented.		ROP
	2.5.1	There is a policy for the management of high-alert medications.	**MAJOR**
	2.5.3	The policy includes a list of high-alert medications identified by the organization.	**MAJOR**
	2.5.5	Concentrations and volume options for high-alert medications are limited and standardized.	**MAJOR**
	2.5.6	Client service areas are regularly audited for high-alert medications.	**MINOR**
	2.5.7	The policy is updated on an ongoing basis.	**MINOR**
	2.5.8	Information and ongoing training is provided to team members on the management of high-alert medications.	**MAJOR**
2.10	The interdisciplinary committee develops a process for using sample medications.		
6.2	Teams can access information on high-alert medications (including current protocols, guidelines, dosing recommendations, checklists, and standard order sets) both in the pharmacy and clinical service areas.		!
9.2	To minimize compounding, commercially-manufactured medications are purchased when available.		
12.6	Look-alike, sound-alike medications; different concentrations of the same medication; and high-alert medications are stored separately, both in the pharmacy and client service areas.		!
12.8	The use of multi-dose vials is minimized in client service areas.		!
15.1	The pharmacist reviews all prescription and medication orders within the organization prior to administration of the first dose.		!
15.4	The pharmacist contacts the prescriber if there are concerns or changes required with a medication order and documents the results of the discussion in the client record.		!

15.5	There is a procedure to address disagreements among the team regarding medication orders.	
16.4	Sterile products and intravenous admixtures are prepared in a separate area with a certified laminar air flow hood.	!
23.3	An independent double check is conducted at the point of care before administering high-alert medications.	!

Surveyor comments on the priority process(es)

Priority Process: Medication Management

Given the context of the lack of pharmacists and technicians which is difficult to resolve in the short-term, as well as the possibility of retirements within the next 5 years, certain measures must be planned in the short and medium-term to improve the efficiency of the service and the safety of the medication circuit, in particular:

Technology modernization:

Meditech pharmacy computer system: each area has a different version. It is essential to conduct a global review of this working tool in all areas to either modernize it and standardize it in all areas, or replace it so as to ensure the efficiency and safety of pharmaceutical and nursing actions. The current system does not permit the Medication Administration Record (MAR) to be computerized in Tracadie. Nurses have to manually write up an MAR with all the risks of medication errors that this involves.

- Review of the process and optimization of the restructuring of the staff workload: automation of the medication container/content verification.
- Review of the technical staff working process on sites with no pharmacist.
- Replacement of pneumatics by the digitization of orders.

All these measures will enable the technical time of the pharmacists and that of the technical assistants to be reduced so that they can be reallocated to clinical programs such as the management of antimicrobials and the medicinal reconciliation (MR).

Nursing care services:
- Review of the process for the preparation of bagged medication.
- Review of the template for the Medication Administration Record (MAR) so as to reduce the preparation and administration of medication and avoid the risks of medication errors.
- Replacement of broken medication carts in the care units.

MR:
Since Summer 2016, the MR for admission has been introduced into all care units. However, with the lack of staff in the pharmacy, the activity has significantly reduced and is very variable from site to site.

The roll-out plan for the next stage is the introduction of the MR for transfer to intensive care as well as the discharge MR in all care units.

The organization is invited to review the roll-out plan in order to target some key care units and to ensure a complete MR process instead of the incomplete services in all care units.

Standards Set: Medicine Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.		
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.		
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.		
2.7	A universally-accessible environment is created with input from clients and families.		
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.		
Priority Process: Competency			
3.1	Required training and education are defined for all team members with input from clients and families.		!
Priority Process: Episode of Care			
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.5.1	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.	**MAJOR**
	8.5.2	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.	**MAJOR**
	8.5.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**

8.8	Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis. NOTE: This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older. This ROP does not apply to day procedures or procedures with only an overnight stay.	ROP
8.8.1	There is a written venous thromboembolism (VTE) prophylaxis policy or guideline.	**MAJOR**
9.2	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.	ROP
9.2.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
11.5	Information is documented in the client's record in partnership with the client and family.	
12.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	

15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The specific aims and objectives of the health services are developed with input from users and families through consultation and with the approval of the members of the Board of Directors.

The information on the services is made available to users and families and community partners through the organization's website. A full range of useful and relevant information can be found there.

Grand Falls General Hospital
The manager in office is also responsible for the emergency room. This enables him to keep control over bed occupancy. Moreover, it launches the overspill plan as soon as it reaches 20 beds.
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Priority Process: Competency

Training and education are offered to members of the team on how to work respectfully and effectively with users and families having a diversified cultural heritage, religious beliefs and needs in respect of care. More specifically, training dealing with the native culture is in place in certain sectors.

The maintenance of staff skills is monitored by the management team. Some training has been completed by a large number of employees, others required specific attention by the managers.

A survey is given to users and their families at the end of an episode of care. The comments gathered from these are used as the basis for discussions and measures for improvement in the clinical unit.

The effectiveness of the collaboration within the team and its operation is assessed and improvement opportunities are defined. The critical shortage of labour is a sizeable issue for the clinical teams.

Chaleur Regional Hospital
Training and education on how to define needs in respect of palliative care and end of life are not offered specifically to the clinical unit. However, as required, an operator from the palliative care unit intervenes in the clinical unit.
Recognition activities are organized so that members of the team are recognized for their contributions.

Local activities are also offered.

Grand Falls General Hospital
Members of the care teams, professionals and support staff have all undergone a performance appraisal over the last year. Staff mentioned to us that they appreciate this approach with their immediate superior.

Edmundston Regional Hospital
Staff appraisals have been completed in accordance with the target set.

Dr. Georges-L.-Dumont University Hospital Centre
Rigorous orientation program on recruitment and education for staff. Performance appraisals have achieved the target set.

Pediatrics
In addition to the training facility available to all those involved, the Pediatrics program helps maintain skills with specific mandatory courses for clients. The arrival of a nursing resource in the care unit is an important addition for the integration and standardization of practices and for support in the development and maintenance of skills.

Priority Process: Episode of Care

A collaborative working project is planned for Autumn 2017. We encourage the organization to roll out this pilot project and to ensure it is followed up.

A documented and coordinated approach for the prevention of falls is implemented in the clinical units.

A colossal amount of work has been carried out so that clinical users at risk of having a venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identify and receive the appropriate thromboprophylaxis.

Although regionalization remains an issue, the team puts in the effort needed so that treatment protocols are systematically followed so as to offer the same quality of care to all users, in all environments.

As required, users or families are directed towards the services responding to their needs, such as palliative care and psychosocial services.

The efforts deployed for compliance with the organizational practices required are remarkable. All the screening and monitoring tools are found in the file.

The doctors work as a group and hand over users with a written report which can be found in all the files. This is a handover note.

Multidisciplinary unit (clinical-surgery-orthopedics and pediatrics). Chaleur Regional Hospital

A complete and personalized care plan is developed in partnership with the user and the family.

The average length of stay at Bathurst is fairly short, which makes achievement of the care plan difficult. The shortage of labour makes it difficult for this to be drawn up.

The organization would benefit from using a sample of users, families or organizations to which they have directed users, to regularly assess the effectiveness of the transition or the end of the services. The assessment of transitions represents an opportunity to check that the needs of the user and the family have been satisfied and that their concerns or their questions have been addressed.

Grand Falls General Hospital
We encourage the clinical team to continue its plans for its post-hospitalization telephone follow-ups. There are several stages still to come.

Edmundston Regional Hospital
The required organizational practices (ROP) are complied with, including the medicinal reconciliation (MR) in its entirety.

