Forecast Report

2008

The Bermuda Hospitals Board
Paget,

Report Issue Date: June 24, 2008

ACCREDITATION CANADA
AGRÉMENT CANADA

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Confidentiality Statement

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of The Bermuda Hospitals Board.

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

While this confidential report is intended for the organization, Accreditation Canada encourages that the information herein be disclosed and promoted, in the interest of transparency, to stakeholders, clients and their community.

V.1.0.0.0

Table of Contents

About the Accreditation Report

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

This report provides guidance for future quality improvement initiatives by documenting the findings from the organization's recent accreditation survey. An initial report is left on site after the survey visit to give the organization the opportunity to immediately review results and address the areas needing attention directly after a survey visit. Shortly after the survey visit, a full report is sent to the organization, which includes the survey findings and a forecast of the accreditation decision. This report also contains a summary of the indicator and instrument data that the organization has collected. The forecast of the accreditation decision is provided to demonstrate the organization's current position within the accreditation program. The organization is then given further opportunity to follow-up on identified areas for improvement and submits further evidence of action taken to address these areas before an official accreditation status is given. Pending the organization's follow-up and submission of evidence, as well as the review by Accreditation Canada's accreditation review committee, the final report is sent to the organization, 6 months after the onsite survey. The final report includes the official accreditation decision and updated information based on the organization's updated performance measures on indicator and instrument data and evidence of action taken.

Legend

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

Items marked with a GREEN flag reflect areas that have not been flagged for improvements. Evidence of action taken is not required for these areas.

Items marked with a YELLOW flag indicate areas where some improvement is required. The team is required to submit evidence of action taken for each item with a yellow flag.

Items marked with a RED flag indicate areas where substantial improvement is required. The team is required to submit evidence of action taken for each item with a red flag.

Items marked with a WHITE flag indicate areas that are non-applicable or where data has not been collected.

¡ A brief description or interpretation of the results is provided.

- Leading Practices are noteworthy practices carried out by the organization and tied to the standards. Whereas strengths are recognized for what they contribute to the organization, leading practices are notable for what they could contribute to the field.

Items marked with an arrow indicate a high risk criterion.

Accreditation Summary

This section of the report provides a summary of the survey visit and the status of the accreditation decision.

The Bermuda Hospitals Board

Survey Date:	May 18, 2008 - May 22, 2008
Report Issue Date:	June 24, 2008
Forecast Accreditation Decision:	Accreditation with Condition
Official Accreditation Decision:	To Be Determined

The following locations were visited during this survey visit:

1 King Edward VII Memorial Hospital
2 Mid-atlantic Wellness Institute

The following service areas were visited during this survey visit:

1 Addictions/Gambling
2 Ambulatory Care
3 Blood and Transfusion Services
4 Cancer Care
5 Diagnostic Imaging
6 Emergency Department
7 Home Care
8 Hospice/Palliative Care
9 Intensive Care Unit/Critical Care
10 Laboratory
11 Long Term Care
12 Managing Medications
13 Maternal/Perinatal
14 Medicine
15 Mental Health
16 Operating Room
17 Rehabilitation
18 Surgical Care

Surveyor's Commentary

The following global comments regarding the survey visit are provided:

Strengths

The strategic plan was updated for 2008-2011. Strategic priorities have been identified and goals and objectives are articulated for each of the priorities. The overall strategic drivers are the patient experience, clinical quality, workforce, economics, and physician relations. The board will receive monthly updates on the achievement of these goals and objectives. The staff and physicians were heavily involved in this process. The staff guided the development and the prioritization of the value statements that are now used by the organization.

The board has gone through a significant renewal process in the last 18 months. It started with a retreat that led to the strategic planning process. The retreat served as an excellent orientation for several of the newer board members. Board members identified that they have grown to focus more on governance issues versus the micromanagement perspective they may have held in previous years. This is due in large part to the more balanced composition of the board membership and the trust in the new leadership team.

The government is opening two new urgent care centres on the island and it has asked the hospital to run these urgent centres. This is a testament to the renewed relationship with the government/ministry and its faith in the operations and quality of the BHB.

The 2007 ombudsman report tabled 15 recommendations that are now in varying stages of implementation. There does seem to be improvement noted in the physician relationships with the organization. The organization continues to actively look for creative ways to educate and create awareness among all staff and physicians regarding diversity, tolerance, and appropriateness of behavior.

The organization has turned around financially. There is a financial strategic plan with a three year outlook to support the strategic directive of economics. In addition there is a process in place to hold all managers accountable for their budgets. This has been done through one-on-one education delineating the expectations regarding stewardship.

The introduction of the "Staff Alley" is an excellent concept. It includes poster boards and other bulletin board information on a main hallway to the cafeteria. It is here that many of the staff accomplishments and initiatives are showcased. Examples are the RISE program (recognize, inspire, services and excellence) recipients and the perfect attendance board. Frontline staff from across the organization are recognized for their leadership and exemplary work habits.

The office of staff affairs has developed several initiatives to support new staff in the organization and Bermuda. One member of the staff affairs office is dedicated to keeping in touch over time with new staff members. Another member does outreach to the schools on the island informing students of the opportunities in health care and the personnel development opportunities that exist at the hospital.

There is a wellness program and recently the gym has been opened and there is an active walking program.

A staff satisfaction survey was completed in 2007. The results have been tabulated and communicated to the staff. Corporately the human resources team has identified the top ten opportunities for improvement and has developed an action plan to address each of the themes. The staff satisfaction survey identified that internal communication could be improved. The monthly newsletter is now published monthly and the website is being upgraded.

Each department head has identified the top three opportunities specific to each department/service. This constitutes the goals and objectives for the year. Status reports are generated for the board as these goals and objectives are linked to the overall strategic plan and the strategic directive of workforce.

Clinical education seems to be excellent. Several of the new nurses commented on the excellent orientation they received. Education certification and recertification are documented and are kept on the units for reference. A copy is kept on the personnel record of the staff member. Clinical educators and trainers are well prepared for their roles and

responsibilities.

There is a robust IMG strategic plan in place for 2009-2012. This will be important as there will be personnel changes to the department in the next 12 months. This will be necessary and helpful to guide the transition when it occurs.

The infection control program is excellent. All three infection control practitioners are certified.

The home care program is excellent with thorough client plans of care in place. Safety is foremost for this team and they have processes to ensure their safety when they do home visits.

There is an excellent quality management program in effect with a quality council that reports to the board on a regular basis. This is coupled with a performance improvement plan that further delineates the processes around quality improvement. It is considered an excellent resource for all staff. There is a work plan in place for the year and it stipulates who will be required to present to the quality council. The physicians have received a copy of the PIM; however, this is recent and the COS is working to ensure full understanding of the PIM processes.

There are over 300 active volunteers that are very supportive of the BHB. The family support program is an initiative of this group.

There is a process in place to access interpretation services if needed.

The new office of staff affairs is in place as well as a new safety officer position.

