Accreditation Report

Prepared for:
The Bermuda Hospitals Board

Paget, Bermuda

On-site Survey Dates:
May 9, 2011 - May 13, 2011

June 6, 2011

Accredited by ISQua
About this Report

The results of this accreditation survey are documented in the attached report, which was prepared by Accreditation Canada at the request of 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. The contents of this report is subject to review by Accreditation Canada. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to The Bermuda Hospitals Board only. Accreditation Canada does not release the Report to any other parties.

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

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

Legend

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

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

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

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

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

⬆️ Items marked with an arrow indicate a high risk criterion.
Accreditation Summary

The Bermuda Hospitals Board

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

On-site survey dates  May 9 to 13, 2011
Report Issue Date:   June 6, 2011

Accreditation Decision  Accreditation with Condition (Report)

Locations

The following locations were visited during this survey visit:

1  King Edward VII Memorial Hospital
2  Lamb Foggo Urgent Care Centre
3  Mid-Atlantic Wellness Institute

Service areas

The following service areas were visited during this survey visit:

1  Addictions/Gambling
2  Ambulatory Care
3  Child Welfare
4  Development Disabilities
5  Diagnostic Imaging
6  Emergency Department
7  Home Care
8  Intensive Care Unit/Critical Care
9  Laboratory
10  Long Term Care
11  Maternal/Perinatal
12  Medicine
13  Mental Health
14  Operating Room
15  Point-of-Care Testing Services
16  Rehabilitation
17  Sterilization and Reprocessing of Medical Equipment
18  Surgical Care
Surveyor’s Commentary

The following global comments regarding the survey visit are provided:

The Bermuda Hospital Board’s commitment to quality improvement and patient safety is extraordinary. “Accreditation Everyday” is a slogan noted on many materials and this certainly has been found to be true in all corners of the organization whether it be in service delivery areas, support service areas, or senior leadership.

The Values of the organization are Culture, Quality, Service, People, Integrity, Leadership, Communication and Stewardship. The organization is commended for ensuring that these values inform all activities and are used to guide decisions. Alignment between the Vision, Mission, Values, the Strategic Plan and strategic priorities is very well done. Numerous examples were evident such as the application of values in informing key strategic priorities such as the commitment to wellness of both staff and the community at large. The organization also was able to demonstrate its clear understanding and commitment to its role as a community hospital and its strengths and limitations in fulfilling this role.

The staff of the Bermuda Hospital Board is its greatest resource. The preparation for the accreditation process has been excellent and the commitment to ongoing quality and patient safety is evident throughout all areas. In order to maintain a culture of continuous quality improvement and patient safety, it will be imperative that quality is seen as an ongoing journey and not an audit or static process. An area that will require ongoing diligence is where policies are developed and updated, attention needs to continue to pay to successful implementation through communication, education and quality monitoring. Support for ongoing professional development is very well done. Also of note is the progress made since the last accreditation visit in the area of patient engagement for patient safety. Examples include the new patient handbook, a specific brochure articulating the patient’s role in patient safety, falls prevention brochure and education related to specific patient medical issues such as DVT and VTE.

Meaningful working relationships with community partners in Bermuda as well as clinical linkages outside of the country were evident and well supported. These linkages support excellence in all service areas and ensure quality patient care. For example, best practice identification has been enhanced through ongoing consultations. As clinical services continue to evolve and care is increasingly provided in innovative ways in client homes and in the community, it will be important to continue to pay attention to the working relationships with local community partners. Many of the partners interviewed during the Community Partners group interview had several suggestions as to how these may evolve and progress. The organization is encouraged to explore ways to maintain an ongoing dialogue with these groups and develop mechanisms to ensure their ongoing input in planning and problem solving activities.

Inter-professional practice has also been evident throughout the survey process. This approach supports quality patient centered service. Numerous examples were provided and include items such as the recent change of the membership of the Quality Council, the Infection Prevention and Control Committee, multidisciplinary huddles and the development of the multidisciplinary patient education form.

In summary, the Bermuda Hospital Board is congratulated for its commitment to the Accreditation Canada accreditation process and it demonstration of using the standards to achieve excellence. Throughout this surveyor visit, evidence was noted that all previous report suggestions have been implemented.
Organization's Commentary

The following comments were provided to Accreditation Canada post survey.

The Bermuda Hospitals Board (BHB) extends a warm thank you to Accreditation Canada and the surveyors for being an integral part of our quality journey. We are most proud of our BHB colleagues for the dedication and commitment they demonstrate every day to service excellence in its widest sense - from the quality of our care, to the service standards we aim to meet. Our patients, residents and services users are the reason we are here, and their wellbeing, safety and care is central to our commitment which drives us every day. We realize that improving quality is a constant journey and going through the survey process only provides a snapshot of where we are, but it is not an end result.

The BHB is excited about the revamping of our Quality Council and we look forward to sustaining ongoing projects and starting new quality and safety initiatives that enhance the quality of our patient care. We rise to the challenge of providing the best care for our patients despite the economic climate.

The survey process is a point from which we will learn and grow - a stop in the journey where we can take stock on where we are and plan our next steps. The surveyors have helped us identify where we can improve and we will move towards these goals and tackle the challenges with confidence that we are on the right path. There are a few areas noted in the preliminary report that are worthy of mention and comment:

The Bermuda Hospital Board named was identified as the Bermuda Health Board in the report and this error was highlighted to us by the lead surveyor prior to her departure.

It should be noted that Child and Adolescent Services at the Mid-Atlantic Wellness Institute used ‘Child and Youth Population’ standards. This information was shared with Accreditation Canada following the conference call to finalize the surveyor schedule. During the survey they were evaluated on the ‘Child Welfare Services’ standards. Although a majority of the Child Welfare Service standards address Child and Youth Population standards, it is noted that there are some standards that are unique to each set and not present in the other set of standards. More importantly, the 3 unmet standards are not a part of the Child and Youth Population’ standards.

We appreciate that the Qmentum process is still relatively new to us, as well as to the surveyors and there appears to have been some confusion during the survey, possibly related to the new software used for entering compliance.

In Long Term Care, we noted the surveyors’ comments and wanted to state our position on the 2 ROP’s that were identified as being unmet. We were very surprised to see that the two ROPs mentioned below were identified as we have clear processes in place throughout the organization. We did not feel that the findings from the surveyor, based on one patient interview justified an organizational failure. It must also be mentioned that Long Term Care is not an acute facility; however they abide by all our policies and procedures within BHB. We have detailed some of our specific findings:

16.4 The team informs and educates its clients in writing and verbally about the client and family role in safety.

In Standard 16.4, we have evidence that we educate patients and family members on patient falls (Staff Against Falls Everywhere (SAFE) Pamphlets). We have a Residents Council for Long Term Care Services and this forum is used to educate patient’s families about their role in promoting safety.
The surveyor noted in the preliminary report that ‘this council contributed $20,000 from their own funds to purchase bed alarms to help keep the residents safe’. It was also noted that ‘they also have reduced the rates of MRSA through good hand washing, education to families on hand washing…..’ It was also highlighted in the debriefing presentation that patient involvement in patient safety and documentation of patient education were successes since the last accreditation survey. We utilize a Multidisciplinary Education Form that is used to document patient and family education throughout the BHB. We also understand that only one patient was asked regarding this standard in Long Term Care and we feel this raises the possibility of the information being misunderstood or forgotten by the patient at the time. Verification of this standard by other patients would have been useful to verify compliance. We feel we should have been given the opportunity to demonstrate our ability to show compliance with the ROP.

16.5 The team implements verification processes and other checking systems of high risk activities

There is clear evidence that we perform high risk processes for receiving critical lab results and verbal/telephone orders. In discussion with the surveyor, it was indicated that standard 16.5 was not applicable to Long Term Care Services. We were initially told by the surveyor that she evaluated the ROP based on the high risk activities on her list. She informed us that she flagged this standard as non-applicable as the activities on her list were not practiced in Long Term Care. When we had mentioned that critical lab results and verbal orders were performed in Long Term Care and throughout the organization, she stated that she was not aware of this at the time of her submission.

The BHB feels that we have met these 2 ROPs in Long Term Care and throughout the organization and we strongly request that Accreditation Canada review these ROPs further with a view to amending the initial findings.

In the Managing Medications standards, we are looking to address the 2 priority items identified as unmet as there are already processes in place that address them, but it was not evident during the survey visit. We noted that we have improved in many facets of Managing Medications since the last accreditation visit in 2008 with the introduction of the Pyxis and MAK (Medication Administration Checking).

This was the first Accreditation Canada survey for our Pathology and Laboratory Services Department which also included Point-of-Care testing, Laboratory and Blood services, Blood Bank and Transfusion Services and Biomedical Laboratory services. An additional surveyor was added to the team to address all the Laboratory services at BHB. We noted the priority action items identified in these areas and we will be addressing these standards in the upcoming months.

There were some recurring themes that were identified in various standards which are opportunities for BHB to improve our processes. The BHB recognizes and acknowledges that there are opportunities to improve our formal process of developing evidence-based guidelines throughout BHB. More work can be done to ensure that we standardize best practices for the benefit of our patients/service users. Also noted in the report was the BHB’s ability to train and educate staff, patients and families on ethics-related issues. This is an area that BHB will be striving to enhance for our staff, patients and families via the Ethics committee.

The individual teams will now review the preliminary findings in detail, and when we receive the Quality Road Maps, we will address any unmet standards as well as ensure that the standards that are in place are reinforced. The Qmentum is designed to promote continuous process improvement as we prepare for the next survey visit in 2014 but in addition, we are ensuring that our patients receive the appropriate care everyday according to the standards that are based on best practice. We appreciate the surveyors’ commentary as it provides the organization with an opportunity to celebrate our successes and work on our process improvement opportunities as we continue to strive for safe, efficient, equitable, effective, timely, and patient-centered care.
Leading Practices
Recognizing innovation and creativity in Canadian health care delivery

Leading practices are commendable or exemplary organizational practices that demonstrate high quality leadership and service delivery. Accreditation Canada considers these practices worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue.

Leading Practices
• are creative and innovative
• demonstrate efficiency in practice
• are linked to Accreditation Canada standards
• are adaptable by other organizations

The Bermuda Hospitals Board is commended for the following:

Succession Planning
To date, over 50 (more than 25% of our leadership population) BHB leaders have Professional Development Plans in place. In the last year, eight BHB leaders have been hired or promoted with the support of the Succession Planning processes and tools. Bermudian employees are asking about the succession planning process and want to know how they can become involved in it. They realize that they can aspire to move up in the organization and have the opportunity to be developed professionally. (Effective Organization)

Turning Point Multi Family Group
We started the multi family group in November, 2010. Our aim is to have clients and their families attend the 16 week program to achieve a completion certificate. Since that time, we have a core group of at least 6 clients’ families who attend on a very regular basis, with several other families attending on an occasional basis. We have heard comments such as:

“This course is only 16 weeks. What will I do on Thursdays when it is over? Can we keep coming back even after we have finished the 16 weeks?”

We are aware that our core group have encouraged others to join us citing that they find the group helpful to not only understand the addict, but to come to grips with their own recovery journey and the effect the disease has had on them.