Dr. Georges-L.-Dumont University Hospital Centre
We noted an overspill issue which causes a work overload for staff. Excellent collaboration between the pharmacy and the nursing care in the completion of the Admission MR. Users are involved in their episode of care.The unit is a teaching unit linked to the clinical training program within the University of Sherbrooke. There are still two external and teaching staff there. We note that there is equipment in the corridors. The reorganization of the pharmacy could help to reduce the task of nurses and improve safety in the preparation and administration of medication. The venous thromboembolism (VT) ROP has not yet been introduced. We encourage the organization to embark on the introduction.

Renal medicine
There are regional meetings with the Network's renal team. We note the work of the interdisciplinary team with users and the presence of the pharmacy within the team.

Pediatric Clinic
A special mention must be made of the Georges-L.-Dumont Pediatric Clinic which supports pediatric practices at a regional, provincial and international level. The participants are committed and passionate about the satisfaction of unmet needs in the community, such as the management of concussions directly in schools, sports teams, etc. The team recognizes a need and is developing projects to improve quality which are rolled out on a small scale. This interdisciplinary clinic is a leading partner in care centres for the user, close relatives and above all in the community. The interdisciplinary clinic is an innovator in its conception itself and in its community approach. The presence of community coordinators enables the key partners for children within the team to meet. Best practice, the review of guidelines and research are at the heart of all the procedures carried out, which above all aim to give power to the user and to mobilize the entire user's environment in the monitoring of disease.

There are stable partnerships with the Horizon Health Network, organizations and schools and there are even links with the Ministry of Justice and Education and Public Health, in particular for the Fetal Alcohol Spectrum Disorder (FASD) Centre of Excellence which has even succeeded in creating links with the First Nations.

Priority Process: Decision Support

We note the number of users awaiting placement, which is causing overspill issues in several sites.

Chaleur Regional Hospital
Record-keeping practices have been assessed in the past, but not recently. A process is in place and would benefit from being applied. Paper files are kept and there are electronic files in some sectors, which creates problems for staff. A process has been implemented in the 2nd West to ensure that all information is held in the paper file. Sometimes, the lack of staff delays the implementation of this process.

We encourage the Bathurst team to continue the introduction of the care transition report and to assess the effectiveness of this.

Grand Falls General Hospital
The file, which is on paper, is correctly completed and easily retrieved. Nursing staff have access to records, policies and procedures, as well as information on medication on the Boulevard application.

Edmundston Regional Hospital
The user's file, which is on paper and the information is correctly filed therein. However, we were able to record that the form for the level of care is missing despite admission having taken place several days previously.

Dr. Georges-L.-Dumont University Hospital Centre
Teaching unit. The file is on paper and electronic for nursing care

Renal medicine
The dedication, availability and humanity of all participants in the renal network was recorded, also the quality of the procedures by a specialized and collaborative team which knows how to be innovative in training strategies to make users more accountable. Clinical advisers support the review of best practice, the standardization of practices and protocols and the integration of changes in practice throughout the continuum. Setting up of regional renal committees: management committee, clinical committee, quality committee (however, the user does not take part).

Increase home dialysis: the training plan is structured and used. Users fulfill the criteria but the lack of equipment does not currently enable the volume to be increased.

The waiting list for the satellite unit in Tracadie is an issue.

Priority Process: Impact on Outcomes

Input from users and families, when integrated in the various stages, will have a significant impact on the organization's results. The objective of the use of users' and families' experiences through consultation is to determine whether the method used follows an approach focused on the user.

All reports or procedures originating from users or their families are noted and, as required, improvements are put in place to reduce the risks for clients.

The users we met said they were very satisfied with the services, the staff are courteous and the food excellent.

Chaleur Regional Hospital
Comments on the subject of the quality of the services were gathered through a survey on the satisfaction of the user and the family or on the experience received by the users, or drawn from complaints, from various indicators, results or information resulting from the analysis of incidents and financial reports. The comments gathered are analyzed and prioritized in the form of an improvement action to be carried out. Input from users and families in the selection of priorities is encouraged.

Actions to improve quality are rigorously monitored by the team through the use of a dashboard and improvements which turn out to be effective during the trial phase are implemented on a large scale throughout the organization. The results obtained are then shared locally and with the population.

An information package is systematically given to clients on admission. This contains, among other things, a document on users' rights and responsibilities.

Grand Falls General Hospital
Users' files are on paper.

Dr. Georges-L.-Dumont University Hospital Centre - Pediatrics:
There is an official tool for transitions developed within the institution. The care transition report is used, but telephone calls also have a place in the transfer practice, as participants complain that the tool is not adapted for pediatric clients.

The Pediatrics program has developed quality improvement projects which are known by the participants and which are displayed at the station on a dashboard. The mobilization of staff while awaiting the indicators has yet to be pursued.

There is an excellent culture within the Pediatric Clinic at Moncton. The indicators are compiled, reviewed and discussed during team meetings. The complexity of the management of participants by several different managers causes pitfalls and could be reviewed to define a simplified management structure.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.6	Processes and policies to meet the diverse needs of the clients and families served are established with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.9	Education on the safe and appropriate use of seclusion and restraints is provided to the team.	
4.1	A collaborative approach is used to deliver services.	!
5.6	Education and training are provided on how to identify, reduce, and manage risks to client and team safety.	!
9.15	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
2.7	The physical environment is safe, comfortable, and promotes client recovery.	
6.1	Access to essential and urgent mental health services is facilitated 24 hours a day, seven days a week.	
7.10	The client's informed consent is obtained and documented before providing services.	!
7.11	When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.	!
8.3	Goals and expected results of the client's care and services are identified in partnership with the client and family.	

8.6	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	8.6.1	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.	**MAJOR**
	8.6.2	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.	**MAJOR**
	8.6.3	A current medication list is retained in the client record.	**MAJOR**
	8.6.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	8.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
8.8	Clients are assessed and monitored for risk of suicide.		ROP
	8.8.1	Clients at risk of suicide are identified.	**MAJOR**
8.10	A process to assess the client prior to granting off-unit leave and upon return from leave is followed by the team in partnership with the client and family.		!
9.10	The client's physical activity needs are supported as part of comprehensive service delivery.		!
9.18	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	9.18.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	9.18.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.	**MAJOR**
	9.18.3	During care transitions, clients and families are given information that they need to make decisions and support their own care.	**MAJOR**

9.18.5	The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	**MINOR**
Priority Process: Decision Support		
11.1	An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.	!
11.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
13.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
14.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
14.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The collaborative co-management model between mental health and the community mental health centre is a strength in the user's care continuum. This strength is especially present in child psychiatry, where the participants in the care unit are the same as those who operate in the community.

The care teams are committed to showcasing the strengths of users by adopting an interdisciplinary approach. The philosophy of intervention for the restoration of health is at the heart of the decisions and interventions. All participants care about the development of a treatment relationship with users to mobilize them in their episodes of care.

The teams meet weekly to discuss each user and to review the plans for intervention. In child psychiatry, the user and their family take part in the team meeting and they are involved in the development of

objectives. The team is encouraged to formalize an interdisciplinary intervention plan centred on the objectives of the user and their family which could even serve as a self-management plan for users.

The child psychiatry teams are encouraged to pay particular attention to the close relatives of clients who have decision-making authority from the age of 16. This transition period changes the role of close relatives from decision-maker to participant. Families have expressed to us their issues with living through this period and understanding the change. Support from the team would ease the transition.

When planning for discharge, mental health teams are asked to include the family more systematically, with the user's agreement. The family may become a pillar of integration in the discharge plan and the most important area of support for the implementation of the continuum strategies and health maintenance. This factor turns out to be even truer with large users of the mental health services.