It appears that there has been significant mending of poor relationships over the past few years. In particular the BHB has a much more collegial relationship with the ministry/government as well as with its physicians. In the recent past, physician relations were less than satisfactory and were even described as "hostile" by one senior team member. This is much improved with new physician leadership and overall engagement of the physicians in decision making. The hospital is now moving towards a hospitalist program in the near future.

Areas for Improvement

The organization has identified the need to address staffing ratios to ensure that they are consistent with best practice especially on the medical and surgical units. Work is underway to address this and may form the basis for an overall organizational review of staffing complements.

The centralization of all contracts should be explored. Currently all contracts are kept by three owners, chief of staff, facilities management, and by finance. Centralization of all the contracts or at least a centralized listing of all contracts may be helpful in monitoring compliance to the contracts that are in effect. There are numerous contracts for medical devices.

The organization tracks and monitors key performance metrics. A dashboard is in place to depict these metrics overtime. The metrics are flagged as green, yellow, or red and they are reported to the board on a monthly basis. Some of the service teams have an understanding of key performance metrics and their use in quality improvements; however, this is at very high level.

The teams that are tracking indicators have not advanced the indicators to the outcome measurement level. The organization is encouraged in its efforts to emphasize the importance of these metrics to the frontlines to effect the desired change. The performance improvement plan was updated for 2008 to ensure that the frontline staff have some of the background necessary to make process improvements in their workplace.

The delineation of patient specific plans of care for the inpatients is inconsistent especially in the medical and surgical areas. Plans of care are important to support continuity of care and communication among the care team members. Care paths do exist and are used as appropriate.

The organization needs to review the OT and PT needs of the continuing care unit.

The organization is supported in its efforts to look at job descriptions that are competency based with linkages to the performance review process. This work has started.

A review of the processes related to medication management is recommended. Currently there is inconsistency in how medication orders are copied onto the physician medication and treatment order sheet. Some areas use this sheet for only medication orders and others use it for all orders. This sheet is then faxed to pharmacy for the medication order to be processed. This has contributed to medication errors and delays. The BHB is aware and plans to strike a team to look at the standardization of medication management soon.

An electronic system to streamline the booking and scheduling processes in ambulatory care may be beneficial. Currently this is a cumbersome manual process.

Patient education materials exist and the teams are encouraged to continue to develop materials in languages pertinent to the population it serves. For example there is a large Portuguese population on the island.

Challenges

The ability of staff and physicians to act as change agents is a challenge. The staff and physicians are clinically sound but many of the staff are foreign and they are varied in their practices and their experiences with quality improvements processes and techniques. The organization has just completed a performance improvement plan for 2008 - 2010. It delineates the expectations related to quality and has outlined indicators of performance. It also provides a basic understanding of the tenets of quality improvement techniques and processes.

Standardization of practices across the organization given the varying backgrounds of many of the personnel may pose a challenge from time to time. The leadership of the dedicated director of nursing will be helpful in guiding standardization across the organization.

Succession planning and leadership development is a challenge.

The organization is encouraged to update all job descriptions to a competency based approach. This should also occur in the performance management process to ensure that there is alignment in the processes.

The age of the facility especially the medical and surgical units is challenging. A master estate plan has been developed and it now rests with the ministry for approvals. In the meantime the upkeep of the care areas continues to be an area of focus.

Education of staff and managers on the use and interpretation of data is needed. Data analysis is required as a next step but they are not all skilled in data interpretation.

Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

The Bermuda Hospitals Board wishes to thank Accreditation Canada and the surveyors for collaborating with us to improve the quality of care in our organisation. Without the surveyor's commentary which would include unit specific information, we cannot accurately assess whether the on-site report captures the organization's successes. The new Tracer Methodology was found to be much more flexible and interactive between front-line staff and surveyors. Consequently, most staff really felt they were part of the accreditation process this year!

As was previously discussed with Accreditation Canada surveyors, the BHB has experienced instability among leadership since our last Accreditation in 2005. In 2006, a new Premier was elected and he introduced a new Cabinet and new Minister of Health. At about the same time, a new CEO, Mr. David Hill was appointed. In 2007, Mr. Hill introduced a new management structure and government appointed a new Bermuda Hospitals Board Chairman and Deputy Chairman. We now feel that the new leadership has the requisite stability, experience and skills to drive through necessary changes.
The Governing Board held a comprehensive strategic planning session in early 2008. This offsite reviewed the vision, mission and value statement which had been amended to incorporate comments received from hospital staff. The vision, mission and values became the foundation for the 2008-2011 Strategic Plan. We feel that the implementation of an Accreditation Communications Team (ACT) was a great way to communicate the new strategic plan. This was done through multiple forums which included town halls, manager's meetings, emails, posters, learning lunches and name badge attachments. The "Lets Get It Started" video which was presented to the surveyors was a great example of the engagement of all staff at the BHB. We also feel this video represented a great "best practice" initiative.

After working intensively with the Board for the development of the new Strategic Plan, we revisited and reviewed the Quality Performance Roadmap (QPR) for the Governance Team. The communication process was so effective that it resulted in nearly all of the red-flagged result areas of the report to convert to green! At this time, we are currently working with the senior and middle managers to further develop departmental goals and objectives which include performance and outcome indicators that correlate with the strategic business plan.

One of the Board initiatives is to meet best practice/patient safety standards. Consequently, we hired a new Patient Safety Officer in early January 2008 who assisted with the implementation of the Required Organizational Practices and patient safety initiatives which included the Speak Up Programme. This role will be instrumental in the development of a full Patient Safety Programme for the organization. We plan to continue with the education of staff, families and visitors about their role in promoting patient safety. Another successful patient safety initiative was the implementation of verbal shift handover reporting. In partnership with the Chief of Staff, we effectively implemented the Medication Reconciliation process. We will continue to monitor the progress of this important patient safety initiative. Another initiative was the introduction of SBAR as a standardized communication tool. It is currently used throughout the hospitals and its effectiveness will be audited on a quarterly basis.

The BHB's Performance Improvement Plan for 2008-2011 is a comprehensive document that denotes the organisation's strategy to monitor and improve the performance of all care and services provided at the BHB. The strong administrative physician membership on the Quality Council promises to heighten ongoing quality improvement efforts. The new Chief of Staff will help to drive all quality improvement initiatives through this committee. Dr. Thomas III is currently developing a number of educational programmes for the new Administrative Physician Directors to help enhance their understanding of quality improvement.
One great new patient care initiative which was partially implemented as of April 1st, 2008 is the Hospitalist Programme. This programme has been designed to help elevate the level of care delivered to hospitalized patients, without creating extra strain on already overburdened general practice and specialists. A Director for Hospitalists Services has been hired and another full time hospitalist has been hired since the on-site survey.

It would be remiss not to mention the number of renovations that have been completed in the current facility since the 2005 Accreditation award. Most patient care areas have had major ward renovations which include new lighting, painting, and acquisition of new patient furniture, visitor furniture, patient and bulletin boards. We are currently

planning the complete renovation of all patient rooms and there is a capital project plan in place that addresses this project.