During the session when a parole officer attended with a client, he stood up at the end and said words to this effect:

“I owe you all an apology and I ask your forgiveness. I am a senior probation officer and until this night, I did not understand the disease of addiction. I thought it was all about will power. I am grateful for this new understanding and the impact it will have as I go forward. I hope to encourage my colleagues to attend, with the permission of the group.” (Substance Abuse and Problem Gambling Services)
Nursing Competencies

The Nursing Staff Development Department’s main goal has been to provide an easily accessible venue for our nursing staff to complete their required competency assessments. The Clinical Nurse Educators (CNE) had a vision to place as many of the competencies on-line as possible. The competencies are now on the hospitals’ network and the Clinical Nurse Educators perform the return demonstration competencies on the individual units. This vision has now become a reality by decreasing the CNE’s time required to run Competency Fairs and take learning and assessments to the point of care. The ability to remain on their Units and still meet the requirements of competency assessments has been a welcome practice by both Nursing leadership and the staff nurses. Also, this has proven to be a cost saver as staff does not have to be replaced while attending competency fairs. This leading practice supports the Bermuda Hospitals Board’s mission of: To ensure the highest quality healthcare through service, education, and leadership. (Surgical Care Services)
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.

<table>
<thead>
<tr>
<th>Quality Dimension</th>
<th>Met</th>
<th>Unmet</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Focus (Working with communities to anticipate and meet needs)</td>
<td>88</td>
<td>1</td>
<td>0</td>
<td>89</td>
</tr>
<tr>
<td>Accessibility (Providing timely and equitable services)</td>
<td>146</td>
<td>1</td>
<td>3</td>
<td>150</td>
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<tr>
<td>Safety (Keeping people safe)</td>
<td>664</td>
<td>12</td>
<td>42</td>
<td>718</td>
</tr>
<tr>
<td>Worklife (Supporting wellness in the work environment)</td>
<td>183</td>
<td>3</td>
<td>1</td>
<td>187</td>
</tr>
<tr>
<td>Client-centred Services (Putting clients and families first)</td>
<td>237</td>
<td>7</td>
<td>10</td>
<td>254</td>
</tr>
<tr>
<td>Continuity of Services (Experiencing coordinated and seamless services)</td>
<td>86</td>
<td>1</td>
<td>2</td>
<td>89</td>
</tr>
<tr>
<td>Effectiveness (Doing the right thing to achieve the best possible results)</td>
<td>994</td>
<td>29</td>
<td>48</td>
<td>1071</td>
</tr>
<tr>
<td>Efficiency (Making the best use of resources)</td>
<td>88</td>
<td>3</td>
<td>2</td>
<td>93</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2486</td>
<td>57</td>
<td>108</td>
<td>2651</td>
</tr>
</tbody>
</table>
## 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.

<table>
<thead>
<tr>
<th>Standard Section</th>
<th>Met</th>
<th>Unmet</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustainable Governance</td>
<td>91</td>
<td>0</td>
<td>0</td>
<td>91</td>
</tr>
<tr>
<td>Effective Organization</td>
<td>103</td>
<td>3</td>
<td>0</td>
<td>106</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>96</td>
<td>1</td>
<td>6</td>
<td>103</td>
</tr>
<tr>
<td>Ambulatory Care Services</td>
<td>118</td>
<td>0</td>
<td>2</td>
<td>120</td>
</tr>
<tr>
<td>Biomedical Laboratory Services</td>
<td>51</td>
<td>1</td>
<td>0</td>
<td>52</td>
</tr>
<tr>
<td>Blood Bank and Transfusion Services</td>
<td>131</td>
<td>3</td>
<td>30</td>
<td>164</td>
</tr>
<tr>
<td>Child Welfare Services</td>
<td>106</td>
<td>3</td>
<td>4</td>
<td>113</td>
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<tr>
<td>Critical Care</td>
<td>128</td>
<td>0</td>
<td>1</td>
<td>129</td>
</tr>
<tr>
<td>Developmental Disabilities Services</td>
<td>88</td>
<td>2</td>
<td>1</td>
<td>91</td>
</tr>
<tr>
<td>Diagnostic Imaging Services</td>
<td>96</td>
<td>2</td>
<td>6</td>
<td>104</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>104</td>
<td>1</td>
<td>16</td>
<td>121</td>
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<tr>
<td>Home Care Services</td>
<td>88</td>
<td>3</td>
<td>3</td>
<td>94</td>
</tr>
<tr>
<td>Laboratory and Blood Services</td>
<td>162</td>
<td>9</td>
<td>5</td>
<td>176</td>
</tr>
<tr>
<td>Long Term Care Services</td>
<td>111</td>
<td>6</td>
<td>4</td>
<td>121</td>
</tr>
<tr>
<td>Managing Medications</td>
<td>125</td>
<td>5</td>
<td>5</td>
<td>135</td>
</tr>
<tr>
<td>Medicine Services</td>
<td>100</td>
<td>3</td>
<td>2</td>
<td>105</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>110</td>
<td>0</td>
<td>1</td>
<td>111</td>
</tr>
<tr>
<td>Obstetrics/Perinatal Care Services</td>
<td>118</td>
<td>0</td>
<td>1</td>
<td>119</td>
</tr>
<tr>
<td>Operating Rooms</td>
<td>102</td>
<td>0</td>
<td>0</td>
<td>102</td>
</tr>
<tr>
<td>Point-of-Care Testing</td>
<td>75</td>
<td>10</td>
<td>2</td>
<td>87</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>88</td>
<td>1</td>
<td>14</td>
<td>103</td>
</tr>
<tr>
<td>Reprocessing and Sterilization of Reusable Medical Devices</td>
<td>92</td>
<td>4</td>
<td>3</td>
<td>99</td>
</tr>
<tr>
<td>Substance Abuse and Problem Gambling Services</td>
<td>102</td>
<td>0</td>
<td>1</td>
<td>103</td>
</tr>
<tr>
<td>Surgical Care Services</td>
<td>101</td>
<td>0</td>
<td>1</td>
<td>102</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2486</td>
<td>57</td>
<td>108</td>
<td>2651</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Required Organizational Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care Services 16.4</td>
<td>The team informs and educates its clients and families in writing and verbally about the client and family’s role in promoting safety.</td>
</tr>
<tr>
<td>Long Term Care Services 16.5</td>
<td>The team implements verification processes and other checking systems for high-risk activities.</td>
</tr>
</tbody>
</table>
Detailed Accreditation Results

System-Wide Processes and Infrastructure

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

Findings

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

Planning and Service Design

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

Surveyor Comments

Up to date vision and mission statements are in place. Of note has been the extensive input solicited in preparing these statements. The Bermuda Hospital Board (BHB) ensured that not only has staff input been included throughout the developmental process but also, that suggested priorities were included. For example, staff expressed the need for culture to be expressed as the first value as without attention to the culture of the organization, other values would not have the necessary context for action and application. Also noted was the staffs, community's and Board's commitment to enhance the focus on wellness. This thoughtfulness and inclusion is commended. The vision, mission and values are noted in all documents and throughout the organization.

The Mid-Atlantic Wellness Institute is recognized for having a mission statement that is clearly aligned with the overall organization while also acknowledging the unique role and services at this site.

A great deal of work has been done to develop a comprehensive ‘rolling’ strategic plan. Of particular note is the annual review and update to this plan on an annual basis. The “Five-Year Strategic Plan, financial years 2011-2015” document was reviewed at the time of the surveyor visit. The plan is extensive and notes driving strategies, priority areas each with associated initiative tactics and FY 2011 targets. This plan, including the strategic target measures also informs the Board’s dashboard reporting. Again, a job well done.

The overall organizational strategic plan also informs and guides site specific strategic planning. For example, the Mid-Atlantic Wellness Institute (MWI) uses the BHB strategic plan in developing the strategic directions for the institute. During the budgeting process for the 2011/2012 fiscal period, budget reductions required accommodation at the MWI. The strategic plan and the BHB values assisted in guiding difficult decisions while also maintaining client services and safety.

In 2009, Healthcare Partners Ltd. (a private company) was formed. This has successfully enabled the Bermuda Hospitals Board to respond to market threats while also enhancing service delivery.
This is another example of the organization’s ability to strategically position itself to address service needs and enhance partnerships through the development of joint ventures.

Recently (April 2011), the government released the National Health Plan public consultation paper. Again, the Bermuda Hospitals Board is well positioned to respond to and address the many suggested changes in this plan. Through the ongoing involvement of senior staff in the development of this plan, the plan has included relevant issues and has also enabled the Board to align its strategic plan with that of the government. A central Coordinating Committee is also in place which has representation from various government ministries. These numerous examples of collaboration with government certainly guides the organization in determining its long term direction and supports constructive solution development as potential areas of conflict arise.

A Health In Review document is prepared for the country. This document provides population health information and is used by the organization in identifying population trends and health issues.

Of note is the active participation of the senior leadership staff in providing advice and input into the organization’s strategic direction. The board provides excellent support and openly challenges and encourages the leadership group to be innovative and ‘think outside of the box’ as issues arise and opportunities present themselves. The board varied skill sets and experience certainly assist in this regard. Numerous examples were provided during the surveyor visit interview.

Changes have been numerous over the past several years. Both the Board and Senior leadership openly discussed a broad range of strategies to address change noting that “by managing change you can ensure that change does not manage you”. Examples and evidence of ongoing engagement of relevant stakeholders, ongoing attention to communication needs and careful strategic positioning were provided throughout the survey visit and have supported the many changes that have, and continue to, occur.

No Unmet Criteria for this Priority Process.

Resource Management

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

Surveyor Comments

An extensive planning process is in place. A ‘strategic map’ is prepared in early fall of each year. This map is informed by the Board’s rolling strategic plan. The map is updated annually and includes the priorities, initiatives/tactics, associated measures as well as baseline and target measures for each of the key areas of a) patient experience, b) organizational culture, c) quality of care (including patient safety), d) financial health, and e) leadership in Bermuda health and wellness. The link between these key horizontal areas with the values of the organization is commended. The strategic map combined with resource consumption experience from preceding years, informs the operational planning process which occurs in January/February prior to the commencement of the next fiscal period. Medical chiefs and leadership in each of the service areas have input throughout the process.

Again, the organization is commended for its innovation in addressing financial health through actions such as support for the change from a per diem reimbursement model to one linked to DRG length of stay and the creation of the Healthcare Partners Ltd. company.
Legal requirements, financial policies and procedures are in place and adhered to. Leadership follows the strategic priorities and approved resource allocations. Processes are in place to move resources within the organization and across operational and service areas as unique issues arise. Ongoing financial monitoring occurs. As the services at the Mid Atlantic Wellness Institute are funded under a separate government funding arrangement, financial monitoring is maintained separately for this site. Monthly financial reports are shared with all of the organization’s managers and finance staff assists all managers as required.

Capital planning processes are well developed and engage all service areas. Five year capital plans are developed but updated and reviewed every year. Leadership in each of the areas is engaged in the capital prioritization processes. Three areas are considered when completing the capital plan; major capital requirements, information technology requirements and minor capital requirements.

A comprehensive supply ordering and accountability process is in place and supported by appropriate policies and procedures. Of note is the new warehousing space. Staff working in this area demonstrated remarkable commitment to supply quality price control and overall quality improvement and efficiency. Again, a job well done.

No Unmet Criteria for this Priority Process.

**Human Capital**

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

*Surveyor Comments*

The governing Board is government appointed. The Board has taken the time to review its needs in terms of skills sets, knowledge and experience of members. It was noted that suggestions for new board members based on the Board’s identified needs in meeting its governance responsibilities have been acknowledged. Also noted is the careful consideration of the leadership of the Board and need to ensure continuity.

The Bermuda Hospitals Board Act 1970 (1970:384) articulates the constitution of the Board, meetings of the Board and the mandate of the Board. By way of the Act, the Board’s responsibilities are noted. During the surveyor interview process, the Board was able to clearly demonstrate the clear division of governance roles and the responsibilities of senior management. Board committees (governance, pension, compensation and audit/finance) are in place and align with priorities. The governance committee also includes in its role the oversight of integrated quality and risk management from a governance perspective. An ad hoc Project committee is also in place given the large capital project currently underway to rebuild the King Edward VII Memorial Hospital.