Priority Process: Competency

The mental health teams are dedicated, mobilized and empathetic and centred on the user. The participants are stable and permit interdisciplinary support and clinical expertise. The presence of a geriatric psychiatrist and a child psychiatrist in Moncton ensures constant improvement of the expertise and a beneficial advantage for clients and for the care team. This specialization is an important asset for the specific care of users. The organization is encouraged to see how this expertise could be used for all institutions in the Vitalité Network.

There is strong clinical leadership in doctors and psychiatrists in some institutions in the Network. The effective collaboration between the clinical sphere, the nursing care and the professionals in these sectors is a model to be followed in the Network to ensure an effective response to users' needs.

The model for the child psychiatry service in Moncton is a good example of the improvement and maintenance of skills to respond to users' needs. The separation of the child psychiatry unit from Pediatrics is a model of success in respect of the segregation of separate issues and enables an improvement in the skills of the teams assigned to this specialization. The specialist approach for night times remains an issue, but the organization has already obtained approval to add one trained nurse to the unit for all shifts.

Continuous training and the maintenance of skills is a key issue in a specialization such as mental health. Several types of training are offered in the Network, but the availability of places and problems in releasing staff sometimes make it difficult to ensure professional education. Furthermore, the lack of specialist clinicians is also an obstacle to the transfer of knowledge. The organization is encouraged to review the training models to plan for a tailored education structure. Avenues such as training modules, lunchtime workshops and exchanges between peers would permit skills to be maintained. The training established by the organization as being a priority and mandatory is followed by the managers but the lack of places sometimes remains an obstacle. The themes of suicide, aggressive behaviour, conflict reduction, restraint, violence in the workplace and risk management are essential in the mental health program.

The academic training for the Postdoctoral Degree in Psychiatry at the University of Moncton is an avenue which will ensure must greater availability of resources in the mental health program and an improvement in the expertise in the Vitalité Network at a clinical level. The organization still has challenges to be noted in respect of recruitment and the availability of resources to ensure the staffing of positions throughout the Network. Over the next five years, the Network will face another challenge associated with the retirement of 45% of the workforce.

The organization is encouraged to adopt a proactive approach and team accountability regarding the management of risks to ensure a hazard-free environment for clients. The equipment which is not specific to the sector such as, for example, an electric bed originating from the emergency department, should not be found in the mental health unit. Visual rounds and team accountability in the management of risks would ensure constant safety in the care units.

Priority Process: Episode of Care

The obstacles relating to access to services are properly identified by the management. We encourage them to continue to consider solutions to eliminate constraints and delays, especially in rural regions. The absence of specialist services in this area requires the user to go through the emergency department in their region to obtain a transfer by ambulance or under police escort to the specialist care unit. One strength to be mentioned is the introduction of mobile crisis units in the organization. The service offering for these units is being increased and constant availability would be an optimum method of prevention. The organization has a clear procedure for reception of clients into the emergency department. The organization is encouraged to review the admission timescales and overspills in the specialist unit. The physical environment within the care unit at Moncton is cramped and does not permit a recovery approach. Single rooms have become double to admit an overflow of clients, but to the detriment of the approach of health recovery. Strategies are in place to ensure confidentiality and to respect clients' privacy in spite of this coexistence. The organization is encouraged to pursue the review of this care gap. The lack of space within the unit means that there is no clear distinction between clean and soiled equipment and
these are accessible to all users and visitors. The need for space is also noticeable in the child psychiatry unit. In both units, users, families and staff highlight the lack of physical or play activities both on a therapeutic and an occupational level. Clinical initiatives and innovations, such as pet therapy, are to be encouraged within the care units. In respect of the environment, initiatives such as the waiting room created with the support of users and the Snoezelen Room in Edmundston should be highlighted, which could serve as a model throughout the Vitalité Network.

There are formalized admission structures in the care units. The roles are clear for each participant. The user admission handbook and that defining the parent or legal guardian for the 3D child psychiatry unit is an example of a tool facilitating the integration of the user and their family, as well as setting out information for the stay and for the resources available on discharge.

The process to assess the user on admission, on discharge, on transfers to the operating room and before and after permission to leave the hospital is well-established. The organization is encouraged to have a process which is as well-defined for discharges outside the care unit and during transfers to other sectors in the institution.

The services are designed to ensure freedom and to limit the disruptions and restrictions associated with hospitalization. The team of participants promotes the empowerment and self-determination of clients during the episode of care. Self-management is a method of care advocated in health recovery. The organization is encouraged to pursue this involvement and to rapidly engage the user in the planning of the episode by an active involvement in decisions and in planning their discharge.

The required organizational practices associated with the medicinal reconciliation, the implementation of the identification and prevention of suicide protocol and the transfer of information to the transition points are practices to be disseminated and standardized to ensure compliance throughout the Vitalité Network. The implementation and compliance with the procedure on the implementation of the restraint, including the agreement of the legal representative, is also a practice which will need to be updated in the sectors.

Priority Process: Decision Support

The different sectors in the institution have clear communications processes on the physical, psychological and social health of each user. Information is transferred in a standardized way to ensure that the user does not have to repeat the same information when being transferred and admitted to a care unit. Participants are familiar with the laws governing the content of files and the confidentiality associated with the transfer of information. The non-standardized file and the parallel medical file sometimes give a fragmented profile of the user. The organization is encouraged to standardize files through collaboration with all participants, including psychiatrists and by auditing the files.

The electronic file is properly established with participants in the nursing care and the various professionals. This method of operation enables facilitation of the transfer of information in the episode of care. The organization is encouraged to continue the computerization of all user information and assessments.

The informed consent of the user is obtained and recorded before the service is provided. Standardization between the various sites in the Network should be continued so that the consent form can be found automatically in the user's file. An audit of the file would also enable this compliance to be monitored.

When the user is discharged from the care unit, the transfer of information to the monitoring partners within the continuum could be standardized. The organization is encouraged to develop a transfer pack in which the responsibilities, documents to be transferred, timescales and method of transfer are well-defined to ensure a continuum of care and standardized and complete services.

The institution journal which belongs to the user, which we were able to observe in a mental health care sector, is a good example of communication of the user's needs, priorities and progress. This tool, which serves as a passport between the various programs in which the user is involved is a practice which could be used as a model for roll-out across the Network.

Priority Process: Impact on Outcomes

A lot of standardization work took place during the last year. There is a group of managers involved who care about the standardization of best practice and the quality of care and services. This standardization work is a good example of the integration of input from users and families. On this recovery committee, in addition to the key personnel in mental health management, there are two users and a close relation who play an active part in the decisions relating to the establishment of priorities and the review of policies and of best practice. The challenge to be met is the standardized updating of the care guidelines established in partnership with users.

The safety commitment is present and there is a culture of disclosure. The work should be continued in respect of the implementation of a process of proactive prevention and accountability for all participants on the declaration of potential risks for clients. The organization is encouraged to review the verification process to reduce higher risk activities. The transfer of electric beds from the emergency department to the care unit and the standardization of the storage of equipment and bedding are factors which could be considered. Users are invited to take part in this process.

Several projects for the improvement of the quality of the management team have emerged. There are currently six projects for the improvement of the quality of care and the services. A control room located at the Restigouche Hospital Centre is a good example of mobilization, project monitoring and indicators for quality improvement. The organization is encouraged to continue down this route and to involve clinicians, users and families in the achievement of these objectives.

The involvement of psychiatrists within the interdisciplinary team is a key asset for monitoring the fragmented client base. The organization is encouraged to promote optimum collaboration by the members of the team, especially at the Restigouche Hospital Centre and to appoint a Head of Psychiatry who will be a facilitator in the rise in quality, the increase in accessibility to care and in monitoring the length of the stay.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.4	Space is co-designed with input from clients and families to ensure safety and permit confidential and private interactions with clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.3	A comprehensive orientation is provided to new team members and client and family representatives.	
3.12	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care		
8.5	Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.	ROP
8.5.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
17.4	Safety improvement strategies are evaluated with input from clients and families.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Dr. Georges-L.-Dumont University Hospital Centre, Moncton
A dynamic team is looking towards the FUTURE and projects to improve services are based on best practice. A new ultrasound unit responding to client needs has been acquired and will shortly be in operation.