The Diagnostic Imaging Department recently upgraded their technology with the purchase of a new 8-slice CT scanner and the upgrade of the current MRI machine to eight channels. We are happy to say that we can now offer next day appointment with reports generated within 24-48 hours of service! This will definitely help to increase patient satisfaction!

On page 9, under the Ambulatory Care standards, there were 22 unresolved criteria sited in the On-site Report. The two areas that use these standards are the Hyperbaric/Wound Care Department and the Orthopaedic Outpatient Clinic. The latter is primarily run by independent medical practitioners who use our facility to examine their private patients. As such, it has been historically treated as a physician's office and not a hospital program. This unique situation may need to be revisited concerning how we fit this into the Accreditation process. Accordingly, standard criteria such as 7.2/7.5/8.2/10.4/10.5/11.5/12.2/13.2/17.1/17.3/17.4 and 17.5 were not implemented or monitored as in other departments or units. On page 23, it was stated that the Orthopaedic Clinic achieved 100% compliance with medication reconciliation, when in actuality that data is not collected.

Rehabilitation Services has now hired a new, full time Program Manager who will consolidate the functions of all Allied Health Services into one Department as mentioned during the on site survey. This will allow us to effectively implement and monitor the Rehabilitation Standards and criteria as sited in the report.

We acknowledge the priority action items listed under the Managing Medications Standards .The BHB has secured the assistance of outside pharmacy consultants who will review our current medication management process with the aim of helping to implement a safer system for both hospitals. We realize that we are challenged by the worldwide pharmacist shortage and we must continue to think of creative ways to ensure that safe medication management standards are met. We are confident that this review will enable us to move forward with all the Accreditation Canada Medication Management Standards.
We are currently revisiting the standards where high-priority deficiencies were found. Action plans with specific outcome measures will be developed to monitor compliance. In addition to what has been stated above, our long-term goal is to demonstrate full compliance with each of the standards before the next accreditation survey. We are also seeking to achieve compliance with the NEW ROPs while improving the achievements made with previously established ones.

Thank you for allowing us to use the Accreditation Canada national standards to survey our organization. With the introduction of the ROPs, we have been able to increase the level of patient safety within the BHB. The QPR will allow us to continue to improve the standard of care we deliver.

Overview by Quality Dimension

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

Quality Dimension	Met	Unmet	N/A	Total
Population Focus (Working with communities to anticipate and meet needs)	65	5	1	71
Accessibility (Providing timely and equitable services)	101	1	3	105
Safety (Keeping people safe)	322	33	17	372
Worklife (Supporting wellness in the work environment)	164	2	2	168
Client-centred Services (Putting clients and families first)	143	10	7	160
Continuity of Services (Experiencing coordinated and seamless services)	57	3	0	60
Effectiveness (Doing the right thing to achieve the best possible results)	524	57	4	585
Efficiency (Making the best use of resources)	68	0	1	69
Total	1444	111	35	1590

Overview by Standard Section

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

Standard Section	Met	Unmet	N/A	Total
Governance	99	1	0	100
Proactive and Supportive Organization	111	3	1	115
Infection Prevention and Control	70	1	0	71
Managing Medications	136	7	0	143
Ambulatory Care	77	22	4	103
Critical Care Services	106	2	4	112
Diagnostic Imaging Services	86	7	2	95
Emergency Department Services	90	8	1	99
Home Care	91	0	2	93
Long Term Care	90	3	0	93
Medicine Services	80	12	1	93
Mental Health Services	85	7	1	93
Obstetrics/Perinatal Care Services	79	11	3	93
Operating Rooms	87	5	2	94
Rehabilitation	72	7	14	93
Surgical Care	85	15	0	100
Total	1444	111	35	1590

Overview by Required Organizational Practices (ROPs)

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

Criteria	Required Organizational Practices
Proactive and Supportive Organization 14.7	The organization clearly delineates the roles, responsibilities, and accountabilities of staff and other providers for client care and safety.
Infection Prevention and Control 1.2	The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends over time, and shares this information throughout the organization.
Ambulatory Care 8.2	The team reconciles the client's medications as part of the assessment process, and with the involvement of the client.
Ambulatory Care 11.3	The team uses both written and verbal communication to inform and educate its clients and families about their role in promoting safety in the service environment and/or the home.
Ambulatory Care 11.4	The team uses at least two client identifiers before providing any services or procedures.
Ambulatory Care 11.5	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Ambulatory Care 13.2	The team reconciles medications with the client at referral or transfer, and communicates the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.
Diagnostic Imaging Services 12.5	The team informs and educates its clients and families about their role in promoting safety, using both written and verbal communication.
Diagnostic Imaging Services 12.7	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Long Term Care 10.5	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Medicine Services 10.5	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Mental Health Services 10.3	The team uses both written and verbal communication to inform and educate its clients and families about their role in promoting safety.
Mental Health Services 10.5	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.
Obstetrics/Perinatal Care Services 10.5	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Rehabilitation 10.5	The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.
Surgical Care 10.3	The team uses both written and verbal communication to inform and educates its clients and families about their role in promoting safety.

Detailed Accreditation Results

System-Wide Processes and Infrastructure

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

Findings

The table below indicates the specific criteria that require attention, based on the accreditation review. Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Criteria	Location	Priority for Action
Governance		
The governing body regularly evaluates its communication strategies, and makes improvements, as required.	16.6	
Proactive and Supportive Organization		
The organization reviews its disasters and emergency plans and procedures quarterly, and revises them as necessary.	13.7	↑
The organization clearly delineates the roles, responsibilities, and accountabilities of staff and other providers for client care and safety.	14.7	↑
There is evidence of attention of staff roles and responsibilities for client safety in job descriptions, performance reviews/appraisals, staff handbooks, orientation material, newsletters, client safety committee minutes, etc.	14.7.2	
The organization selects and monitors both process and outcome measures to evaluate organizational performance.	16.6	↑

Surveyor Comments

There is a contingency fund for emergencies that may arise.

Human Resources (HR) planning is in the developmental stages for all professional groups. The nursing department will have completed its plan by September 2008. The physician/clinical HR planning is under the direction of the chief of staff. They plan to align the two HR plans but this has not yet occurred.

The organization conducted a staff satisfaction survey in 2007. The results have been tabulated and shared with staff. Opportunities for improvement have been incorporated into the HR and the department/service areas goals and objectives.

The board does not conduct a formal evaluation of its accomplishments but it plans to do so in the future. The board committees evaluate their effectiveness and report this to the board.

There is an excellent office of staff affairs.

There is a dedicated and enthusiastic team that addresses patient flow issues. The team has developed an in-house bed tracking system that is utilized to monitor occupancy and bed availability. Data is also being collected on discharge times and utilization that is physician specific. There has been an improvement in the backlog of admissions in the emergency department (ED). The designated overflow area that was highly utilized in the past (6S) has been rarely used in recent months.