An orientation process is in place for new Board members. There is an opportunity to strengthen the Board’s orientation process. Results from the Governance Functioning Tool coupled with input from recently appointed Board members will assist in this regard. All members sign a document confirming their roles and addresses conflict of interest. These are updated on an annual basis.

Annual reports are completed and well done. These are concise and present annual achievements extremely well and include relevant data presented in an understandable and useful manner. Annual reports also include reports on the financial status of the organization.
Annual performance objectives are not only established for the CEO but also the senior leadership team. The performance objectives are aligned with the organization’s strategic priorities and associated initiatives. The CEO performance is evaluated annually and based on these objectives. The Board also evaluates the of the senior leadership team...as a team. This is commended.

Work life balance and staff wellness is a priority for the organization. Innovative approaches have been undertaken to support this. Examples of support for work life balance include role modeling, supporting flexible work hours, and the provision of special leave. Policies have been put in place to support these approaches. Innovative activities to encourage staff wellness have also been implemented. Examples include the development of a Wellness Coordinator position, the support of a wellness committee which now organizes special classes such as yoga and aerobics, changes in staff menus to include healthy food choices, work with the vendor machine companies to offer healthy choices, and the development of activity teams that gather outside of work (such as team walking clubs and sports teams). The commitment to staff health and wellness is commended.

Workplace violence and safe work place policies are in place and have been updated. A code of conduct is in place as is a “Commitment to Standards of Behavior for Staff” that reflects expected behaviors that support the organization’s values. A security review has been completed and is guiding ongoing development of strategies to ensure a safe and secure work environment. This document also supports performance processes. Well done! Reporting of workplace complaints can be confidential and policies are in place to support this and the investigation processes.

The Worklife Pulse Tool has been completed. Of note is how the results have been shared through staff town hall meetings with the CEO, the quarterly human resources newsletter to all staff and through departmental meetings. Also of note has been the similarity of the results gained from this tool with the employee opinion survey.

Staff training and ongoing professional development is supported by the organization. Outstanding examples are the development of a literacy program for employees and the support for ongoing learning both within the organization and overseas opportunities. This is a real strength of the organization and has assisted it in becoming an employer of choice. The succession planning project is outstanding and will be further implemented within the organization.

Human resource records are complete. The organization is commended for moving forward with its plans to electronically maintain all aspects of the human resource files.

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

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<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
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<tbody>
<tr>
<td>Effective Organization</td>
<td></td>
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<tr>
<td>The organization’s leaders develop and regularly update position profiles for each position.</td>
<td>12.5</td>
<td></td>
</tr>
<tr>
<td>The organization’s leaders implement policies and procedures to monitor performance.</td>
<td>12.9</td>
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</table>
Integrated Quality Management

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

Surveyor Comments

Quality of care is a driving strategy of the organization and supported by the Board. Two key domains have also been clearly noted in the strategic plan. These are a) improve patient/client safety and b) improve clinical processes. The National Health Plan 2011 Public Consultation Paper also notes key health sector goals one of which is “The quality of healthcare provision shall be monitored and regulated”.

Integrated Quality Management was observed throughout all aspects of the Accreditation Canada survey visit and is supported by an integrated quality management model. The model is guided by the vision and mission of the Bermuda Hospital Board (BHB). A Quality Council (now multidisciplinary) is in place and has been delegated by the Board’s Governance committee to oversee performance improvement functions as well as key processes associated with implementation activities. A project management approach, including utilization of PDSA cycles of implementation is used when implementing quality improvement strategies.

The concept of quality underpinning the organization's integrated quality model is broad and comprehensive and considers quality improvement, patient and organizational safety, risk management, utilization management, ethics, and communication. The Board's strategic priorities, associated activities and noted measures and targets as identified in the BHB strategic map inform the key areas of focus and the quality monitoring activities. A Vice President and Risk Management position and staff are in place and resources have been allocated to ensure that quality and risk, including support needs such as data analysis, is accessible for all areas of the organization.

Evidence of numerous quality activities at BHB for the period of 2008-2011 were provided for each of the horizontal strategic areas of Patient Experience, Organizational Culture, Quality of Care, Financial Health and the Mid-Atlantic Wellness Institute. Examples include the monthly telephone patient satisfaction survey, the succession planning program, the new on-line incident and near miss reporting, patient falls prevention program, community engagement processes and new board dashboard reporting.

A performance improvement plan is also in place. This plan reinforces the organization's commitment to quality and the need for all employees to actively participate in ongoing and systemic quality improvement efforts. Accountability is clear and ensures that all employees are engaged. The performance improvement plan document is comprehensive and provides an overall of key quality principles and methods. Now that the organization has matured its structure to support the many activities underway as well as the structures to support quality and patient safety, it is suggested that this plan be updated.

Staff recognition processes include recognition of staff contribution to excellence. An example is the Recognition In-service Excellence.
A Client Safety-Related prospective analysis has been completed ‘to proactively analyze a process or processes that comprise the pharmacy automation initiative in order to identify ways the process(es) might fail, what might fail, the effects of failure and how it can be made safer.’ This analysis was comprehensive and extremely well done.

A new automated safety reporting system (Quantros) has recently been implemented. This system will further enhance the organization’s ability to track and trend all patient safety events including ‘near misses’ as well as track all investigations, findings and corrective actions. The Quality Council is monitoring the effectiveness of this new system (of note is the increased level of reporting already realized) as well as any changes that may need to be considered to support all staff in using it. Regular reports related to trends of all incidents are developed and submitted to the appropriate Board committee. Adverse event reporting and disclosure policies and procedures are in place.

A medication reconciliation on admission, transfer and discharge policy and procedure is also in place. All patient/client charts reviewed in all areas of the organization contained evidence that this policy and procedures has been fully implemented across the organization. Well done!

The Patient Safety Culture Instrument has been administered. (October 2011) All 3 sites of the organization participated with 1062 respondents. Results have been carefully reviewed and ongoing work is underway to continue to promote a culture that supports patient safety and learning from all adverse events and near misses.

No Unmet Criteria for this Priority Process.

**Principle Based Care and Decision Making**

Identifying and decision making regarding ethical dilemmas and problems.

**Surveyor Comments**

Strengths Recent revisions of the organization’s mission, vision and values included input from staff and service providers. It was noted that staff suggested the inclusion of “wellness” which has been demonstrated in various initiatives.

The Research Ethics Sub-Committee has produced robust guidelines regarding Reviewing Research Applications, Score card for reviewers of applications for research ethics approval and application package for submission of research proposals. The Research ethics sub-committee works in conjunction with the Government of Bermuda, Department to provide the ethical input for research proposals.

The Ethics committee consists of a group of dedicated professionals and community partners who volunteer their time and services. The committee is progressive thinking and extremely proactive. The committee provided a number of examples of listening, responding to and meeting community needs. This is evident in recent Ethics week presentations, consultations and educational events. There is wide representation from all sites and health care roles.

The subcommittees include End of Life, Education, Policy review, Consultation and Research. A number of individuals are member of more than one subcommittee.
The committee has developed a framework for clinical ethical issues. The committee states that the framework could be adapted and applied to organizational ethics. The organization might benefit from a paper exercise to review the application of the current clinical framework to an organizational ethical topic.

The ethics committee is aware of the need for planning and recruitment for committee members. The terms of reference state that members may participate for a 6 year term. A number of committee members have served on the committee for greater than 4 years. The majority indicated an interest in continuing their involvement with the ethics committee. The committee noted that they have observed and increase interest from staff regarding participation on the ethics committee and should be commended for increasing the profile and visibility of ethics in the organization.

The committee has an outstanding relationship with individuals from Dalhousie University who are available via phone, teleconference and email.

Area for Improvement The ethics committee might benefit from increased awareness from patients and families regarding the services provided by the committee. The patient handbook distributed by the organization has reference to the ethics committee. The committee is considering inclusion in monthly newsletters and publications. In the past the committee has included a lawyer from the community. The committee might benefit from review of this practice and the composition of the committee. With the creation of a formal position of patient advocate, the organization might benefit from the inclusion of the patient advocate as a member of the ethics committee.

No Unmet Criteria for this Priority Process.

**Communication**

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

**Surveyor Comments**

Records of the governing body's activities including each of the Board committees are maintained and up to date. All records appropriately record the terms of reference and roles and responsibilities of each committee. Appropriate advice and support is provided to the CEO and the senior leadership team. In camera sessions are held by the Board as required. A great deal of work has been undertaken to ensure both internal and external communication.

A communication plan is in place which notes internal and external communication strategies.

The intranet site has just been launched. The vast majority of policies and procedures have been updated and posted and are now readily accessible to staff. The majority of staff has access to a computer at work. IT staff are currently exploring avenues such as the development of kiosks, to ensure that all staff have access. Communication, IT and quality staff are commended for their efforts to engage all staff in completing the accreditation surveys. An IT training lab has been established and staff was provided access to these resources.
The Public Relations Department is an extremely committed and organized area. Remarkable achievements have been made including the development of corporate identify and branding guidelines, the development of potential parliamentary questions and responses related to the Bermuda Hospital Boards activities and strategies, preparation of budget brief documents, intranet announcements of key organizational activities and the branding and printing of key patient information documents to name a few. Omnibus survey results in March 2011 noted that residents “are now more aware of the redevelopment plans for the hospital and that the general opinion has improved slightly since the preceding year.” This is an example of the commitment to communication and the tracking of outcomes of the communication strategies undertaken.

Leaders meetings are held monthly with the CEO. Presentations at these meetings include updates on all major activities as well as updates on quality and patient safety including an overview of the organization’s dashboard reports. The presentations are also posted on the intranet further supporting extensive internal communication.

Ongoing external communication and engagement of stakeholders occurs. Town hall meetings have been held by the CEO. Another example of community consultation and engagement has been the extensive work done by the staff of the Mid Atlantic Wellness Institute. For example, input was sought when renaming the site and a study has been completed to determine public awareness and perception of the Institute.

During the Community Partners interview, several partners noted that in some areas, community consultation and follow up partnership with partners could improve. Examples of suggestions of improvement provided by several partners were 1) increased awareness of the organization’s vision, mission and values and 2) increased input into the staff orientation process with particular attention to service partners.

Confidentiality and information privacy and security policies and procedures are in place. An ITS Strategic plan (3-15 months), dated February 11, 2011 is in place. The plan is very well done and notes the need to aggressively implement and enhance many computer applications. As this plan evolves, there will also be the need to develop formal policies to guide the procedures related to the collection and confidential storage of data, entry of data and the use and dissemination of data.

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The organization’s leaders implement, review, and update policies and procedures to support the collection, entry, use, and reporting of information. 13.2

Physical Environment

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

Surveyor Comments

The KEMH is an older facility that has been maintained with a focus on safety in most areas. There are some concerns in some areas of Emergency that will be highlighted under that Episode of Care.
There was clutter in corridors noted in the care units, emergency, and many other work areas.

Lack of storage for boxes, etc. was also noted. Attention must be paid to these areas to ensure pt and staff safety as well as a concern for fire safety.

The new facility planning is well underway with good input from staff and stakeholders. Staff is very proud to talk about their new facility.

It is important that this facility KEMH however be maintained, to ensure staff and patient safety, as the move to the new facility is not until 2014.

I saw examples in the building where renovations are taking place and barriers have been put up to ensure client and staff safety while that work is taking place.

They do have major challenges with parking now as the new facility is under construction. There also seems to be some confusion for visitors in where to access the hospital due to construction and signage, although the residents had no problems.

I would suggest to the physical environment directors that the facility maintain security at all times during the day as well as after hours.

I saw many entrances to this facility that were fully accessible from the outside posing a risk to clients and staff.

Backup plans are in place for system failure. The lag time for generator is approx. 3 minutes.

The organization does some recycling, although noted not everyone adhering throughout the facility.