Obstetric services are provided in an environment which no longer fulfills the requirements and growing needs of young women, babies and neonatal care. The organization is encouraged to assess the possibility of restructuring these specialist facilities to bring them up to standard.

Edmundston Regional Hospital
A new structure is in place in order to promote collaboration between the four sites. The objectives are to offer the population high quality services based on best practice and to have a specific place to share the teams' successes.
The standardization of practices between the centres has begun. The team appears to be very open to adopting practices which meet the high-quality standards.

A regional committee should begin its activities shortly. Various other committees are active, such as the perinatal bereavement committee, the local breastfeeding committee and the community committee. The aim of the community committee is to promote the services available in the region. So as to get users to take part in decisions, it is suggested that they are identified to associate them with the decision-making committees.

Chaleur Regional Hospital
The standardization of practices has begun.

Priority Process: Competency

Dr. Georges-L.-Dumont University Hospital Centre
The team has acquired expertise in natural childbirth presenting in the breech position. The results have been significant in considerably reducing the rate of Caesarian sections. The service's clinical team has begun to make the other obstetric services in the south and north regions aware. Arrangements are in place with the Halifax Hospital for the transfer of a new-born experiencing complications. The air ambulance collects the child, accompanied by members of staff. The managers appraise the performance of each member of the team annually and as required. This approach is very much appreciated by the staff. The members of the team receive various types of training to increase their skills. Some of these are mandatory and have to be renewed annually. One of the mandatory training programs for nurses relates to neonatal resuscitation and this must be renewed every year. Several mandatory training programs are offered online. Furthermore, the training module enables managers to monitor the progress of every employee. Here are a few examples: user safety, clean hands, RCI (Respiratory Care Interventions), protection of privacy, awareness of violence in the workplace.

Chaleur Regional Hospital
The lack of resources is felt above all in nursing. The manager must adjust schedules depending on expertise and the availability of staff. The team is asked to continue its recruitment efforts and to develop an orientation program for nurses.

Priority Process: Episode of Care

Dr. Georges-L.-Dumont University Hospital Centre
In the pre-natal phase, a health assessment questionnaire has been modified for the early detection of consumption habits in the mother-to-be. This practice permits intervention to take place proactively.
The team has implemented a monitoring process for the safe ventilation of the new-born.

Edmundston Regional Hospital
Significant efforts have been made for the implementation of the program for the prevention of falls. The roll-out of the MR (medicinal reconciliation) is not optimal. There is, however, good collaboration with the pharmacy service, which is certainly a measure of success.
The members of the team appreciate the presence of a new breastfeeding adviser. She will define her role in relation to the support to be provided to the team and in respect of the services to be offered to mothers.

Chaleur Regional Hospital, Bathurst
The mother-child-family sector is remote from the hospital services, causing unnecessary travel for users. A construction project is planned for the relocation of the delivery room within the mother-child-family sector. The Baby Friendly Initiative was begun, but has been granted less importance over the last two years. The team is asked to look for strategies to motivate participants to resume the activities of this initiative.

Priority Process: Decision Support

Dr. Georges-L.-Dumont University Hospital Centre
Edmundston Regional Hospital
Chaleur Regional Hospital

Users' obstetrics records are stored safely and comply with current laws for the protection of privacy. Nursing staff and professionals continuously record their notes on these. However, we noted that the pregnancy monitoring records are kept in the care unit (Edmundston). This practice is to be reviewed, given the risk incurred in respect of user security. All files should be found in a secure and confidential environment, similar to the medical archives.

All reference documents, including policies and procedures, are held on Boulevard and are easy to access, which is appreciated by the staff.

Priority Process: Impact on Outcomes

Dr. Georges-L.-Dumont University Hospital Centre
A meeting was held with a young mother and her spouse and they expressed their great satisfaction with regard to all services, except for food. A follow-up is given to young mothers in the post-natal clinic, as well as by public health.

Edmundston Regional Hospital
The head of the unit cares for the safety of users and for quality. The team has developed quality indicators which are rigorously followed. The teams on the ground are aware of these, take part in their monitoring and contribute measures for improvement. Furthermore, the MAPOR (Multidisciplinary Approach for the Prevention of Obstetric Risks) program is in its third year of existence. A doctor is involved in the management of the program; he also monitors the indicators and collaborates in staff training sessions.

Risk management on a day-to-day basis resides in the care sector, and all staff are very aware with regard to the safety of the mothers. Incident-accident declarations are made within a context of continuous improvement for certain members of the team. It is suggested that meetings are held with employees who do not adhere to this incident-accident declaration process so as to reduce their fear of being blamed following an event. The team is asked to improve the rate of Caesarian sections, which is at 30%, whereas the WHO (World Health Organization) has a target rate of between 10 and 15%. The families we met expressed their total satisfaction with regard to the services.

Chaleur Regional Hospital
The Multidisciplinary Approach for the Prevention of Obstetric Risks program (MAPOR) has been set up, but it has not had the desired results in relation to the work with the clinical team. However, in respect of the work between nurses, there have been notable changes and benefits noted. MAPOR plus will be implemented in the Autumn.

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

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
6.1	Required training and education are defined for all team members with input from clients and families.		!
Priority Process: Episode of Care			
11.2	The assessment process is designed with input from clients and families.		
11.6	FOR INPATIENTS ONLY: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.		ROP
	11.6.4	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.	**MAJOR**
	11.6.5	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.	**MAJOR**
12.3	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.		ROP
	12.3.1	At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
14.11	Immediately prior to the procedure, a preoperative pause to confirm the client's identity and nature, site, and side of the procedure is conducted and documented.		!
17.4	Prophylactic antibiotics are administered by qualified team members within the appropriate timeframe.		!
Priority Process: Decision Support			

21.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
22.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
23.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
23.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
23.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
23.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
24.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
24.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
24.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
24.4	Safety improvement strategies are evaluated with input from clients and families.	!
24.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Priority Process: Medication Management		
5.3	The contents of medication carts for the surgical area are standardized across the organization.	
15.5	An independent double-check is conducted before administering high-alert medications on the sterile field.	!
16.3	Medications and related supplies stored on anesthesia carts are standardized.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The perioperative services and invasive procedures respond appropriately to this priority process. Everything has been implemented so that their services are optimal and high quality for users. The policies and procedures are in place and known. Results should be shared with users and with the teams.

The major challenges to be noted over the next few years are to get users and families to take part in the design and assessment of the services.

Priority Process: Competency

An excellent orientation program for new employees is in place. The implementation of a retention plan is to be encouraged for employees who are in their first year in the operating facility, to ensure they stay in the role.

Staff are proud that they work in this service and that they apply best practice. Continuous training is planned on the IT systems. Staff are assessed annually and an action plan on the training requirements identified is developed. Staff in the operating facility and the unit receive training on all new techniques, procedures, etc. A training plan is produced annually. Training is offered throughout the year when new equipment is acquired and new techniques implemented.

Priority Process: Episode of Care

Dr. Georges-L.-Dumont University Hospital Centre

Skilled and devoted staff work in the operating facility and are constantly looking for new practices to improve services. The room managers are highly qualified and are the cornerstones of the operation throughout the procedures. User satisfaction is very high. It is remarkable that in such restricted facilities, the practices are of high quality. The facilities in the operating facility need to be renovated, but the work has not begun due to the shortcomings observed during the last accreditation visit. Soiled equipment passes through the clean area.
The team has conducted a Lean approach which has greatly improved access to the facility where the equipment for surgery is kept. There is a lack of space, but the storage areas planned in the new operating facility will remedy this problem. The team is encouraged to review the number of products in future facilities.The move to new facilities will permit the majority of the irritants to be remedied. There needs to be a rethink on the housekeeping service, as procedures will be carried out in facilities, the surface area of this will be significantly larger.