There are linkages with the disaster planning committee and the emergency preparedness committee related to bed flow issues.

There is a significant amount of education to create awareness regarding proactive discharge planning throughout the organization. The new hospitalist program will also support the smooth flow of patients throughout the system.

The hospital is encouraged to continue to develop metrics to monitor flow, and provide further delineation of the expectations related to appropriate utilization in all of the job descriptions for managers and staff.

There are many examples of excellent communication vehicles in place. Internally there is a monthly staff Communiqué, bulletin boards for celebrating staff or sharing information, town hall meetings, and email. Externally there are media briefs, public meetings, and the Pulse community newsletter that is published quarterly.

The hospital has focused on ensuring data integrity; the next area of focus will be on ensuring that the data is user friendly for the managers.

The staff have commented that communications have improved but there should be a formal evaluation of the internal and external communications strategies to ensure that the organization's message is being heard. There is a plan to do an evaluation soon.

There are many linkages with off shore health care agencies such as John Hopkins. There is an excellent library service with a dedicated decision support person in place. Confidentiality processes and policies are in place. The IMG strategic plan was updated for 2009 to 2012. The website was updated with more focus on health promotion and health information.

The organization is collecting volume and process data but has not moved to outcome indicators. The team has focused on data quality and needs to further develop indicators. The senior team, the board, and the middle managers have an understanding of the indicators being tracked but this needs to be rolled out across the organization at all levels. It is important to note that the clinical teams have their indicators and are expected to discuss them at staff meetings. The poster boards on the clinical team areas depict their indicators.

There is good use of space in the environment and compliance with legislation. There is evidence of staff and client health and safety during the recent construction in long term care. Back up systems are in place and a redundancy plan for any utility failure exists. There is a plan to enhance the care of the environment with more attention to recyclables.

The hospital sees the client as a customer. The design, development, and implementation of a hotel model for Environmental Services promotes this customer service model through an approach that provides non-clinical staff with the expertise to provide services that empower the client and meet identified service needs in a safe and respectful manner. The client's room and surroundings, linen and laundry, and food service are provided by supervised staff with the knowledge and skill sets to recognize the client as a customer. The staff receive a seven-day orientation and ongoing mandatory inservices. Part of the approach that supports quality care and services is an ongoing assessment using a patient environment checklist. The culture of the organization encourages the client to articulate any dissatisfaction with the quality of care from environmental services.

A waste management committee is in place. There is a recycling process and they are in the process of expanding this beyond the present parameters. This planned initiative includes an education program for staff and patients to reduce the volume of waste in the organization.

While the buildings at KEMH and MWI are both older buildings, there is evidence of major attempts to keep the present buildings safe and attractive in keeping with the style and culture of the community. There are recently renovated intensive care and long term care units and the exterior of the building and the landscaping plans were addressed as well.

There is compliance with all fire drills, and follow up debriefings were presented as evidence.

Because the buildings are old, there is a need for improvement in many departments to increase the safety of staff and clients. There was a notable lack of space in outpatients where it is often necessary to provide pharmaceutical counseling without a private space. Staff lounges on each ward are very small and not optimal for employee work breaks and meals. OHS meeting minutes indicated that environmental problems of mould, exposed wires in the gym, asbestos, and plywood nailed to the window exist and need attention. This is an old building but priority attention needs to be given to these patient and employee hazards. This was a recommendation of the last accreditation report. Apparently requisitions have been put in for this work but there has been no repair work done.

The biomedical engineering team advised that there is consultation around the procurement of new equipment.

Sterilization is done mainly in the sterilization area to avoid flash sterilization. A flash sterilizer is in the budget for the operating room.

A prototype bio-incinerator is used. The organization owns the water and sewage treatment plant.

MWI reports that preventative maintenance on items such as saws needs improvement. MWI housekeeping is contracted and most of the building is clean.

Occupational health and safety (OHS) minutes were reviewed and followed up. They demonstrate that MWI areas are in a dangerous state of repair related to asbestos and plywood on the windows. Patients were evacuated to a nursing home recently. No patients are presently in the area. They will be moved back to a newly renovated area as per the QI and risk management staff.

There is evidence of testing emergency plans through fire drills and other virtual disasters. The team reports a review and updating of all elements of the emergency preparedness plan. The designated role of the emergency nurses on each alert level was articulated and documented as a result of a debriefing after the last test of a mock disaster. Emergency drills/testing, however, is not done quarterly at MWI.
Pandemic planning follows the protocol. This is an island-wide initiative and government members and emergency measures staff are on this team. It is a very collaborative process.

This team has received excellent education on ethics and it uses a very proactive approach to address organizational ethics. An administrative tracer and a clinical tracer were done and they indicated that within the parameters of the British law that governs the island, the team has used the ethical framework and team expertise to seek solutions. This is a very active and well rounded team. A more active role of the team in policy development beyond the present policy review would be beneficial. The organization would benefit from administrative support.

Direct Service Provision

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

Findings

The table below indicates the specific criteria that require attention, based on the accreditation review. Following the survey, once the organization has the opportunity to address the unresolved criteria and provide evidence of action taken, the results will be updated to show that they have been addressed.

Criteria	Location	Priority for Action
Infection Prevention and Control		
The organization tracks infection rates, analyzes the information to identify clusters, outbreaks, and trends over time, and shares this information throughout the organization.	1.2	↑
Staff know the relevant infection rates.	1.2.2	
Managing Medications		
To help differentiate products with similar labeling/packaging, the organization obtains products from different manufacturers.	3.3	↑
The organization stores medications intended for administration in client care units in labeled, unit-of-use containers.	7.4	↑
The organization uses a computerized prescriber order entry (CPOE) system with the capacity to guide the use of accepted drugs and established protocols, and alert attention to unsafe orders during input.	10.2	↑
The pharmacy receives a complete, clear, and readable medication order that includes drug interaction and allergy information.	10.4	↑
The pharmacy uses a biohazard hood for antineoplastic products.	12.6	↑
The organization has a process to determine when, or if, medications can be returned to the pharmacy.	15.5	
The pharmacy has a quality control mechanism to return restocked products to the correct location.	15.6	
Ambulatory Care		
The team's leaders work together with staff, service providers, and volunteers to develop team goals and objectives.	2.1	
The team's goals and objectives are clear, measurable, and directly linked to the organization's mission or strategic plan.	2.2	
The interdisciplinary team regularly evaluates its functioning and makes improvements as needed.	3.7	
When scheduling services for clients, the team coordinates with other service areas in the organization to schedule multiple services for the same client on the same day, as applicable.	7.2	
The team monitors and works to reduce the length of time clients wait for services from the time the appointment was scheduled to begin.	7.5	