When complaints are raised around air quality, a request is submitted to have the air quality checked and a report provided and improvements made.

Smoking is only allowed outside the building some distance away. There is the problem of the smoke reverted back into the facility.

Security is provided 24/7 at facilities for staff and client safety.

The physical environment group was knowledgeable and aware of the facilities they are responsible for.

Their offices are off site but they did not see that as a problem. It was apparent that this group is approachable with ideas and input from staff.

There seems to be a fairly robust focus on safety, with respect to regular inspections of the facility, fire extinguishers, system generators... There were safety assessments done throughout the building with improvements made to address issues and concerns.

No Unmet Criteria for this Priority Process.

**Emergency Preparedness**

Dealing with emergencies and other aspects of public safety.

**Surveyor Comments**

The Bermuda Hospitals Board has excellent processes in placed for emergency preparedness. The facility committee demonstrates a lot of expertise in the field with a true team approach. There is very good integration with external groups. Good opportunities are provided for training, this includes external groups to the organization. The team is commended for their dedication and commitment in doing their best to help the organization and Bermuda.

No Unmet Criteria for this Priority Process.

**Patient Flow**

Smooth and timely movement of clients and their families through appropriate service and care settings.
Surveyor Comments

Patient flow in the emergency dept does not seem to be an issue. It takes approx 1 hr to move through Fast Track to discharge. The time frame from admission to getting into a bed can vary depending on the availability of beds. Pts awaiting continuing care beds is presently at 40. The emergency dept does have a plan to follow in moving pts elsewhere in the facility when the need presents for example in overcrowding in the ER, Disaster pts would be accommodated in the fracture clinic or PACU, admitted pts would not be housed in the ER hallways. The Lamb Foggo Urgent Care Centre can be used as a stand-alone emergency center in the event of a disaster or a crisis. It would not be used to divert ambulances to in managing overcrowding. There are no other healthcare facilities on the island.

The Bed Flow team is encouraged to consider options like admitting to all services 7 days a week; enhanced home care may assist with keeping pts in community longer with the right supports, defining specific criteria for admissions to continuing care.

The bed flow manager is a good addition to the team, to coordinate the various stakeholders and ensuring appropriate pt flow into and out of the facility; thereby ensuring beds are available when needed.

The pre assessment clinic for surgery is a great way to adequately prepare same day admissions for procedures.

The surgical team calls the pt 1 day after discharge and document any concerns on a special form. This information is shared with the team and the concern is followed up.

The surgical team is very customer focused and there has been a lot of training on customer service delivery and satisfaction.

The team makes every effort to ensure a good experience for the pt and their families by addressing questions, following up on concerns and using this feedback to implement improvements for future pts.

There was an Inpatient Bed Flow project proposal submitted in May 2011. It outlines the challenges to managing existing bed capacity, admissions and discharges.

These challenges include:
- high LOS for medical patients
- limited community facilities and services
- patients requiring isolation
- surges in admissions
- a fragmented process at present
- inconsistent communication between teams
- variable bed state data and information source
- current process not sustainable.
- impact on patient experience in a negative way
- multiple pt transfers and moving pts from one room to another
- long waiting times for beds
- time and number of activities required for bed turnaround
- delays in processes that facilitate timely discharge.

The team is meeting now and is interdisciplinary in scope; however, I would suggest they expand to include some Chiefs of departments, hospitalist, and senior management. Perhaps further down the road, a financial resource would be beneficial to review costs and savings.
The team needs to define criteria to prioritize their work and to identify good benchmarks to monitor their outcomes, successes.

The bed rounds were another strategy used to manage the beds and had good representation in attendance, but physician representatives should be included.

We also discussed other strategies to assist them, for example they presently Fast Track pts in the emergency dept but may want to consider implementing further care maps, research Super Fast Track option, educate the community on the importance of timely discharge and therefore have access to beds when need arises, setting discharge date at time of admission, monitor the attention to paid to discharge times.

The pt flow in diagnostic imaging is good in KEMH and urgent care.

No Unmet Criteria for this Priority Process.

**Medical Devices and Equipment**

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

**Surveyor Comments**

The sterilization and Reprocessing department (SPD) does not have a hand hygiene facility close to the entrance or the exits from the reprocessing area. A sterilizer dispenser is installed on the wall and is presently use for hand cleaning. A sink should be installed in this location or plan to incorporate one in the future department. No policy or procedure for inventory was found on the hospital site. The sterilization department is very well organized and has managed to respond adequately to the increasing demand for certain equipments. The delivered service is so efficient that, in last year no flash sterilization was used. Although the quality management program in this department is well established and efficient, periodic audits are not performed and documented. A schedule for those audits should be included in the program.

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<th>Criteria</th>
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<tbody>
<tr>
<td>Reprocessing and Sterilization of Reusable Medical Devices</td>
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<tr>
<td>The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>The medical device reprocessing department’s hand hygiene facilities are equipped with faucets supplied with foot-, wrist-, or knee-operated handles, or electric eye controls.</td>
<td>5.2</td>
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</tr>
<tr>
<td>The team follows policies and procedures for inventory control of sterilized devices.</td>
<td>11.1</td>
<td></td>
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<tr>
<td>The team participates in periodic audits.</td>
<td>12.9</td>
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</table>
Direct Service Provision

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

Findings

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

Ambulatory Care Services

Clinical Leadership

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

Surveyor Comments

The following programs were reviewed as part of the survey visit: The David and Mary Barber Diagnostic Unit, The Beresford Swan Dialysis Unit, and the Chronic Disease Management Program. The David and Mary Barber Cardiac Diagnostic Unit are highly responsive to population needs. There is ongoing emphasis on staff training and the staff is keen and committed to professional development. The relationship with the Lahey Clinic continues to enhance the quality of the delivery of services.

The Beresford Swan Dialysis Unit is very well organized and is highly responsive to population and patients’ needs. It utilizes best practices in association with Brigham and Women’s Hospital in Boston. There is a very effective team approach with highly competent staff including highly specialized physicians.

The Chronic Disease Management (Disease Management) Program for asthma, diabetes and cardiac diseases is a comprehensive approach to care which is highly rated by the users of the service. This program is a foundation and model for the ongoing initiatives related to education and lifestyle changes for which the hospital strategically wants to do more of and for which is highly commended. Good relationship with national initiatives with the Ministry of Health re. disease management approaches for diabetes and hypertension. This demonstrates the Board and hospitals leadership in advancing the health promotion agenda for Bermuda.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

see above

See above.
No Unmet Criteria for this Priority Process.

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

*Surveyor Comments*
see above

No Unmet Criteria for this Priority Process.

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

*Surveyor Comments*
see above

No Unmet Criteria for this Priority Process.

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

*Surveyor Comments*
see above

No Unmet Criteria for this Priority Process.

**Biomedical Laboratory Services**

**Diagnostic Services - Laboratory**
Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

*Surveyor Comments*
The laboratory has a very good and efficient competency assessment program. It covers all aspects of the quality management program and follow-up are done by the seniors technologists on a regular basis. The working relationship established with their main referral site allows the laboratory to offer a service almost as good as if those tests were done in-house. Results are reported directly to the patients' chart via an interface between the two LIS. This service decrease the turn around time and potential transcription error in data entry. There is presently no verbal request procedure approved by the Medical Director. The quality coordinator is working on one who should be available in a near future. The transport of samples to and from the hospital should revised and the complete packing should be done by the laboratory personnel. It should not be left to the courier to handle them in a cooler where samples requiring different temperatures are place side by side. It would also assure that the containers are cleaned on a regular base and prevent contamination to the driver or the transport vehicle.
Almost all samples are relabelled when they are received in the laboratory. This practice increases the possibility of making a mistake and could become a major security issue. It is suggested that bare-coded labels be printed on the specific units and specimens identified at the patient's bedside. This procedure should also be implemented for out-patients.

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<tr>
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<tbody>
<tr>
<td>The laboratory has a written procedure for responding to verbal requests for procedures.</td>
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<tr>
<td>ISO Reference: 15189-07, 5.4.13</td>
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<tr>
<th>Criteria</th>
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<tr>
<td>Blood Bank and Transfusion Services</td>
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<tr>
<th>Blood Services</th>
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<tr>
<td>Safe processes to handle blood and blood components, from donor selection and blood collection through to providing transfusions.</td>
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<tr>
<th>Surveyor Comments</th>
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<tr>
<td>All blood donations are considered walking donors. The donor clinic is managed very well and follows high quality standards. The donations are made in a friendly and comfortable environment. The selection process is very well established and meets all laws and regulations. The program is supervised by a haematologist on site. This specialist also assists and offers counselling for surgery patients requiring autologous transfusions. There is no directed or designated donations. Newborn requiring a transfusion would be transferred to another hospital. There is no perioperative program on site or home transfusions. The laboratory or transfusion services do not have their own procedure for informed consent. It is suggested to add it to the general hospital Informed Consent policy. There is no written documentation provided to patients after they have received a blood unit or components. It is suggested to modify the documentation send with the product to be able to detach part of it for the patient. It is also recommended that a card be sent to patient identify with an antibody. This card should be with the patient at all time and especially when the patient is travelling abroad.</td>
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<tr>
<td>The SOPs describe the responsibilities of each team member involved in blood and blood component processing.</td>
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<tr>
<td>CSA Reference: Z902-10, 7.1.1</td>
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<th>Location</th>
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<tr>
<td>The organization follows a standard operating procedure (SOP) to obtain the recipient's informed consent prior to transfusion.</td>
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<tr>
<td>CSA Reference: Z902-10, 11.2.1</td>
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<tr>
<td>The team provides all recipients with written information about the blood or blood product they receive.</td>
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<tr>
<td>CSA Reference: Z902-10, 11.2.2</td>
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<th>Location</th>
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Child Welfare Services

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

Surveyor Comments
The Child and Youth team is an interdisciplinary, strong and unified group made up of psychiatry, OT, social worker, family therapist, nurses, resident psychiatrist, and psychologist. They are very responsive to the needs of the population, especially around those at risk of self-harm. Referrals can come from family, neighbors, physicians, self, the courts, school. Referrals can be written, by telephone, and sometimes court reports are requested. They have established great community partnerships and are viewed as credible by the community. The team supports student placements and is aware of the expectation of their roles. The services are provided to all ages up to 19 yrs. Then these service users transition to the adult population, Developmental Learning Disability services. The team ensures this is a smooth transition for the clients.

No Unmet Criteria for this Priority Process.

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

Surveyor Comments
The team meets regularly to review service users and define case load, address workplans, etc.. One team member stated that they felt very supported within the team and comfortable to speak freely, raise issues, voice their opinion, etc.. The team has access to regular education events, ie peer review twice per month, research items of interest and bring the information to the team, learning lunch held weekly, access to internet, conferences...There is a Research and Audit committee that reviews and monitors leading practice. Performance reviews are completed annually and all staff have had a recent appraisal completed. The staff fell supported to attend educational events. The team review the clients on a regular basis to determine who best to manage the case, based on skills, what the child needs... The team are very complimentary of each others services. They seem to go above and beyond to meet their service users needs. They are very aware of those community resources available to them and are strong advocates for their clients.
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<th>Priority for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.</td>
<td>3.5</td>
<td></td>
</tr>
</tbody>
</table>

**Episode of Care**

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

**Surveyor Comments**

The services include 4 inpatient beds, approximately 400 outpatients, and 10 in day program. The team is interdisciplinary in scope and work well together to meet the multi-client needs. An admission assessment is done by the social worker and the team reviews to determine who best to manage the client. A Child Behavior checklist is done on admission. Sometimes the team has the difficulty around the different age group in the day program however they do try to work around that. They have been very creative in their initiatives. The pt satisfaction survey was very positive for this service in their response. The wait times for the child psychologist has been an issue as position vacant, as well as confidentiality is an issue with the small waiting room for clients. The team have addressed that by ensuring clients don’t overlap in the waiting room. The team is very responsive of client needs especially around concerns of self-harm. If the team cannot meet client needs or don’t feel they are the best resource, and then they will refer them on as they have a great understanding of the community resources available to them. They will also advocate on behalf of the client. Each client has an interdisciplinary comprehensive service plan to guide their care. These plans are reviewed and modified on a regular basis. A Post discharge follow up call is done 1 month after discharge. Each client is provided assistance when they are transitioning from child services back into home or school.