Edmundston Regional Hospital:
The operating facility is fairly modern and has the three appropriate areas. The restricted central access corridor also serves as a storage area for sterile equipment and is cluttered. Good compliance with

criteria. At the time of the tracer, no surgical break was observed while the surgeon continued staining when being questioned, although he appeared to listen. An interesting service offering with thoracic and vascular surgery. The team wants to recruit an ear, nose and throat specialist (ENT). Problem with recruiting nurses for the operating facility. Project to introduce nursing auxiliaries which has worked well. Excellent training and performance appraisal program. In the surgical unit, the files are complete and the different ROPs are complied with.

Priority Process: Decision Support

The teams achieve a high level of compliance relative to this process, but the culture of participation by the user and family is not in place.

Access to the file by the user is still complex and doctors must be asked for authorization before he is allowed to read it. It will be suggested that a procedure is put in place on the access to the file by the user and his family. Although the staff are very well-intentioned towards the user and his family, the patient partner culture is not integrated and few employees we met were aware of the underlying concepts: with the participation and input from users and families.

Priority Process: Impact on Outcomes

The staff from the perioperative services and invasive procedures show a commitment towards the provision of quality and the quality of the services.

The management of the operating facility is complex and varied. There are daily meetings so that the day's activities are known. Since the last visit, the operating room in maternity has been moved and is now located in gynecology. The staff from the facility work there.

The daily challenge is to be found in space restrictions, but the team provides safe and quality services. Much work has been carried out by the managers and staff to establish the organizational practices required. The transfer reconciliation is not yet in place, as there is no official form to carry this out.

The team from the facility and from the surgical unit have determined their quality and performance indicators.

The results are being monitored. In unit 4A, the computerization of these indicators should be formalized to facilitate the monitoring and reading thereof. It is strongly suggested that the achievement of the objectives is presented to the teams from time to time and any deviations evaluated.

So as to ensure safety in 4A at all times, it would be good to assess the possibility of purchasing new medication carts, but to keep the sealed carts until then.

Priority Process: Medication Management

All processes relative to the management of medication are complied with. The medication carts are not secure, however. None of the carts examined had seals and several were located in a place accessible to users. It is recommended that the possibility of purchasing new carts for the care unit is investigated.

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

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Point-of-care Testing Services

The laboratory is responsible for the supervision and implementation of this standard, but the actions are performed by the nursing staff throughout the organization. We noted excellent collaboration between all players.

The supervision and monitoring mechanisms are present in each of the organizations. The roles of the various participants throughout the process are defined. A regional interdisciplinary committee has just been formed, the roles and responsibilities are to be redefined.

For each of the delocalized biology analyses (ADBD) carried out, there is a standardized operational procedure (SOP) and forms relating thereto.

The use of glucose monitors is well-structured and supervision by the biochemist ensures the quality of these analyses.

The external monitoring program is not in place.

The laboratory must obtain a quality management system, document any non-compliance and ensure quality indicators are monitored so as to support the interdisciplinary committee in its decision-making. The implementation of a complete regional program will require sustained efforts and the involvement of all management teams affected by the performance of the ADBDs to carry this project to its conclusion and to ensure the reliability and accuracy of the analyses conducted at the user's bedside in all points of service in the organization.

We noted that some ADBDs are not under the governance of the laboratory but under that of primary care. The institution is encouraged to work on this issue so as to ensure that all the delocalized biology analyses are defined by the policy and are subject to the checks required by the laboratory, as specified in the standards.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
Priority Process: Competency		
3.1	Required training and education are defined for all team members with input from clients and families.	!
3.4	A comprehensive orientation is provided to new team members and client and family representatives.	
Priority Process: Episode of Care		
6.6	During regular hours, same-day access to primary care services is available to clients and their families, as required.	!
6.8	An out-of-office and after-hours care process is followed for clients and families requiring access to primary care services outside regular business hours.	!
6.9	The out-of-office and after-hours care process includes how to respond to requests for medication refills and medication information after hours and in emergencies.	
8.16	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
11.13	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
12.8	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	

Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
15.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
15.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
15.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
15.4	Safety improvement strategies are evaluated with input from clients and families.	!
15.7	Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.	!
16.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Good internal and external communications initiatives are in place. Projects with the population are in place. The primary care teams are present in the territory to get to know the population and to make their services known.

Grand Falls General Hospital
There is no privileged access to the primary care services on the same day for all the primary care services.

Priority Process: Competency

There is nothing to indicate that the training and education which must be undertaken by all members of the team has been defined with input from users and families.

Lamèque Hospital and Community Health Centre:
It would be beneficial to develop a program for the welcome and orientation of new members of the team so as to facilitate the transfer of knowledge and the monitoring of the objectives to be achieved.

Priority Process: Episode of Care

The organization is encouraged to develop and implement a process to involve users and families.

We congratulate the teams for the impressive work of mapping access to family doctors. This information will help greatly in the planning and implementation of solutions to improve access to primary care.

Lamèque Hospital and Community Health Centre:
Area 6 has a computer file for all primary care users.

St. Joseph Community Health Centre in Dalhousie:
The physical environment of the premises at the collaborative practice's reception does not permit user confidentiality to be assured.

Priority Process: Decision Support

The team is to implement a regional action plan. They are aware of the population and collaborate with various partners in the community.

We highlight the source of information made available by the New Brunswick Health
Board. The organization is encouraged to develop and implement a process to involve users and families.

St. Joseph Community Centre:
The user participates in round table discussions and working groups associated with the service offering.

Priority Process: Impact on Outcomes

The team is to implement a regional action plan. They are aware of the population and collaborate with various partners in the community. We highlight the source of information made available by the New Brunswick Health
Board. The organization is encouraged to develop and implement a process to involve users and families.

St. Joseph Community Centre:
The user participates in round table discussions and working groups associated with the service offering.

Standards Set: Public Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
4.2 Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Public Health	
3.5 The resources needed to achieve public health goals and objectives are identified.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The emergence over the last few years of a populational health profile has enabled improvement objectives to be identified which respond to the needs of the population. The team is encouraged to develop and monitor a list of indicators which will provide a shorter-term trend linked to the current initiatives. These new priorities will also have to be aligned with the Ministry's programs. The sharing of good practices and fruitful initiatives with other regions in the province is to be encouraged. The team has a robust public business plan.

Priority Process: Competency

The current structure dates back to 2008 and the team seems to have now achieved a level of maturity permitting it to proactively take ownership of its mandate. The management of public health within the Vitalité Health Network raises certain issues, given that the division of the territory under the authority of the Chief Medical Officer at provincial level for the protection of health does not correspond with the division of the territory in the Networks, which are responsible for providing the prevention programs.

Priority Process: Impact on Outcomes

The team is encouraged to involve users and families in defining the training and education required. The team has been very successful in adapting to the specific needs of the Syrian refugees recently welcomed into the region.