The team reconciles the client's medications as part of the assessment process, and with the involvement of the client.	8.2	↑
The process includes generating a single documented, comprehensive list of the current medications that the client has been taking.	8.2.2	
The process includes documentation that differences between the two lists have been identified, discussed, and resolved, and that appropriate modifications have been made to the new medications that have been ordered.	8.2.4	
These processes are a shared responsibility involving the client, nursing staff, medical staff, and pharmacists, as appropriate.	8.2.5	
The organization has an implementation plan for the spread of the medication reconciliation process, across the organization, before the next accreditation survey.	8.2.6	
Medication Reconciliation	8.3	
The team collects data on medication reconciliation as part of the assessment process.	8.3.1	
Percentage of clients who receive medication reconciliation as part of the assessment process.	8.3.2	
The team follows up with clients and providers to determine whether the ambulatory services provided contributed to the achievement of the client's service goals and expected results.	9.7	
The team obtains the client's informed consent before providing services.	10.4	↑
When clients are incapable of giving their informed consent, the team refers to the client's advance directives and/or obtains consent using a substitute decision maker.	10.5	
The team uses both written and verbal communication to inform and educate its clients and families about their role in promoting safety in the service environment and/or the home.	11.3	↑
Clients consistently indicate that they have received both written and verbal communication about their role in client safety.	11.3.3	
The team uses at least two client identifiers before providing any services or procedures.	11.4	↑
The team uses at least two client identifiers before providing any service or procedure.	11.4.1	
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	11.5	↑
The team evaluates the fall prevention strategy on an ongoing basis to identify trends, causes, and degrees of injury.	11.5.4	
The team uses the evaluation information to make improvements to its fall prevention strategy.	11.5.5	
The team records, stores, handles, and disposes of samples and experimental medications in the same manner as any other medication.	12.2	↑
The team reconciles medications with the client at referral or transfer, and communicates the client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	13.2	↑
The organization has an implementation plan for the spread of the medication reconciliation process at referral and transfer, across the organization, before the next accreditation survey.	13.2.6	
The team works with the client's other providers to develop and document a comprehensive and integrated follow-up plan.	13.5	
Following transition or end of service, the team contacts clients, families, and referring providers to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	13.6	↑

The team identifies and monitors process and outcome measures for Ambulatory Care services.	17.1	↑
The team monitors clients' perspectives on Ambulatory Care services.	17.3	↑
The team monitors the achievement of its goals and objectives.	17.4	↑
The team compares its results with other similar interventions, programs, or organizations.	17.5	↑
The team uses the information it collects about performance to identify successes and opportunities for improvement, and makes improvements as needed.	17.6	↑
Critical Care Services		
If the team offers outreach services in the form of a rapid response or medical emergency team, it defines the role of this team and communicates it to other teams in the organization.	3.5	
Medication Reconciliation at Admission.	7.5	
Percentage of clients who receive medication reconciliation at admission.	7.5.2	
Diagnostic Imaging Services		
The team's service providers meet at least quarterly to discuss changing client needs, and makes changes to its services as appropriate.	1.3	
The manual of policies and procedures includes detailed procedures for positioning.	5.4	
As policy and procedure manuals are updated, previous versions are retained for at least 10 years to comply with legal requirements.	5.10	
The team develops a safety manual.	12.3	↑
The team informs and educates its clients and families about their role in promoting safety, using both written and verbal communication.	12.5	↑
There are both written and verbal communications for clients and families about their role in safety.	12.5.1	
Clients consistently indicate that they have received both written and verbal communication about their role in client safety.	12.5.3	
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	12.7	↑
The team evaluates the fall prevention strategy on an ongoing basis to identify trends, cause(s) and degree(s) of injury, and uses this information to make improvements.	12.7.4	
The team retains repeat/reject records for a minimum of two years.	15.5	↑
Emergency Department Services		
The team has the workspace needed to deliver effective services in the Emergency Department.	2.9	
The team collects information about waiting times for services and information, and the average length of stay (ALOS) in the Emergency Department.	6.10	
Medication Reconciliation following Triage.	8.3	
The team collects data on medication reconciliation following triage.	8.3.1	
Percentage of clients who receive medication reconciliation following triage.	8.3.2	
The team reviews and fills prescriptions, and dispenses medications in a timely and accurate way.	9.6	↑
The team has timely access to the appropriate information technology that impacts client care decisions.	12.1	
The staff, service providers, and volunteers use information technology to share information with the interdisciplinary team.	12.2	

The team regularly reviews the selected evidence-based guidelines to make sure they are up to date and reflect current research and best practice information.	13.3	
The team compares its results with other similar interventions, programs, or organizations.	14.7	↑
Long Term Care		
Medication Reconciliation at Admission.	7.3	
Percentage of clients who receive medication reconciliation at admission.	7.3.2	
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	10.5	↑
The team uses the evaluation information to make improvements to its falls prevention strategy.	10.5.5	
The team monitors clients' perspectives on long term care services.	16.2	↑
Medicine Services		
The team's leaders work together with staff, service providers, and volunteers to develop team goals and objectives.	2.1	
The team's goals and objectives are clear, measurable, and directly linked to the organization's mission or strategic plan.	2.2	
The team's leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.6	
The team works with the client and family to identify the client's individualized service goals and expected results.	8.1	
The team develops an integrated and comprehensive service plan for each client.	8.2	
The team shares the client's service plan in a timely way with all of the client's providers.	8.3	
The team monitors whether clients achieve their service goals and expected results, and makes adjustments to the service plan as appropriate.	8.5	
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	10.5	↑
The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes and degrees of injury.	10.5.4	
The team uses the evaluation information to make improvements to its fall prevention strategy.	10.5.5	
Following transition or discharge, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	12.5	↑
The team identifies and monitors process and outcome measures for medicine services.	16.1	↑
The team monitors the achievement of its goals and objectives.	16.3	↑
The team compares its results with other similar interventions, programs or organizations.	16.4	↑
Mental Health Services		
Medication Reconciliation at Admission.	7.3	
Percentage of clients who receive medication reconciliation at admission.	7.3.2	
The team works with the client and family to identify the client's individualized service goals and expected results.	8.1	
The team monitors whether clients achieve their service goals and expected results, and makes adjustments to the service plan as appropriate.	8.5	