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

The team has a process to educate children, youth, and families about their rights when they are required to seek services through the judicial system.

The team follows the organization’s process to identify, address, and record ethics-related issues.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The team has a process to educate children, youth, and families about their rights when they are required to seek services through the judicial system.</td>
<td>8.12</td>
<td></td>
</tr>
</tbody>
</table>

The team follows the organization’s process to identify, address, and record ethics-related issues. 8.13
Decision Support
Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.

Surveyor Comments
Each client has an up to date record that is kept confidential. Some clients have been on the service for a long time and there is a good process in place to purge charts and secure them in the building, in the event they have to access. There is no research taking place at this time. Each new client has a falls assessment and a child abuse check done at admission to ensure safety to the client.

No Unmet Criteria for this Priority Process.

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

Surveyor Comments
The team addresses the challenge of having different age groups in the day program using many creative strategies. The team feel safe and supported in their work. There is a sending staff out safety protocol. The staff carry a communications device and have a phrase to alert others that they are in trouble. They also always let others know where they are going. Security officers always available at the facility. The facility has a Health and Safety committee, each room is equipped with panic alarms. The facility is secure and swipe cards are in use for access to the facility. There is ongoing education for staff around hand washing, security, occupational health...

No Unmet Criteria for this Priority Process.

Critical Care

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

Surveyor Comments
see below No Unmet Criteria for this Priority Process.

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

Surveyor Comments
See below. No Unmet Criteria for this Priority Process.
Episode of Care
Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.

Surveyor Comments
see below No Unmet Criteria for this Priority Process.

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

Surveyor Comments
see below No Unmet Criteria for this Priority Process.

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

Surveyor Comments
see below No Unmet Criteria for this Priority Process.

Organ and Tissue Donation
Donation services provided from identification of a potential donor to donor management and organ recovery.

Surveyor Comments
The critical services are functioning well within the parameters of the strategic plan. There is a cohesive team, which is very patient centred, multidisciplinary in nature with vast cultural diversity. There is good provision of educational opportunities both internally and externally. The orientation program for new staff is comprehensive. Good processes for team communication are in place, including a daily multidisciplinary team rounds lead by the ICU physician. Patient satisfaction with this program is very high. There are very good relationships with external providers of more specialized services in the United States, example the New England Donor Bank and John Hopkins Medical School. There appears to be a healthy culture and organization within the Critical Service.

No Unmet Criteria for this Priority Process.

Developmental Disabilities Services

Clinical Leadership
Providing leadership and overall goals and direction to the team of people providing services.
Surveyor Comments

This team is interdisciplinary, strong and very passionate about the service users to which they deliver services. The team contains all health providers including social work, dietician, psychiatry, ot, physio, speech language and dietician are as consultative providers, outside dental service, outside physicians, the referral is processed through the social worker. There is a gap now in the psychologist position. They team access pharmacy through MAWI mental health. The service has 14 community homes (71 service users in the community homes and 4 in house beds at the Coral House, where ofcs and day program are housed). Day services are offered 5 days per week. Respite is offered to a maximum of 6 wks/year.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

The team has a very nice renovated work space. It is very pleasant and appealing. I visited the following group homes: Coral House (home base with 4 inpatients, also has the Day Program), Keepers Cottage, Sunset Villa, Mount Hill, West Side Villa, Rose Villa, Bostock Hill.. Each home was very pleasant as a home setting, very well maintained and decorated, clean, each had fire alarms, fire exits and fire plans. Each service user has a home risk assessment completed as well as a falls assessment to ensure safety. The staff are passionate about the work they do, these homes are truly homelike settings with evident caring and the staff are strong advocates for these clients. The team has good support for educational opportunities. They have a Journal club, access journals, internet, lunch and learn. Allied services have a Research Committee meet monthly to discuss best practises to ensure they are delivering up to date services. The services were reviewed by Dr Jim Williams from the UK in June 2010. He is specialized in learning disabilities. The report was favourable for the service and the team have implemented the recommendations. Some staff are completing the Community Worker for Learning disability course that is offered by those staff certified in teaching this program. The team supports student placements which encourages new graduates to work in this service area. The client satisfaction survey was very good, they scored 100%. The team celebrate these successes. One area for improvement was around transportation and they now have a new van wheelchair ordered. The other area for improvement is for more activities.

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

<table>
<thead>
<tr>
<th>Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td>The team is regularly educated and trained on how to handle ethics-related issues.</td>
<td>4.6</td>
<td></td>
</tr>
</tbody>
</table>
**Episode of Care**

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

**Surveyor Comments**

The team makes every effort to meet the client needs. For example: one community home took in an additional service user and made some modifications in the home to accommodate her. The team also made the effort to ensure some clients transitioned into the community together as they were together for a long time and they wanted to make transition easier for them. The staff is advocates for their service users. Please note that the organization has substituted clients and patients with service users. I use service users and client interchangeably. The mandate of the team is to transition their service users from the institution into the community for an improved quality of life.

No Unmet Criteria for this Priority Process.

**Decision Support**

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

**Surveyor Comments**

The mandate of the team is to admit service users with an IQ below 50 and don’t demonstrate dangerous behavior that may pose a risk to staff. Computers have been approved for the community homes. This will be a big improvement for the staff in these homes. It will improve communication with email access, internet...The team rotates mtgs around to the different homes on a monthly basis and staff appreciates that.

Staff said they feel a bit isolated so the organization is encouraged to focus on ensuring staff feels supported, knowledgeable of what is going on within the health system, and feel a part of the larger system.

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization has a process to select evidence-based guidelines for developmental disabilities services.</td>
<td></td>
<td>15.1</td>
</tr>
</tbody>
</table>

**Impact on Outcomes**

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

**Surveyor Comments**

The team collects data that they use to benchmark and make improvements and changes. The team meets regularly to discuss referrals, service users, benchmarks.
The team is proud that they have been able to close 2 units at Coral House and move 40 service workers into the community thereby transitioning those clients into the community. No new funds were required. Staff says they are happy and satisfied with what they are doing in the community and the clients have an improved quality of life and are in a more home like setting.

No Unmet Criteria for this Priority Process.

**Diagnostic Imaging Services**

**Impact on Outcomes**

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

**Surveyor Comments**

Area of strength The majority of patients report the questioning of 2 identifiers by staff.

No Unmet Criteria for this Priority Process.

**Diagnostic Services - Diagnostic Imaging**

Availability of diagnostic imaging to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

**Surveyor Comments**

Strengths Changes in service demand and patient utilization patterns were the impetus for modifications in staffing hours. It was determined that there was increased demand for late morning and early afternoon time slots. Subsequently staffing and staff lunch hours were adjusted to meet this community need, increase patient flow and patient satisfaction.

Staff in the mammography department have designed and implemented a suite which is aimed at creating a patient centric, comfortable environment in an attempt to decrease barriers for client access. The colours, design, music and audio visual inputs are all directed to create a less threatening venue for clients. Client feedback has been extremely positive.

Client areas for general Xray (KEMP and Lamb Foggo) CT, MRI, Mammography (KEMP) are separate from procedure areas.

The majority of verbal requests would be made by a physician directly to a radiologist.

CT and MRI staff at the KEMH maintained a paper and electronic accession record. The remainder of areas maintained an electronic record. The information is also available electronically. At the Lamb Foggo Urgent Care centre an electronic accession record is used.

An extensive library of patient education materials have been developed. Staff indicate that frequently patients have not received education and information from the referring physician and appreciate brochures and instructions as supplied by the DI department. The materials available were reviewed and found to be extensive.

The DI department follows the Ministry of Health of Bermuda Safety Act rather than the Radiation Protection Act.
The team conducts surveys of clients and prescribing professionals when evaluating its DI services.

The organization follows the Ministry of Health of Bermuda Radiation Act rather than the Canadian Nuclear Safety Commission.

The department is in the process of converting policies from paper to electronic versions.

The department follows the BHB organizational policy of updates to policies every two years and as needed do to significant changes in content.

Staff state that they feel safe performing their work.

Safety and quality are well integrated into the culture, attitudes and daily practice of the DI team. Leadership in DI is respected, approachable and innovative.

Area for Improvement Signage regarding radiation exposure was not present on Xray 1 and Xray 2 at the KEMP. Within 24 hours of first visit the signage had been added to the two areas at KEMH.

Signage was posted on all doors at the Lamb Foggo Centre regarding radiation. At the Lamb Foggo centre there was no signage encouraging female patients to identify the potential for pregnancy. This signage was present in multiple places at KEMP. The organization would benefit from consistent signage.

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<thead>
<tr>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>The team posts safety warnings at the entrance of the procedure room and restricts access when it is in use.</td>
<td>4.6</td>
<td>↑</td>
</tr>
<tr>
<td>The team follows a specific procedure for persons assisting during imaging examinations.</td>
<td>10.5</td>
<td></td>
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</tbody>
</table>

**Emergency Department**

**Clinical Leadership**

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

**Surveyor Comments**

The Lamb Foggo Urgent Care center services the ambulatory population on the east end of the island. The Urgent Care center meets the needs of the local community as well as the greater island by providing efficient services for non-emergent concerns. The Urgent care center is located in an area of rapid development and growth. The mandate of the Urgent Care center is aligned with the strategic direction of the organization.
The Ladies Auxiliary at the KEMH (the Pink Ladies) has generously donated funds to purchase a mass causality vehicle for the pre-hospital ambulance program responding to a community need.

Language and interpretation services are good examples of both collaboration and meeting needs of the community. To communicate with the transient tourist population with numerous language needs the organization has identified a number of translators available to assist in communication.

Student placement at both KEMH and Lamb Foggo Urgent Care center would be preceptor based. Volunteers are present at KEMH but not at Lamb Foggo.

At both Lamb Foggo and KEMH staff states that they have the opportunity for input to roles and case assignments as appropriate.

Strengths

Both KEMH and Lamb Foggo Urgent Care center serve specific identified community needs. The collaboration and identification of services along with education of patients and families has lead to decrease through times in both facilities.

Safety and quality are integrated into the culture, attitudes and daily practice of the ER team. Leaders in ER are respected, approachable and innovative.

No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

A robust interdisciplinary team delivers care in the Emergency Department at KEMH. The Emergency Medical Technicians are an integral part of the team.

Communication appears to be an area of strength. Venues of communication include email, meetings, communication boards, in service activities, postings in staff lounge areas and face to face. Staff stated that they felt up to date on information.

All staff indicated a performance appraisal within the last calendar year.

Orientation appears to be an area of strength. The clinical nurse educator provides a robust orientation for staff.

A number of committees meet monthly with reports at staff meetings. As well information is disseminated via the venues noted above.

Orientation includes education pertaining to the unique cultural milieu of Bermuda.
Education regarding both prevention and avoidance of workplace violence was extremely well done and well received by all ER staff.

Staff appreciate the input to staffing and workload.

Staff appreciate recognition by the ER leadership team. The example of team cohesiveness during a recent hurricane prompted leadership to nominate a number of ER staff for a “You make a Difference” STAR peer to peer recognition award. The staff displaying a STAR were proud and happy to comment on receiving the recognition and award.

Strengths At both Lamb Foggo and KEMH staff are cohesive and supportive of team members.