Priority Process: Public Health

A profile of the health of the population in the Network (Le Coup d'œil [The Glance]) has been carried out every three years since 2014. The team is encouraged to capitalize on the Network's recent mission and vision, which highlights the improvement in the health of the population and the latter's commitment in this improvement process so as to boost the public health profile within the organization. A recent prioritization exercise permitted the major public health issues to be identified for the population in the sector. The resources needed for the implementation of action plans addressing these priorities are yet to be determined. The organization maintains several partnerships with local authorities having a link to public health. The organization is encouraged to capitalize on these partnerships to produce synergies enabling the public health objectives to be achieved as efficiently as possible. The organization is also encouraged to call for the creation of a centralized vaccination register so as to have a better overall view of the vaccination status of the population served. There are several initiatives to boost the health of the population: positive fines for wearing a cycle helmet, places for breastfeeding in towns, partnership with community development agents in well-being centres, removal of energy drinks from municipal buildings, targeted approach for the First Nations, ecofriendly and healthy lunch boxes and information sessions on self-regulation in nurseries.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
8.4	Standardized assessment tools are used during the assessment process.	
10.8	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
11.1	An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.	!
Priority Process: Impact on Outcomes		
13.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
13.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
13.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
13.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
13.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
14.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
14.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!

15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The clinical team includes two geriatric physicians and two general practitioners. Their leadership within the team is strong and motivational. The team of doctors carries out a preliminary assessment of all users who have been directed to the unit for admission.

The approach of the care team advocates the accountability of the user. The rehabilitation team is encouraged to give increasing power to the user and his family by involving them from admission onwards in discussions and decisions. The formalization of an interdisciplinary intervention plan centres on the user's expectations and objectives and those of his family will give added value and will give a greater capacity for self-determination to the user.

To support the decision making, the priorities for improvement and the evaluation of the rehabilitation program, the organization is encouraged to review the compilation of performance measures to be able to establish the length of stay, the success of the return to home and the issues facing failure. The mindset of rehabilitation clients towards other units in the institution and the change in status at the time of a request for accommodation following the ending of procedures make the monitoring of results challenging for managers and limit the mobilization of staff in the plans for the improvement of quality.

Priority Process: Competency

The recruitment process is complete and includes a theoretical section on the structure and philosophy of care and a clinical integration section, during which support is offered on the organizational practices required in rehabilitation.

The online training software is a valuable and user-friendly tool for participants and enables improvement to be monitored by the manager. The integration into this software of specific training for rehabilitation would be valuable and could facilitate the maintenance of specialist skills. Several training programs are offered by the organization, in particular the management of disruptive behaviours, but the participants mention the increasing need to offer more availability, as places are limited.

The arrival of a specialist nurse in the care unit is an asset in the maintenance and transfer of skills. This adviser may provide impetus in the continuous pursuit of quality. The interdisciplinary team is encouraged to pursue improvement initiatives such as training modules, lunchtime workshops and exchanges between peers, to maintain practice standards. The organization is encouraged to adopt a

proactive approach and team accountability regarding the management of risks to ensure a hazard-free environment for clients. The manager carries out regular visual rounds. Information and training on safety and the development of a culture of team accountability in the management of risks would ensure constant safety in the care units within a context where the environment is a challenge.

The geriatric physicians in the care team openly discuss spirituality and end of life with clients and close relatives and have had to respond to a request for assisted dying. The doctors in the unit are leaders in this process and know how to offer support and obtain the resources as required.

Priority Process: Episode of Care

The empowerment and accountability of the user in his rehabilitation process is a practice recorded in the procedures within the care unit. Communication between professionals and the care team is fluid and enables information to be transferred on the development of autonomy by users. These are encouraged to play an active part in the morning routine and in managing their daily schedule. The self-management of medication is attempted when there are doubts over
the ability of the user to take over this routine in their lives. The use of self-administration may be broadened and put into the hands of the user even if their ability is not in doubt. The rehabilitation team adopts a healthy management of risks to improve autonomy, to facilitate growing awareness of the risks by the user and the family and to simulate functioning approaching that in the home.

The limited professional resources mean it may be difficult to achieve an optimal intensity of treatment in an intensive operational rehabilitation environment. The high number of users forces participants to make choices and to establish priorities. The number of hours of treatment for users having suffered a stroke (CVA) does not comply with the guidelines for looking after these clients.

Recreation is involved in activities for users and offers group activities five days a week. Close relatives mention they are encouraged to take part in the rehabilitation activities and to continue the exercises at the user's bedside. However, the lack of space and absence of available rooms to continue the rehabilitation plan limits their efforts. They also mention the lack of activities within the unit at weekends.

On a clinical level, the implementation of standard assessments on depression, the risk of suicide and dysphagia are practice standards which would benefit from being reviewed.

The physical environment in the care unit is cramped and does not permit an optimum rehabilitation approach. The unit deals with constant overspills in the occupancy of beds and we found users who had to stay in the corridor. The organization is encouraged to continue the analysis of this gap in care to promote an environment favourable to recovery and free from risks.

In respect of the environment, the creation of closed areas not open to access should be considered for clean and soiled equipment. The medication carts should always be locked, as they are situated at all times in areas accessible to users and families. The organization is encouraged to review the presence of a half-door for one room in the unit which is not in line with the mission of the care unit.

Preparation for discharged is planned and meetings held with close relatives as required. A direction for an assessment of the home by an occupational therapist is made as required and temporary trial discharges before the final discharge form part of the unit's practice.

The program for rehabilitation at home (R & R) is a good model for optimization of the user's autonomy. This program for intervention in the environment is standardized with specific criteria based on the risk and from observing the user, as well as the objectives to be achieved. The health plan associated with this program is a good transition model.

One of the challenges of rehabilitation is securing long-term accommodation. The wait for a place getting longer, users must often wait in beds reserved for rehabilitation.

Priority Process: Decision Support

The structure of the care permits an assessment of the physical, psychological and social health of each user. The transfer of information between the emergency department, the various care units and the members of the interdisciplinary team limits the repetition of information and assessment and allows a fluid continuum.

The electronic file is properly established in the nursing care and with the professionals. The organization is encouraged to pursue the computerization of the file in all care sectors.

The parallel medical file sometimes gives a fragmented profile of the user.

The files which have been thinned down due to lack of space within the unit are very well identified. The list of documents which cannot be removed is clearly defined.

Those involved in rehabilitation are familiar with the laws governing the content of files and the confidentiality associated with the transfer of information.

The organization is encouraged to continue auditing the content of the files to ensure total compliance. In the case of restraint, the family consent form must always be filed in the user's file. The restraint monitoring record containing the assessment made during the frequent visits to monitor the health and integrity of the users must stay in the file and be kept up to date.

A good process seen in the rehabilitation service is the transition process established by the doctors in the unit. Standard practice when the user is discharged is a call to the family's doctors to outline the situation and to explain the end of treatment plan. Access to the electronic data by family doctors is also a strength in the transfer of information.

Priority Process: Impact on Outcomes

The rehabilitation teams discuss their clients regularly. However, the user is not invited to these meetings and plays no active part in his personalized intervention plan. The organization is encouraged to review the process to find an integrated planning tool which could be used as an action plan for the user in his rehabilitation. The presence of the user and, if necessary, his family provides support in the integration and mobilization of the user in his rehabilitation.

The presence of users and families on clinical committees to determine priorities, review practices and assess the environment is an avenue to be explored within the program to orientate and support clinical decisions.

All participants care about the quality of the care and the safety of clients. A proactive, predictive approach should be used with input from users and families to identify risks. The involvement of all members of the team would be a powerful asset in respect of the shared responsibility within the care unit.

There is a quality chart accessible to users, families and members of staff. Quality improvement projects are correctly identified with specific results indicators. The senior management has identified three specific objectives relating to the safety of users and staff. The organization is encouraged to continue the mobilization of participants in these quality improvement projects.

The organization is also invited to review its overspill management strategies to limit the noise level and congestion within the care unit. There are currently overspill beds and interns' desks in the corridors, which creates a potentially hazardous environment for staff and users.