The team uses both written and verbal communication to inform and educate its clients and families about their role in promoting safety.	10.3	↑
There are both written and verbal communications for clients and families about their role in safety.	10.3.1	
Clients consistently indicate that they have received both written and verbal communication about their role in client safety.	10.3.3	
The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	10.5	↑
The team evaluates the fall prevention strategy on an ongoing basis to identify trends, causes, and degrees of injury.	10.5.4	
The team uses the evaluation information to make improvements to its fall prevention strategies.	10.5.5	
The team responds to clients' requests to bring in or self-administer their own medications.	11.5	
Following transition or discharge, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	12.5	↑
Obstetrics/Perinatal Care Services		
The team proactively collects information about its clients and the community.	1.1	
The team's leaders work together with staff, service providers, and volunteers to develop team goals and objectives.	2.1	
The team's goals and objectives are clear, measurable, and directly linked to the organization's mission or strategic plan.	2.2	
The interdisciplinary team regularly evaluates its functioning and makes improvements as needed.	3.7	
Medication Reconciliation at Admission.	7.3	
Percent of clients who receive medication reconciliation at admission.	7.3.2	
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	10.5	↑
The team evaluates the fall prevention strategy on an ongoing basis to identify trends, causes, and degrees of injury.	10.5.4	
The team uses the evaluation information to make improvements to its fall prevention strategy.	10.5.5	
Following transition or discharge, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	12.5	↑
The team links with its partners and other organizations to share research and best practice information.	15.5	
Staff and service providers communicate the evidence-based guidelines, research, and best practice information to clients receiving services.	15.6	
The team monitors the achievement of its goals and objectives.	16.3	↑
The team uses the information it collects about performance to identify successes and opportunities for improvement, and makes improvements as needed.	16.5	↑
Operating Rooms		
The team uses team meetings, committees, interdisciplinary conferences, and information systems to support communication and problem solving among team members and other teams or services in the organization.	1.4	↑
The team follows a policy and process to resolve conflicts between team members.	1.5	

The interdisciplinary team regularly evaluates how well it functions as an interdisciplinary team and makes improvements as needed.	1.6	↑
The team uses a smoke evacuation system when an electrosurgical unit is operated.	9.5	↑
The team benchmarks or compares its results with other similar interventions, programs, or organizations.	14.5	↑
Rehabilitation		
The team's leaders work together with staff, service providers, and volunteers to develop team goals and objectives.	2.1	
The team's goals and objectives are clear, measurable, and directly linked to the organization's mission or strategic plan.	2.2	
The team's leaders regularly evaluate and document each team member's performance in an objective, interactive, and positive way.	4.6	
The team implements and evaluates a fall prevention strategy to minimize the impact of client falls.	10.5	↑
The team uses the evaluation information to make improvements to its fall prevention strategy.	10.5.5	
The team identifies and monitors process and outcome measures for rehabilitation services.	16.1	↑
The team monitors the achievement of its goals and objectives.	16.3	↑
The team compares its results with other similar interventions, programs, or organizations.	16.4	↑
Surgical Care		
The team proactively collects information about its clients and the community.	1.1	
The team uses the information it collects to define the scope of its services.	1.2	
The team's leaders work together with staff, service providers, and volunteers to develop team goals and objectives.	2.1	
The team's goals are clear, measurable, and directly linked to the organization's mission or strategic plan.	2.2	
Each team member is aware of the other team members' roles and responsibilities, and how these contribute to achieving the team's goals and objectives.	3.2	
The interdisciplinary team regularly communicates and meets to coordinate services, roles, and responsibilities, and to make improvements to processes or services.	3.6	
The interdisciplinary team regularly evaluates its functioning and makes improvements as needed.	3.7	
The team follows set criteria and gathers input from all providers when deciding whether to offer services to potential clients and families.	6.7	
The team records in its files its decision about whether to offer services.	6.8	
Medication Reconciliation at Admission.	7.9	
The team collects data on medication reconciliation at admission.	7.9.1	
Percentage of clients who receive medication reconciliation at admission.	7.9.2	
The team uses both written and verbal communication to inform and educates its clients and families about their role in promoting safety.	10.3	↑
Clients consistently indicate that they have received both written and verbal communication about their role in client safety.	10.3.3	
The team links with its partners and other organizations to share research and best practice information.	15.5	
The team identifies and monitors process and outcome measures for surgical services.	16.1	↑
The team sets monitors the achievement of its goals and objectives.	16.3	↑

The team compares its results with other similar interventions, programs, or organizations. 16.4

Surveyor Comments

Long Term Care

Families and clients receive verbal introduction regarding the unit operations including patient safety. There used to be an information booklet available but it is currently being reviewed according to the staff. The team is encouraged to ensure that families and clients receive both written and verbal information about their roles and responsibilities on the unit. (6.4)

Medication reconciliation starts at the point of referral. Referrals can be taken from the community or from the acute inpatient areas. Upon referral a geriatric assessment process (GAP) analysis is completed. A component of the GAP is the listing of all medications. Upon admission the list is verified by the physician and the pharmacist. Nurses are part of this reconciliation process. The team is not aware of the percentage of clients who receive medication reconciliation on admission but this is now being tracked corporately. The monitoring of the percentage compliance has been in effect for only one month. They plan to share this data with each of the programs once there is enough data to analyze.

There is at least a yearly case review of every patient in the CCU. The team would like to move towards a more frequent review of at least every six months or perhaps even quarterly. The program did not have a medical lead for a period of time so this case review process was affected. The review process is interdisciplinary and includes nurses, physicians, occupational therapy (OT), physiotherapy (PT), social work (SW), and the family members.

Staff are aware that there is an ethical committee but they are often on their own when it comes to timely ethical decisions. The staff in the CCU know to use the patient case conferences for ethical debate and resolution but this may not be done in the required timeframe. (9.8)

The clinical educator does an annual review related to the use of infusion pumps. This was validated by several frontline nursing staff members.

The team has partnered with the Bermuda College in the placement of nurses aide students. The students have their practical placements on the unit.

There is an information strategic plan and each team had input into the prioritization of technology and information needs. Staff received computer workshops to enhance their computer skills. This workshop was mandatory for nurses.

There is no formal patient satisfaction survey but this is being considered for the future. The team receives feedback from the resident council but this may not be representative of all of the families' perceptions of care.

The new safety office sees all admissions and provides them with verbal and written information regarding their roles and responsibilities related to safety. Staff are encouraged to be a part of these discussions.
There is an excellent falls strategy that is well integrated across the organization. There does not appear to have been any evaluation on the program; however, the teams are all monitoring falls at a corporate and team level.

There is a dedicated clinical educator for the program area. The team has the services of OT and PT along with SW but the clients would benefit from additional OT/PT support. A rehabilitation services review is under way in Bermuda. This review may inform the program about the resources required to carry out the level of service necessary for the patients. There is a well developed activation program for the residents in the CCU seven days per week.

Rehabilitation

This service is a day hospital; therefore, services are provided on an outpatient basis, five days per week. There are no formal written goals and objectives for this program area currently (2.1 and 2.2).
All job descriptions are currently being revised to a competency based job description. Alignment and linkages to the performance management process are envisioned in the future.

The "Staying Steady" program is in place. The team is encouraged to further develop indicators to ensure that it is actually affecting or achieving the intended patient outcomes (16.1, 16.3, and 16.4).

Diagnostic Imaging (DI)

The team regularly discusses changing needs and responses but this is not necessarily done quarterly (1.3). A positioning policy is not included (5.4).

Calibrations are done according to the manufacturers' specifications. Safety information is primarily verbal, though in some high risk instances it is given in writing and the patient may sign to acknowledge the information. Safety manual development is in progress and is near completion (12.3). American standards are used for radioactive materials.