Patient care is the primary focus in service delivery.

Staff are proud of the quality of care given to patients and family.

Performance appraisals are all current.

Team member appreciate recognition for their efforts.

Area for improvement

At KEMH the registration desks are not equipped consistently with safety alarms. The desk closest to the outside door is equipped with a panic button. The desk closest to the ER was equipped with a central alarm button. Should the situation arise, the person sitting at the desk closest to the outside door would need the person to her right in the next cubicle to activate the alarm.

At the Lamb Foggo urgent care centre the alarm button in the xray room was activated. The alarm at the registration desk which is connected to police was not activated. Individuals could not recall a testing of the alarm system. To ensure patient and staff safety, the organization might benefit from a test of the alarm which is located at the registration desk.

No Unmet Criteria for this Priority Process.

**Episode of Care**

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

*Surveyor Comments*

Staff safety was certainly emphasized. All staff commented on a comfortable level of personal and professional safety working in the ER.

The KEMP ER offers services 24 hours a day, 7 days a week. The Lamb Foggo Urgent Care center hours are limited from 4 pm and 12 am on weekdays and 12 noon to midnight. Extensive marketing and communication regarding services and hours of operation have been presented to the community.

Off load times are recorded in minutes and not an issue for the KEMH organization.
The team uses ESI Emergency Severity Index which is a 5 level system similar to CTAS with Level 1 being immediate and Level 5 less acute.

There is a process to address the communication of missed x-rays and critical test results.

The ER incorporates a Nursing transfer sheet for intra hospital transfers. Patients being transferred to the mainland would be transferred from ICU rather than ER. This would include an Air Ambulance check list transfer sheet which would be generated in ICU.

Strength Medication Reconciliation is done for patients for decision to admit and at transfer.

Patients have options regarding the appropriate site to visit for all medical concerns ranging from minor to emergent. Many staff works at both KEMP and Lamb Foggo Urgent Care center.

Areas for improvement

At the KEMP here are two areas in the waiting room with decreased visibility of seating areas. One area is to the right of the triage window toward the cashier office. The second area is being a pillar to the left of the triage window. This issue might be rectified with the installation of mirrors allowing visualization of the blinded areas. In addition, the window in the triage desk is high and limits visibility directly in front of the office.

The organization might benefit from a consistent inter facility transfer form which could be utilized by all clinical areas including ER.

Poster notification reminding patients to return to triage if their condition changes would reinforce information given to patients by staff.

No Unmet Criteria for this Priority Process.

Decision Support

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

Surveyor Comments

Staff was extremely enthusiastic regarding the new electronic system in ER - MED HOST. Staff appreciated the ease of use, the functionality, the robust potential for retrieving specific data and patient information. The level of detail available on discharge instructions and the fact that discharge instructions can be customized to individual patients increases the quality of care, safety and education delivered to all ER patients. In addition, the ease of retrieval of patient information, labs, Vital signs and progress notes was most impressive. The chart audit potential is impressive.

Staff report that patient satisfaction has certainly increased with the amount of information and education given to patients and family.

Guidelines that have been adopted are reviewed.
Strengths The adoption of the new record system Med Host has been a positive inclusion in the ER. Ease of use, functionality, education and data retrieval are all noted benefits.

Area for improvement There is no formal process for the identification and selection of evidence based guidelines. The organization might benefit from a consistent formal process to select and review evidence based guidelines. It should be noted that evidence based guideline are currently in place but without a formal, reproducible process to identify, select and review processes with the input from an interdisciplinary team.

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</thead>
<tbody>
<tr>
<td>The organization has a process to select evidence-based guidelines for Emergency Department services.</td>
<td>14.1</td>
<td></td>
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</tbody>
</table>

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

Surveyor Comments
Benchmarking partners include Mass General for trauma and Lahey for vascular issues. KEMH average wait time to see a physician is 59 minutes. KEMH average throughput time for discharged patients is 220 minutes and 10.2 hours for admitted patients. Ambulance staff state that off load times are usually measured in minutes.

Strengths Majority of staff at KEMH and Lamb Foggo Urgent Care centre state that they have received prevention of violence in the workplace training. Staff states that they feel comfortable with deescalating techniques and approaches to the violent patient. Staff states that they appreciate this education.

Patient satisfaction scores are approaching or at targets for all areas.

The incorporation of an ED Fast Track at the KEMH and the Lamb Foggo Urgent Care center have assisted in the decrease of throughput times for patients and increased staff as well as patient satisfaction regarding efficiency of services delivered.

The majority of staff stated that they felt safe doing their work.

Area for improvement Regarding the reduction of risk for staff it was noted that glass windows at the triage area for both KEMH and Lamb Foggo Urgent Care center is not safety glass.
The organization might benefit from a formal mechanism to deliver results of patient satisfaction survey to patients and families.

No Unmet Criteria for this Priority Process.

**Organ and Tissue Donation**

Donation services provided from identification of a potential donor to donor management and organ recovery.

*Surveyor Comments*

The ER team is not actively involved in organ and tissue donation. All communication with the New England Organ Bank would be initiated by staff in ICU. ICU staff are trained and educated regarding process and procedures relating to organ donation. Staff in ER would rarely be the first contact to the New England Organ Bank.

Area for improvement ER staff might benefit from awareness and education regarding the process involved in patient referral for organ donation.

No Unmet Criteria for this Priority Process.

**Home Care Services**

**Clinical Leadership**

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

*Surveyor Comments*

This team started as the Early discharge team in 1996 and has since had their name changed to the Home care team. There is one manager and 4 nurses that serve various parishes to ensure continuity in care delivery which is important to the clients. Various reports (Anderson report, Care of the Elderly in Bermuda) identified a gap in service from hospital care to the home therefore home care services helped to bridge that gap. They have a very high satisfaction rate from their clients; clients want to be at home and there is much evidence that they improve faster at home. GAPP- Geriatric Assessment, Planning and Placement committee is in place to address referrals from hospital to continuing care, it is determined who would benefit from home care services and who requires a higher level of care. The home care team is encouraged to consider a more interdisciplinary team, to provide enhanced services to their clients. At this point in time, their main focus is on wound care, education on various health related issues.

The Home Resource aides, who provide personal care in the home, are supported thru government.

The home care services are allotted 60 hrs for hospital and home care. Additional time can be requested for the client or a community referral can be completed to ensure care is not interrupted.

The home care nurses provide care to 14-20 clients 7 days per week. They do glucose monitoring, vac drsgs… They validated that they adhere to 2 pt identifiers and there was evidence of that during my home visits. They were very respectful of the clients and their surroundings.
Most all equipment is disposable and provided by the hospital. Scissors and other instrument that were reusable were cleaned using appropriate process by the nurses. They have a good understanding of infection control practices and use very good technique in drsg procedures. The nurses use medication reconciliation on admission and transfer/discharge.

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

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<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
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</thead>
<tbody>
<tr>
<td>The organization identifies the resources needed to achieve its goals and objectives.</td>
<td>2.4</td>
<td>↑</td>
</tr>
</tbody>
</table>

**Competency**

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

**Surveyor Comments**

The home care team completes the RN competency assessment. They have job descriptions that they are familiar with, have annual performance reviews and feel supported in education and ongoing professional development. To work in home care you must have a minimum of 2 yrs nursing experience.

No Unmet Criteria for this Priority Process.

**Episode of Care**

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

**Surveyor Comments**

Since the home care team is small and made up only of registered nurses, they review clients together; they assign caseload according to parishes and equitable workload. They implemented care paths and plans of care for each client, client goals are specific and time related, these goals are reviewed regularly by the nurse and documentation provided. Each nurse documents shortly after they complete the client care. Each client has a consent and contract signed at the beginning of the service. Each nurse starts and finishes her day at the hospital office; therefore all documentation is kept secured there. They make a very good effort to ensure client privacy as everyone knows each other in most communities.

Staff feels safe in their jobs, they are provided with cell phones and pagers. If there is a risk or nurses don't feel comfortable seeing a pt alone, then 2 nurses are assigned. They do have the option to decline a pt for specific reasons. They have a good understanding and implementation of medication reconciliation. They are hoping to expand their focus, from mostly wound care and mgmt into other service areas. Their client satisfaction results are very good and all clients today were pleased with their services. The community wants to be at home sooner to continue to heal and recover and are requesting more home care services provided to them and at an earlier point in their continuum of care.
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<tr>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>Staff and service providers work in teams to deliver home care services.</td>
<td>3.1</td>
<td>↑</td>
</tr>
</tbody>
</table>

**Decision Support**

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

*Surveyor Comments*

The team uses various sources to ensure they are providing leading practice to their clients in care delivery. They have inclusive documentation that is recorded appropriately and kept secure. They carry a minimum chart component with them to the client’s home for documenting the progress in care. The goals for client are reviewed on a regular basis.

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<tr>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>The organization identifies its needs for technology and information systems.</td>
<td>13.1</td>
<td></td>
</tr>
</tbody>
</table>

**Impact on Outcomes**

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

*Surveyor Comments*

The team ensures that client goals are identified and reached within timelines. If not then new timelines are identified. Client satisfaction survey results are very good and they use these results to make improvements and changes. There is evidence that this team provides education to their clients and families around safety.

They always identify a backup plan, in the event they can’t get to the client. For example, they will provide education and training to the client or family about how to do the dressing change, what to observe for, what to report.

No Unmet Criteria for this Priority Process.
Infection Prevention and Control

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

Surveyor Comments

Four preventionists are employed by the organization. Resources are allocated to infection prevention and control but what is more impressive is the extensive interprofessional infection prevention and control committee. This committee has representation from all relevant areas such as microbiology, pharmacy, hospitalists, housekeeping and human resources to name just a few. Commitment to quality and patient safety is readily apparent as the work of this committee is not only inclusive of all areas but is also accountable to the overall Quality Council and subsequently to the governance committee of the Board.

Infection rates are tracked and regular updates are provided to the national public health department and also internally to relevant areas. Reporting is timely and the frequency of reporting is adjusted based on the issue(s) at hand. For example, MRSA and clostridium difficile rates are currently reported on a weekly basis.

The committee has access to a broad range of evidence and is able to stay up to date through the use of the excellent library services available through the organization and the technology links with major overseas centres. Extensive infection prevention and control policies are in place throughout the organization. Not only are these in place for organization wide procedures but also, each service and support area also has relevant infection prevention and control policies and procedures in place. All policies reviewed reflected appropriate research and best practice information and documented references where applicable. Examples of extensive infection prevention and control policies in place include and apply to housekeeping, laundry, cleaning agents, aseptic techniques, construction/renovation and air filtration units. Also of note is the policy requiring adherence to the Canadian Standards Association's Infection Control during Construction, Renovation and Maintenance of Health Care Facilities.

Ongoing education regarding policies and procedures occurs. Hard copy manuals are in place in each care area. Policies and procedures are now also available on the Intranet site. Specific relevant education and training opportunities are provided for staff. An example provided is the housekeeping inservice education provided regarding 'C Diff' cleaning practices. This in conjunction with a cleaning audit supports successful implementation of the policy.

As issues arise, the infection prevention and control committee is commended for it thorough exploration of potential root causes and solutions. A "bundled" approach whereby relevant stakeholders are involved in determining the appropriate course of action is taken. This is commended.

A comprehensive hand hygiene program is in place. Education regarding the importance of hand hygiene, the indications for hand hygiene, and hand hygiene techniques has occurred throughout the organization and is well articulated in the hand hygiene policy. Guidelines for the selection of hand hygiene products is in place as are hand care, finger nail care, and other important considerations. A hand hygiene audit has been in place for some time and with ongoing attention and support, the organization has realized enormous success in many areas with an 80% hand washing compliance rate achieved in some of those. The Committee is encouraged to continue its intensive efforts in supporting staff and auditing compliance in this regard.
Progress has been made in ensuring that information and education about preventing infections is documented in the client record. The organization has developed a multidisciplinary patient education record which notes the education needs of the clients as well as identification of the learner (client/family), teaching method and outcome.