Standards Set: Substance Abuse and Problem Gambling - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
3.1 Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
11.8 There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team has helped staff to feel at ease with the changes taking place. We note that several structures support the quality improvement actions, such as quality committees, the leadership team, the managers, the Board and joint action with the community.

Priority Process: Competency

The team is very committed and takes into account the needs of the specific populations, such as the First Nations. The involvement of a social worker in the community is also a plus. There are key tools for users and families, such as the guide for families and the admission package. There are opportunities to better advise users' families about the support services which are available to them.

Priority Process: Episode of Care

The team offers a high-quality service to users. Partner patients sit on several operational committees and many volunteers are involved in the program. There are possibilities for improvement from the integration of the clinical services in the care offered to users and the training of the team members. One of the major problems noted by users is the absence of a methadone program outside the major cities.

Priority Process: Decision Support

The team is working with several quality tools to orientate its decisions. The principles are: quality charts in public areas, quality improvement project underway and the modification of the admissions process.

Priority Process: Impact on Outcomes

The program has done a lot of work to properly integrate the input from users and partner patients. Several surveys are used to better understand the effect of their involvement. For example, surveys with users, staff and community partners (e.g. other service providers and the police services) are used.

Standards Set: Telehealth - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.3	There are policies and procedures in place, designed with input from clients and families, to govern the delivery of telehealth services.	!
1.4	Service-specific goals and objectives are developed, with input from clients and families.	
2.3	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
4.1	Required training and education are defined for all team members with input from clients and families.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
14.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
Priority Process: Impact on Outcomes		
15.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
15.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
15.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
15.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!

17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The telehealth team is a small, very dynamic team. The team is very focused on the needs of the users who use these services.

The coverage is regional and the needs are constantly changing. There are policies and procedures which structure the entire telehealth process.

Rapid growth is creating pressure on both human and equipment resources. Over the next few years, it will be quite a challenge to respond to demand.

Priority Process: Competency

The telehealth team is very rigorous and devoted. It makes sure it can identify users before making connections. There about two thousand users, some of whom are outside the country.
The staff are available to train and support users so that the experience is satisfactory. The members of the different areas share their expertise so as to provide a consistent and high quality service.

Priority Process: Episode of Care

This service has experienced a significant increase in its activities over the last two years and is constantly adapting to the needs of its different users.

From the clinical side, we are very satisfied with the service offering which avoids users needing to travel. There are multiple services offered and these are aimed at different types of clients. Some users have the option of obtaining these services at home. Some clinics obligatorily use the telehealth services.

The team wants to implement a project for the centralized reservation of the video-conferencing rooms so as to better manage demand.

Priority Process: Decision Support

The video-conferencing systems are on the secure and exclusive network for healthcare in New Brunswick.

The user's confidentiality and privacy are respected. Once the instructions have been given to the user, the user is alone in the room with their doctor. However, if needed, he may contact the telehealth service at any time if a problem occurs or if he decides to suspend the session. Some users having special needs are accompanied by participants.

The team only gathers the data required to set up the video-conferencing session.

Priority Process: Impact on Outcomes

For the implementation of new policies and procedures, the telehealth service relies on best practice, on studies relating to what is done elsewhere in Canada and internationally, as well as on the instructions from the NIFTE2003 (National Initiative for Telehealth Framework of Guidelines). The team takes part in the provincial TMS (troubles musculo-squelettiques [musculoskeletal disorders] committee.

The team encourages users to complete an evaluation form immediately after their experience. However, the results are not communicated to clients, users and families. We encourage the team to formalize the evaluation actions and to communicate them at organizational level as well as to users and to families.

The service is continually adapting to satisfy the increase in the needs of its various types of clients.

The team is working on the development of a leaflet to promote its services.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Transfusion Services		
25.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
25.11	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		
Priority Process: Transfusion Services		

In the care units, any documentation required with regard to transfusion medicine can be found easily. Green bins containing all the equipment intended for transfusions are placed in the specific units, which is an excellent initiative.There is a form relating to consent to transfusion. In the files we looked at, all consents were present and the follow-up note complied with the procedure for the administration of blood products in all points.The transfusion medicine committee is active. We encourage them to develop and conduct surveys with users.

The efficiency of the procedures for the withdrawal and study of previous donations from the Canadian Blood Services is assessed. For training, an online session has been developed and all nursing staff involved in the administration of blood products must follow it. We were able to check the evidence of training.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: January 8, 2017 to January 23, 2017**
- **Number of responses: 23**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	4	0	96	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	N/A
3. Subcommittees need better defined roles and responsibilities.	74	9	17	N/A
4. As a governing body, we do not become directly involved in management issues.	13	4	83	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	4	9	87	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	5	95	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	30	4	65	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	0	100	N/A
11. Individual members ask for and listen to one another's ideas and input.	4	0	96	N/A
12. Our ongoing education and professional development is encouraged.	9	4	87	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	0	0	100	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	9	13	78	N/A
17. Contributions of individual members are reviewed regularly.	9	9	83	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	4	13	83	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	14	41	45	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	4	13	83	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	30	9	61	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	13	17	70	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	10	5	86	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	4	9	87	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	28	22	50	N/A
27. We lack explicit criteria to recruit and select new members.	47	26	26	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	14	27	59	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	9	91	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	0	5	95	N/A
31. We review our own structure, including size and subcommittee structure.	0	9	91	N/A
32. We have a process to elect or appoint our chair.	38	25	38	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	4	17	78	N/A
34. Quality of care	9	13	78	N/A

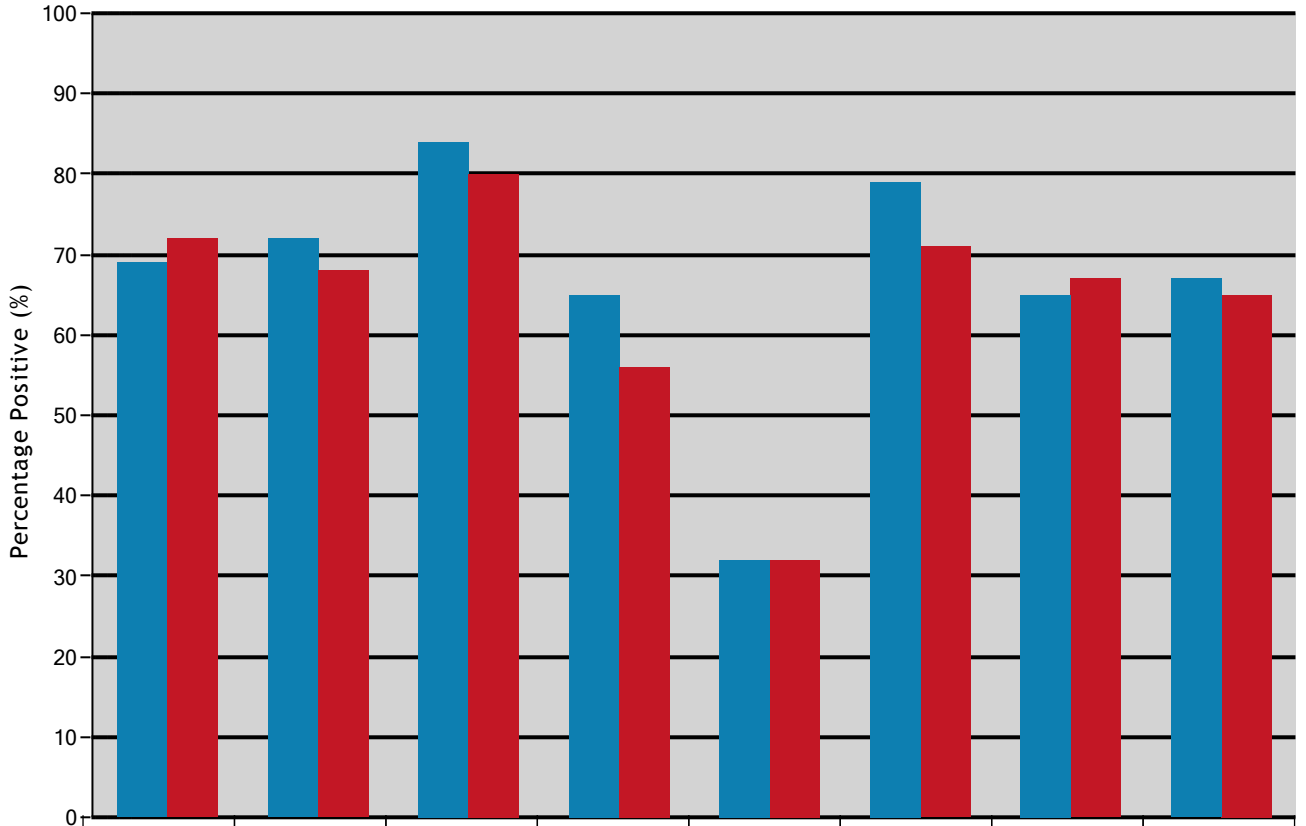
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: October 11, 2015 to November 9, 2015**
- **Minimum responses rate (based on the number of eligible employees): 362**
- **Number of responses: 2969**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	69%	72%	84%	65%	32%	79%	65%	67%
	72%	68%	80%	56%	32%	71%	67%	65%