Pediatric Medicine

Performance evaluations include a thorough review of competencies; however, they have not been completed within the prescribed timeframes for all staff that are three months and annually for five years (4.6).

No health information legislation is in place in Bermuda. (13.2)

No client specific goals and objectives are established as part of a comprehensive service plan (8.1-8.5).

The unit has recently moved towards a unit dose method for medication administration; however, the medication administration process and environment has not been adjusted to facilitate the success of the unit dose strategy. This is particularly important due to the large number of oral liquid medications given on this unit (11.1).

The team does not formally contact clients, families, or referral agencies following discharge to evaluate the effectiveness of services (12.5).

The team works within the organizational mission, vision, and values but it has not established an operational plan including goals and objectives specific to pediatric services (2.1).

The team meets the standards regarding the patient safety culture but it is encouraged to strengthen its efforts regarding regular safety briefings and the use of incident report information for improvement (10.3).

Mental Health

The team is encouraged to adopt charting and documentation strategies consistent with the King Edward site such as DAR charting (13.1).

The teams are encouraged to ensure that service goals are developed and clearly documented; they should evaluate the achievement in all programs. While clearly in place in most areas, some inconsistency is noted (8.1-8.5).

Under specific circumstances, patients may bring in their own medications with the physician's order.

Consistent follow up with clients, families, or referral organizations is not in place to evaluate effectiveness (12.5).

There are minimal student placement opportunities.

Good verbal education is provided for clients and families about their role in safety. Written safety communications are not consistently available (10.3).

The falls prevention program is used throughout mental health services, but it has not been in place long enough to support evaluation of the strategy (10.5).

Ambulatory Care

Patient scheduling for ambulatory clinics is an onerous manual process. The organization is encouraged to consider an electronic scheduling solution for these clinics to streamline the process, allow for better coordination of appointments, and allow for appropriate monitoring of indicators including the next available appointment, wait time, and no show rates (15.1 and 7.2).

The wound clinic, hyperbaric clinic, and diabetes clinic are commended for the use of evidence based guidelines and constant monitoring and updating of guidelines in keeping with best practice.

While the orthopedic clinic recognizes an opportunity for improvement with currently more than 60 appointments and three hour wait times on specific clinic days, no formal quality improvement initiatives have been undertaken to facilitate improvement (7.5).

Medication reconciliation is conducted in the wound clinic. The diabetes clinic is involved in research trials for medications that are dispensed by the clinic nurse with no pharmacy involvement. A form of medication reconciliation is done but it is inconsistent with the robust practices recently implemented for other inpatient and ambulatory services. The pharmacy department was involved in the establishment of processes around the clinical trial.

Formal evaluation of outcomes is encouraged (9.7).

Implied consent for most services is assumed.

Orthopedic clinic staff are encouraged to better familiarize themselves with the "speak up" initiative (10.11).

The orthopedic clinic is encouraged to document a business or strategic plan in keeping with the organizational strategic plan to articulate its goals, objectives, indicators, and monitoring mechanisms (2.1).

The wound care team has an exemplary quality improvement culture in place. The orthopedic team is encouraged to participate in some quality improvement initiatives (3.7).

While considerable written information is available for patients regarding safety, the patients spoken to reported receiving only verbal safety information and instruction (11.3).

The use of armband identification is a new practice in the orthopedic clinic.

The orthopedic clinic does not monitor outcomes or indicators and does not have goals and objectives. The wound clinic has done this very well and can be used as an example to assist development in other ambulatory areas. The ambulatory clinics are encouraged to clearly articulate the patient treatment goals and monitor and document the achievement of goals at the end of service.

Orthopedic policies and procedures require regular review and they were last reviewed in January 2005.

Medication Management

Three files were selected for tracers from the adverse events files. Two were near misses and both patients were discharged but the files were reviewed.
Home Care Decision Support

While the country has not developed privacy legislation, there is signed confidentiality document on all employee files and agreement contracts with home care clients. The episode of care observed handled all matters pertaining to the client very discreetly.

All home care clients are seen in the hospital before discharge where the inpatient client file is reviewed by the home care program. This provides adequate information to admit the client into the home care service.

The organization's QI and risk management program encompasses the home care division.

The team suggests that laptops would provide more effective use of time. Information systems will be upgraded to collect and manage data and indicators.

The knowledge and skills required to deliver quality home care are continuously enhanced through participation in lectures.

The team connected to its colleagues to continue the care of patient who were hospitalized. The team is involved in ongoing education that is delivered through KEMH. The team demonstrated the importance of appropriate education for clients and families including a focus on strategies to enhance client independence and have clients articulate their role in personal health and safety.

The team engages with its colleagues in rounds to share client information.

Home Care

The Home Care program is designed for clients who are about to be discharged and require nursing care. The clients must be eligible for that care as a result of the medical budget that has been allocated to them or be classified as eligible for government subsidy.

The team encourages clients to move towards self management of health care needs and it documents their progress. The team ensures that clients understand their rights.
There is a service agreement in place with clients. There is a process is in place to have clients complete advance directives. The team supports the family and client in the management of medications.

The team has access to a team to support solutions for ethics-related issues. The home care team is available 365 days a year and can be reached if a client wants to make a complaint.

The team provided examples of the collaboration that exists among the interdisciplinary team and various nursing agencies in the community. The team articulates the value for both client and the cost savings for the organization in having an effective, safe and goal driven client care program.

Home care nurses support each other in their work and share clients on their days off. They are very positive about the difference they make in the clients' lives.

While the number of clients is small (17), because of the nature of the nursing care they receive and the distances on the island and the number of visits, the staff are working to full capacity.
Although there is no wait list, there would have to be serious consideration given to adding more clients without additional staff (2.3).

The workspace in the home care office is small but there were no complaints from the staff. Infusion pumps are not used in the provision of home care.

Infection Prevention and Control (IPC)

Unit staff from the Mid-Atlantic Wellness Institute (MWI) do not know the relevant infection rates but the management does (1.2.2).

Both methicillin-resistant staphylococcus aureus (MRSA) and c-difficile are monitored and trended by the organization. The rate of timely administration of prophylactic antibiotics is approximately seventy five percent.

The Infection Control team is comprised of organization staff and an employee of the ministry of health. It is evident that this team has developed some very innovative strategies and attempted to measure its effectiveness using the latest IPC research.

Every attempt is made to increase the rate of pneumococcal vaccinations with a campaign planned for this fall (4.2.2). There is a twenty percent vaccination rate for influenza (4.3.3).

The organization is following infection control guidelines from several countries and professional bodies (4.2.1).

IPC information is provided to clients and families. It is inconsistently documented (7.2).

The Spalding guidelines are used to determine the degree of disinfection for any contaminated materials or devices. The flash sterilizer in the operating room is not operational. Reprocessing is overseen by the team and it also occurs in the endoscopy suite where there is strict adherence to protocol. There are observations in all areas and IPC does random and timed checks on hand washing. Sanitizers are in each patient's room within an arms length of each bed. It is obvious from the tour of all units and the documentation reviewed that there is training for hand washing and the providers are familiar with effective hand hygiene. There are plans to put a sink in each patient's room.