Internal processes are in place to promptly identify healthcare related infections as well as potential outbreaks. Processes are also in place to ensure prompt communication occurs with national personnel.

A policy is in place to address loaner instruments processing and sterilization.

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>All endoscope reprocessing areas are equipped with separate clean and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.</td>
<td>13.4</td>
<td>↑</td>
</tr>
</tbody>
</table>

**Laboratory and Blood Services**

**Diagnostic Services - Laboratory**

Availability of laboratory services to provide health care practitioners with information about the presence, severity, and causes of health problems, and the procedures and processes used by these services.

**Surveyor Comments**

Although the laboratory has a copy of their referral sites' licence, a request should be made to received regularly a copy of their External Quality Assurance results.

The data would be a proof of the quality of services provided and would demonstrate their compliance to specific testing instead of general overview.

Records of past employees are only kept in the laboratory 2 years after the individual has left their position. They should be kept for a longer period (10 years) or arrangement should be made with the Human Resource department to transfer the records to them. The organization does not participate at this moment in any research activities. Any request for research activities would be transferred to the Hospital Ethic committee.

Most SOP have been up-dated annually but there is still some who need to be revised. All SOPs are available on the Laboratory site and use on a regular basis as a reference by the technologists.

There is no regular audits for LIS system to verify all the steps involved to transfer a result from the laboratory to patients’ chart in the hospital information system. A process that would verify data from the instrument, through the interface (LIS) and finally, on the patient’s chart should be implement. The calculation done by the LIS (ex: creatinine clearance, 24 hours urine, eGFR, Etc) should be compare periodically to results calculate manually.

The laboratory collection area is lacking privacy and comfort for the patients. The chairs are too high for the elderly patients and do not allow easy access or protection to patients fainting or collapsing while taking their blood. The patients should be identified in a positive way meaning being ask their name and date of birth before a blood sample is collected.
Some work surface are damaged and difficult to clean or disinfect. They should be replace to prevent contamination and employees safety. Only major intervention are kept for the lifespan of the instrument. The procedure should be changed to maintain all record.

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The laboratory verifies the quality of services provided by referral laboratories and consultants.</td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td>ISO Reference: 15189-07, 4.5.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The laboratory annually evaluates the effectiveness of its education, training, and competency assessment activities and records the results.</td>
<td></td>
<td>7.8</td>
</tr>
<tr>
<td>CSA Reference: Z902-10, 4.3.2.3, 4.3.3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The laboratory keeps staff records for a minimum of 10 years after the individual has left the employ of the laboratory.</td>
<td></td>
<td>7.10</td>
</tr>
<tr>
<td>CSA Reference: Z902-10, 4.3.4, 20.6.4.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The organization has a committee or research ethics board that reviews and approves research activities with which the laboratory is involved.</td>
<td></td>
<td>9.8</td>
</tr>
<tr>
<td>The laboratory reviews and updates the SOPs annually or more often if needed.</td>
<td></td>
<td>10.5</td>
</tr>
<tr>
<td>CSA Reference: Z902-10, 4.6.1.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The laboratory reviews data entered into the LIS for accuracy and completeness.</td>
<td></td>
<td>12.5</td>
</tr>
<tr>
<td>CSA Reference: Z902-10, 21.6.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ISO Reference: 15189-07, Annex B.4-B.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The laboratory’s collection areas ensure client comfort and privacy, and accommodate disabilities.</td>
<td></td>
<td>13.3</td>
</tr>
<tr>
<td>CSA Reference: Z902-10, 22.4.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ISO Reference: 15189-07, 5.2.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The layout of the laboratory makes it easy to wash, clean, and disinfect work areas, equipment, and floors.</td>
<td></td>
<td>14.2</td>
</tr>
<tr>
<td>CSA Reference: Z902-10, 22.2.1, 22.2.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The laboratory maintains accessible records for the lifespan of each instrument in accordance with laws and regulations.</td>
<td></td>
<td>16.8</td>
</tr>
<tr>
<td>ISO Reference: 15189-07, 5.3.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Long Term Care Services**

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

**Surveyor Comments**
The teams develop goals and objectives jointly. For example, the team set a goal to be 100% restraint free when the surveyors visited. They made some improvements in the area however they still have 2 on one unit and 7 on the other requiring physical restraint. All chemical restraint has been eliminated. The 9 remaining are reviewed on a regular basis to define options for moving to zero restraint.

There is a Residents Council that is for all units. I was very impressed that this council contributed $20,000, from their own funds, to purchase bed alarms to help keep the residents safe. This is commendable and certainly is evidence that they have safety as a focus.

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<table>
<thead>
<tr>
<th>Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td>The team uses the information it collects about clients and the community to define the scope of its services and set priorities when multiple service needs are identified.</td>
<td></td>
<td>1.2</td>
</tr>
<tr>
<td>The team regularly reviews its services and makes changes as needed.</td>
<td></td>
<td>1.5</td>
</tr>
</tbody>
</table>

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

**Surveyor Comments**
The continuing care team completed the long term care standards. They are responsible for 120 beds plus 2 respite within the hospital. There is a unit with 52 beds that have ventilated resident, a unit with 39 beds and a 30 bed unit for alzheimers and related diseases. The residents not mentioned are seniors, younger population who are physically disabled. There is an interdisciplinary team that includes nursing, geriatrician, clinical managers, environmental staff, dietician, aides, ot/physio and aides, medical social worker...There is no pharmacy involvement and this was identified by a number of team members as a gap in their continuum of care.
The nurses complete the Rn Competency Assessment. The team has completed or are registered in the Non violent Crisis Intervention course. The staff have up to date job profiles and have annual performance reviews completed. No Unmet Criteria for this Priority Process.

**Episode of Care**

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

**Surveyor Comments**

There is limited access to clinical pharmacist for input to the team for these clients; however, they do have access to pharmacy to address their questions and requests. Medication reconciliation is done at admission to KEMH and this information is shared with the continuing care unit. The team on lower unit is very proud of their ability to eliminate or prevent pressure ulcers through stimulation, mobilization, turning clients, good nutrition; they use a very holistic approach with addressing this challenge with success. They also have reduced the rates of MRSA thru good hand washing, education to families on hand washing...

The Alzheimer’s unit is secured. All units have space challenges however I want to commend them for having all equipment to one side of the corridor for easy access in the event of emergency or fire. The upper floor team has implemented Auxiliary and Nurse Councils. The Auxiliary Council has developed a list of issues they want to make improvements in.

The Nurse council has implemented Walk Around, where they walk around to see clients and report at shift change. This appears to have improved their transfer of information for care delivery. Some challenges the continuing care team have is the increased acuity of the clients, and the extra time required to distribute medications with the Pyxis and Mak. They identify and share tips for improving the length of time it takes to distribute the medications.

There was not consistent insight on how often fire drills were held. Fire drills should be held and documented over all shifts to ensure all staff is familiar with what to do in the vent of a fire. They have not exercised evacuations.

There is a chapel available in the hospital. The team has access to bus and van to transport clients out to events. There is a great activity schedule, large to read, posted, and outlining lots of activities for the clients. The clients in the alzheimers unit have food served to them in their dining room and them like that very much. The clients in the upper and lower units do not like the food but are having a new cart system implemented in the near so food will be served at the appropriate temperature.
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<table>
<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following transition, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition planning.</td>
<td>12.8</td>
<td>↑</td>
</tr>
</tbody>
</table>

**Decision Support**

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

**Surveyor Comments**

Each client has a record. There are guidelines on documentation, how often, by which........There is a process in place for a client to access their file. The clients also were familiar with the complaint process. The team has fully implemented Pyxis and Mak to assist them around medication management. Medication reconciliation is done on admission to ensure accuracy of drugs.

No Unmet Criteria for this Priority Process.

**Impact on Outcomes**

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

**Surveyor Comments**

The team had a goal to be 100% restraint free when accreditation came up however they are at 92% which is still good. They have 2 pts on one unit and 7 on another where physical restraints are still in use to protect staff and pts. Chemical restraint is eliminated and the team is proud of that. They continue to review those clients still on restraint regularly to research and evaluate other options. The team has a good falls prevention strategy that has been implemented and monitored to evaluate effectiveness. Client satisfaction surveys demonstrated positive results in continuing care. In discussions with clients and families, they expressed the desire to have the choice to see their own family physicians, to ensure continuity in care as these drs know them.

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</tr>
</thead>
<tbody>
<tr>
<td>The team informs and educates its clients and families in writing and verbally about the client and family’s role in promoting safety.</td>
<td>16.4</td>
<td>↑</td>
</tr>
</tbody>
</table>
Managing Medications

Medication Management

Interdisciplinary provision of medication to clients.

Surveyor Comments

This team has done a good job in ensuring they have an interdisciplinary membership on the committees to address issues, make decisions on formulary, communication and training. There is a Pharmacy and Therapeutics (P&T) committee that meets monthly. The committee has a multidisciplinary membership, including finance, and is responsible for formulary additions and deletions. Best practices, high risk drugs.... They develop a monthly newsletter called P & T Newsletter to communicate information, and to identify changes in the formulary. There is one formulary for the organization as a whole.

There are no sample drugs used across the organization. The only example of investigational drugs is the origin trial for diabetes (double blind study) under chronic disease mgmt... There are pharmacy policies in place to guide that trial. I would recommend that the organization develop policies and monitoring of investigation drugs to include solid documentation to guide the process, if you are going to continue to use investigational drugs.

The Medication Mgmt Committee has replaced the Nursing Pharmacy Committee and includes quality and risk representatives. It is more interdisciplinary in membership as well. This committee reviews medication incidents and provide feedback to staff. They also ensure best practice information is available and they keep abreast of changes in ROP's. And other pertinent information from Accreditation Canada. They also produce a monthly newsletter, called Medication Rounds that talks about medication reconciliation, drug safety tips, and lots of other good info

The new Quantos system will assist with the reporting and tracking of medication incidents, and improve the area of reporting in the event that staff may feel that they are impacting negatively another staff member. It also helps capture near misses.

There is an on call pharmacist available 24/7 from the area, as well as an on call support for entering meds from California.

All staff is orientated to the medication use process before use. Some of those skills for nurses are outlined in the RN Competency Assessment specific to areas where they will work.
Staff and providers are well oriented to ADE’s, and the is appropriate information shared.

There are policies in place that outline the process for adding and deleting meds to the formulary. Often physicians are asked to come and speak to their requests that have been fully documented to the P and T comm.,

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<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
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</tr>
</thead>
<tbody>
<tr>
<td>The organization has a policy and process to manage the use of investigational medications.</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Medications are stored in secure areas accessible only by authorized staff.</td>
<td>6.3</td>
<td>↑</td>
</tr>
<tr>
<td>At the start of service, service providers educate clients and families about how to take an active role in ensuring medication prescribed for them is administered safely.</td>
<td>16.1</td>
<td>↑</td>
</tr>
<tr>
<td>Service providers ensure clients know who to contact, and how to reach that person, if they have concerns or questions about their medication, both while receiving care/service and at end of service or transfer of service.</td>
<td>16.3</td>
<td></td>
</tr>
<tr>
<td>Service providers record in the client record verbal or written information that is provided to the client.</td>
<td>16.5</td>
<td></td>
</tr>
</tbody>
</table>

**Medicine Services**

**Clinical Leadership**

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

**Surveyor Comments**

Strengths The team has made an outstanding effort to gather information regarding clients and community. The increase in Cardio-vascular disease, Diabetes, and Hypertension has caused the Medicine team to review and re-define the scope of its services.