Legend

Réseau de santé Vitalité Health Network

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2016 and agreed with the instrument items.

Worklife Pulse

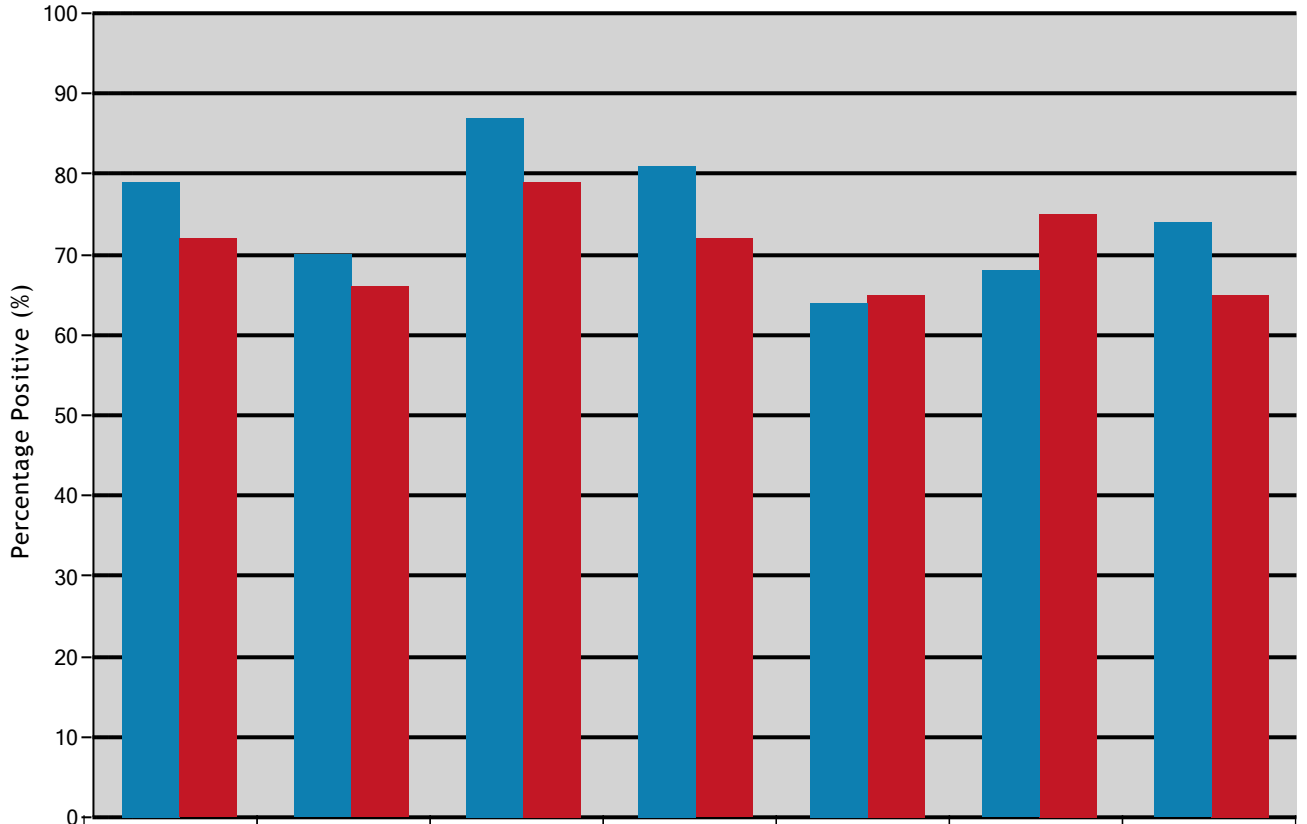
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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

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

- **Data collection period: October 11, 2015 to November 9, 2015**
- **Minimum responses rate (based on the number of eligible employees): 363**
- **Number of responses: 2572**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	79%	70%	87%	81%	64%	68%	74%
	72%	66%	79%	72%	65%	75%	65%

Legend

Réseau de santé Vitalité Health Network

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2016 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

Organization's Commentary

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

Le Réseau de santé Vitalité est fier d'avoir accueilli une équipe de visiteurs chevronnés qui ont sillonnés l'ensemble de son territoire pour échanger avec ses équipes de professionnels dédiées à rencontrer les besoins d'une vaste clientèle, et de rehausser la barre en matière de qualité et de sécurité. L'approche des visiteurs, ainsi que le partage d'expertises ont été fort apprécié par tous les professionnels, les partenaires communautaires, ainsi que les patients et leurs familles.

Le Réseau a également saisi l'opportunité d'accueillir durant cette visite un groupe d'Agrément Canada, responsable du développement de l'approche centrée sur le patient et sa famille. Étant la deuxième entité canadienne à avoir eu le privilège de contribuer à l'épanouissement de cette approche, on ne peut que souligner notre engagement et notre enthousiasme à son déploiement et son intégration à grande échelle.

Par ailleurs, remodelée en octobre 2015, notre démarche d'agrément comprenant six jalons prioritaires nous a permis d'atteindre de nouveaux sommets en matière de qualité et de sécurité. Cela a permis aux équipes d'apprécier davantage la force d'une démarche qualité coordonnée et structurée tout en intégrant au quotidien les meilleures pratiques qu'offrent le programme Qmentum.

Enfin, nous ne pouvons passer sous silence l'excellent travail de nos équipes terrain, de nos partenaires communautaires, et vous chers patients et familles qui participent vivement à notre succès. Chaque maillon d'une équipe est d'une importance capitale et nous sommes choyés de vous compter parmi nous.

Appendix A - Qmentum

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

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

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

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

Action Planning

Following the on-site survey, the organization uses the information in its Accreditation Report and Quality Performance Roadmap to develop action plans to address areas identified as needing improvement. The organization provides Accreditation Canada with evidence of the actions it has taken to address these required follow ups.

Evidence Review and Ongoing Improvement

Five months after the on-site survey, Accreditation Canada evaluates the evidence submitted by the organization. If the evidence shows that a sufficient percentage of previously unmet criteria are now met, a new accreditation decision that reflects the organization's progress may be issued.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions

Priority Process	Description
Population Health and Wellness	Promoting and protecting the health of the populations and communities served through leadership, partnership, and innovation.

Priority processes associated with service excellence standards

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

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