Standards for single use (SU) devices are taken from The Ottawa Hospital and the Federal Drug Administration. Three team members are certified in infection control. There is a major focus on innovation education strategies for all levels of staff.

Surgical Services

A surgeon made a recent request for an additional surgical service related to bariatric surgery.

Meetings among connected services such as the operating room (OR) and the preadmission unit are not occurring as frequently since the organization has entered the current change process. (1.4)

The human resources (HR) department mediates the conflict resolution process.

The Bermuda Nursing Council screens nursing credentials. There is a further review at the hospital HR level. A clinical service educator is effective in responding to educational needs in the OR as well as monitoring the effectiveness of programs offered.

Nursing supervisors are concerned that the development of medical and surgical leadership in the program has shifted some of the responsibilities previously held by nursing leadership to physicians and surgeons (3.2).

There is an excellent patient information binder available in each patient room. It outlines risks, responsibilities, and expectations of patients. Services are offered to all persons requesting it.
Care maps exist for joint replacement surgery and lap-cholecystectomy. At present no lasers are in use.

The smoke evacuation system is not always used. During the OR visit there was a detectable odor of cautery smoke in the corridor outside an OR suite (9.5).

The "Staffing Against Falls Anywhere" (SAFE) program is an effective strategy to minimize the risk of falls.

The only benchmarking that is done for nurse educational programming is against the standards published by the American OR nursing association (AORN) (16.4).

Emergency Department Services

The team uses a triage score, the Emergency Severity Index (ESI) and a five point scale. Volunteers are considered part of the emergency family.

They need to establish an isolation room for infectious diseases patients. This is being developed but will not include negative pressure.

The team is unaware of any data being collected (8.3).

Pain scoring is done continuously. Nurses have hand-held pocket cards for scoring. The team writes prescriptions for ambulatory patients but does not dispense. The pharmacy does the dispensing.

The team does not have the IT resources to capture ambulatory care coding to audit care or departmental performance indicators such as patients leaving without being seen (12.1 and 12.2).
There is no benchmarking with similar organizations (14.7). The team does not have adequate IT resources to collect ongoing information regarding the average length of stay (ALOS) and wait times (6.10).

Critical Care Services

This is a magnificent new unit with an award-winning design. The reassignment of staff when needed is an example of service review and allocation of resources.
Physicians, nurses, physiotherapy, pharmacist, and a social worker are team members. There is no rapid response team in place. The medical director is planning to implement it (3.5).

The team uses ventilator acquired pneumonia (VAP) and CLI safety measures that are not related to Safer Healthcare Now.

The quality improvement (QI) initiatives have included an initiative regarding VAP prevention, medication error prevention, labeling of infusion pumps for safety after a near miss, and a new policy on epidurals for pain control.

Medicine Services

There is a strong planning emphasis with results seen in an improved admission process, cancer care, planning for dialysis expansion, and cardiac rehabilitation.
There is a strong interdisciplinary team with a physician, nurses, social work, pharmacy, speech therapy, and physiotherapy.

The admission nurse project has resulted in more efficient admissions from emergency. This is in place for adult medicine.

The dialysis program is benchmarking its catheter infection rate with a North American reference and it is doing very well.

Information is available to show that most falls are connected to toileting.

There were an increased number of medication incidents recently involving the medication administration records not being accurate when they return from pharmacy (11.7).

Pediatric Medicine

Performance evaluations include a thorough review of competencies; however, they have not been completed within the prescribed timeframes for all staff that are three months and annually for five years (4.6).

No health information legislation is in place in Bermuda (13.2). No client specific goals and objectives are established as part of a comprehensive service plan (8.1-8.5). The team works within the organizational mission, vision, and values but it has not established an operational plan including goals and objectives specific

to pediatric services (2.1).

The unit has recently moved towards a unit dose method for medication administration; however, the medication administration process and environment has not been adjusted to facilitate the success of the unit dose strategy. This is particularly important due to the large number of oral liquid medications given on this unit (11.1). The team meets the standards regarding the patient safety culture but it is encouraged to strengthen its efforts regarding regular safety briefings and the use of incident report information for improvement (10.3).

The team does not formally contact clients, families, or referral agencies following discharge to evaluate the effectiveness of services (12.5).

Obstetrics and Perinatal

No information is collected from the community (1.1 and 1.2). There are no explicit or written goals and objectives (2.2). There is no evaluation of team function (3.7).

The team has just begun to gather data.

Although there is contact with new women six weeks after delivery, there is no systematic evaluation of the effectiveness of the transition home (12.5).

No privacy legislation is in place in Bermuda (13.2). There are no formal linkages related to research and best practices and there is no sharing with patients (15.5 and 15.6). There is no evaluation of the falls prevention strategy (10.5.4 and 10.5.5). There are no goals and objectives (16.3 -16.5).

Client Experience

This part of the report highlights the perspective and experience of clients who receive services.

The Positive Client Experience Tool is currently under development, and was not included in this accreditation review.

Next Steps

The forecast decision has been provided to demonstrate the organization's current position in the accreditation program. The organization is to provide evidence to follow-up on identified areas for improvement through the organization portal by December 24, 2008.

Pending the organization's follow-up and submission of evidence, as well as the review by Accreditation Canada's Accreditation Review Committee, the final report will be sent to the organization. The final report will include the official accreditation decision as well as the organization's updated indicator and instrument data and evidence of action taken.

Please contact your Accreditation Specialist or access the organization portal for more information on the accreditation report and decision.

Appendix A - Accreditation Decision Rules

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

Accreditation Canada High Priority Criteria

Accreditation Canada recognizes that certain specific criteria are deemed important enough that when high priority are found unmet, a report is almost always requested from the organization.

Required Organization Practices (ROPs)

Accreditation Canada recognizes that Required Organization Practices are deemed important enough that when any are found unmet, a report is always requested from the organization.

Based on the above, the following Accreditation Recognition Levels will be granted.

Option 1: Accreditation

An organization is eligible for Accreditation with a full resurvey in three (3) years if all of the following criteria are met:

(a) 10% or less of high priority criteria unmet per standard section, and
(b) Satisfactory compliance with all of the Required Organizational Practices.

Option 2: Accreditation with Condition: Report or Focused Visit

An organization is eligible for Accreditation with Condition: Report or Focused Visit if the following criteria are met:

(a) More than 10% and less than 30% of high priority criteria unmet per standard section,
OR
(b) Unsatisfactory compliance with any one of the Required Organizational Practices.

The condition and time frame for submission of the report or visit is based on the nature of the recommendations.

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

Option 3: Non Accreditation

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

(a) More than 30% of high priority criteria unmet per standard section
OR
(b) Unsatisfactory compliance with all of the Required Organizational Practices.