The Open Airways initiative has demonstrated a dramatic decrease in both adult and pediatric asthma. This has had a significant impact on the number and severity of patient admissions related to asthma.

Input to work design and case assignments was acknowledged and appreciated by staff.
Leadership/management in Medicine is truly respected. The management team is visible, approachable, innovative and progressive in actions. Safety and quality are integrated into the culture, attitudes and daily practice of the Medicine team. Respect for team members is exemplary.

No Unmet Criteria for this Priority Process.

**Competency**

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

**Surveyor Comments**

Strengths The team identified various modes of communication within the team and organization. Staff commented that they felt well informed with the incorporation of email, team meetings, face to face, communication books, postings in staff meeting areas and lounges and informal communication. Communication within the team appears to be a strength.

The team includes the position of patient advocate. The individual in the role of patient advocate is appreciated and acknowledged by management and staff.

All staff members indicated that they had a performance appraisal within the last year.

Many staff were proud to have been the recipient of a STAR award as presented by the organization.

Area for improvement There is no dedicated space for team to relax or debrief. Staff and management did identify a number of places on the ward, and in the organization where they could go to obtain a private place to reflect or support each other in an uninterrupted manner.

No Unmet Criteria for this Priority Process.

**Episode of Care**

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

**Surveyor Comments**

Strengths The organization has developed a robust compliment of patient education materials including a "Patient Handbook", "Safe Programme" for falls, "Your role in Patient Safety", "Preventing VTE", "Let’s talk about advance directives" and "Asthma education centre". All patients and families interviewed acknowledged the Patient handbook and falls brochure. Some patients acknowledged other brochures. The materials are of quality regarding content and visual presentation and were appreciated by patients and family.

Education of patients and families appears to be strength in the Medicine service. Education was extremely well documented in the patient chart on the Multidisciplinary Patient education record which clearly indicates the education needs, learner, teaching method and outcome. As well barriers to learning were identified and documented.
The multidisciplinary patient education record is an excellent tool to document, track and verify that education has occurred, by which health care professional, to patient or family, and by which method.

The organization includes an Ethics Committee. There is a formal arrangement with Dalhousie University in Halifax regarding ethics consults.

On both Medicine wards at KEMH, patients are not permitted to self-administer their own medications. If patients bring their own meds into the organization, there is a formal process to have a pharmacist identify, re-label and store the meds in unit dose which is then dispensed via the Pixel medication system.

There is a transfer form for patient transfers from Medicine to another inpatient unit at BHB.

Area for Improvement To ensure patient safety and the delivery of quality patient care, the organization might consider the development and implementation of a check list for air transfers from the Medicine team to other organizations on the mainland. A consistent, concise check list of information and documentation for air transfers would increase consistency.

Of note - an inter-facility air transfer check list is utilized in ICU. The organization might consider a revision of this checklist for use by the Medicine and ICU teams.

Strength Patient complaints are dealt with in a timely manner. Team leaders are visible on the floor at various times during the day as well as encouraging feedback from clients and families. Team leaders conduct daily rounds and speak directly with clients and families. The Medicine team also benefits from the input by a Patient Advocate who is visible being located on the Medicine floor.

No Unmet Criteria for this Priority Process.

**Decision Support**

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

**Surveyor Comments**

Strength Staff state that they are adequately prepared for changes in technology. The staff states that there are numerous educational opportunities for assistance regarding IT. Staff has embraced the PIXIS system for drug delivery.

Area for Improvement There is no formal organizational process for the identification, selection and review of evidence based guidelines. Guidelines currently exist for multiple conditions but there is no standardized approach to the selection. The organization might benefit from a formal consistent process to identify, select and review evidence based guidelines.
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<table>
<thead>
<tr>
<th>Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td>The organization has a process to select evidence-based guidelines for medicine services.</td>
<td></td>
<td>14.1</td>
</tr>
<tr>
<td>The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.</td>
<td></td>
<td>14.2</td>
</tr>
<tr>
<td>The team’s guideline review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.</td>
<td></td>
<td>14.3</td>
</tr>
</tbody>
</table>

**Impact on Outcomes**

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

*Surveyor Comments*

Strengths All staff observed incorporated two patient identifiers. Patients reported staff using client identifiers when delivering medications and services.

The attention to the falls prevention program and implementation of all components was extremely well done. Staff report a dramatic decrease in the number of falls.

Staff state that they feel safe performing their work.

Area for improvement The organization might benefit from a formal process to deliver the results of patient satisfaction surveys, as well as accomplishments to patients, families and the community.

No Unmet Criteria for this Priority Process.

**Mental Health Services**

**Clinical Leadership**

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

*Surveyor Comments*

see below No Unmet Criteria for this Priority Process.

**Competency**

Developing a highly competent interdisciplinary team with the knowledge, skills and abilities to develop, manage, and deliver effective and efficient programs, services, and care.
Surveyor Comments
see below
No Unmet Criteria for this Priority Process.

Episode of Care
Healthcare services provided for a health problem from the first encounter with a health care provider through the completion of the last encounter related to that problem.
Surveyor Comments
see below
No Unmet Criteria for this Priority Process.

Decision Support
Information, research and evidence, data, and technologies that support and facilitate management and clinical decision-making.
Surveyor Comments
see below
No Unmet Criteria for this Priority Process.

Impact on Outcomes
The identification and monitoring of process and outcome measures to evaluate and improve the quality of services to clients and the impact on client outcomes.
Surveyor Comments
Mental Health Services continue to be restructured to meet the need of the population it serves in Bermuda. There has been a transition into cost effective and less intrusive community programs, eg. Group homes, which are contributing to the wellbeing of patients and family members. More specialized programs have been developed to meet the need of the elderly population, such as the mood and memory clinics. Recognition must be given to the mental health team for the work they have done in the transition of long term patients from the inpatient units to group homes. Since the last accreditation visit there has been some improvement to the physical plant which has contributed to better facilities for staff and patients. Good opportunities are provided for continuing education at all levels of the Service. Overall there is good flow of patients into the facility with the exception of periods when due to shortage of longer term beds there may be delays in admitting patients to the acute care unit. Good training opportunities are provided for all staff, including the ongoing development of managers. The Service is actively involved in the Bermudization of the clinical staff to create more talent pool for future developments. The emphasis of patient and family education is noted. Mental health continues to evolve being cognizant of the community model with an emphasis on the recovery approach. Managers has bought in and are working diligently to help their staff to integrate this philosophy in their practices. Suggestions to consider is the application of standards for the group homes run by the hospital. The momentum of the ongoing changes to expand community services to include day programs and home services needs to be maintained in order to develop services for the Island utilizing the general hospital as the core of the inpatient interventions with a network of progressive community services. This type of model seems to be cost effective and utilizing clinical information systems to coordinate care and using a disease management approach Bermuda.
Could develop a solid psychiatry program. The affiliation with Howard University and other possible international
Centres could help in providing more specialized expertise, which could be access via telepsychiatry. Mental
health services complied very well with the high priorities criteria and the required organizational practices of
Accreditation Canada.

No Unmet Criteria for this Priority Process.

**Obstetrics/Perinatal Care Services**

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

*Surveyor Comments*
see below No Unmet Criteria for this Priority Process.

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

*Surveyor Comments*
see below No Unmet Criteria for this Priority Process.

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

*Surveyor Comments*
see low b No Unmet Criteria for this Priority Process.

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

*Surveyor Comments*
see below No Unmet Criteria for this Priority Process.

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

The Obstetric Perinatal Services demonstrates an integrated approach to care of their patients and families. The staff is competent, willing to learn and are much involved in continuing nursing education such as journal clubs and peer presentations based on relevant components of their practices. Best practices are reviewed and applied on an ongoing basis. The Service is commended for their high rating in patient satisfaction and for their response to their client suggestions which has led to improvements in the delivery of services, including the meal service. This Service promotes continuity of care and has good links with the local physicians. The Booking Book, a simple and effective tool, allows for the provision of better care and for the planning of manpower needs. The neonatology component medical leadership and nursing team contribute significantly to the quality of the program.

No Unmet Criteria for this Priority Process.

Point-of-Care Testing

Point-of-Care Testing Services

Provision of testing outside the laboratory, near where care is delivered to the client, in order to provide practitioners with information about the presence of health problems, and the procedures and processes used by these services.

Surveyor Comments

The interdisciplinary POCT committee is very active and involve in the process of selecting new POCT but it does not review the quality control data on a regular basis. The data is brought up only when there are major concerns or unresolved issues. The organization has one coordinator to oversee the entire POCT program. The success of this program is mostly due to this enthusiastic person and her availability. The coordinator position is occupied by a nurse. Her presence has managed to create a better understanding between the laboratory and the nursing. There is 6 different analysis presently offered on POCT devices. The program will need more personnel to continue to offer the same level of follow-up and competency assessment. The extra time could also be used to set up an external quality program for each testing being done at the patient’s bedside.

The organization does not have a standardized policy for reporting and disclosing POCT results. A section covering the post-analytical process could be added to the existing SOPs. It is impossible for the organization to control the use of most POCT since they are manual techniques. Instrumentation and standardization of urine test, BHCG and Drug screening would help the organization to achieve this goal.

The request for glucose is not always documented in the patient file. It would be a process improvement to develop a standing order for all patients (Emergency, clinic and In-patients) Although only glucose results obtain from a POCT device is document on the patient insulin chart, the results are not identified as such. The chart should be revised to include the POCT devise and the units used.
The table below indicates the specific criteria that require attention, based on the accreditation review.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The interdisciplinary committee review POCT quality control data on an annual basis and make improvements as needed. CSA Reference: Z22870:07, 5.6.6</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>The organization has the appropriate mix and number of staff to carry out POCT. CSA Reference: Z22870:07, 5.1.1</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>The organization controls the use of POCT equipment by assigning each health care professional delivering POCT unique identification numbers.</td>
<td>5.7</td>
<td>↑</td>
</tr>
<tr>
<td>For each point-of-care test, the health care professional delivering POCT must receive a written or electronic request from a clinician.</td>
<td>7.1</td>
<td>↑</td>
</tr>
<tr>
<td>Before performing the test, the health care professional delivering POCT verifies that the clinician has complied with the procedure for requesting a point-of-care test.</td>
<td>7.2</td>
<td>↑</td>
</tr>
<tr>
<td>In cases where the organization receives a verbal request for POCT, there is a written procedure for responding to the clinician and requesting a written or electronic request.</td>
<td>7.3</td>
<td>↑</td>
</tr>
<tr>
<td>The organization has a standardized written or electronic policy or procedure on how to report and disclose all POCT results. CSA Reference: Z22870:07, 5.8.2</td>
<td>9.1</td>
<td></td>
</tr>
<tr>
<td>When the health care professional verbally reports POCT results to clinicians, the results and methods used to obtain those results must later be documented in a written format and identified as POCT results.</td>
<td>9.5</td>
<td>↑</td>
</tr>
<tr>
<td>When completing the POCT report and filing it in the client record, the health care professional delivering POCT clearly labels the results as “POCT”.</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td>The organization participates in an external POCT quality control program. CSA Reference: Z22870:07, 5.6</td>
<td>10.9</td>
<td></td>
</tr>
</tbody>
</table>
Rehabilitation Services

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

Surveyor Comments
This new team (of 3 yrs) is identified as Allied Health Services (AHS) which has applied the Rehab Standards to their services. This team is made up of allied health service providers, including ot, pt, sw, dietary, speech language, physician.... They have added a consultant physiatrist, Chief of Rehab, Cardiovascular exercise program, hand therapy program, pulmonary assessment service has expanded, lymphedema mgt clinic expanded, increased oncology referrals received. This has increased their team and expertise substantially to better meet the client needs. This is a very cohesive, committed and strong team who strive to meet client needs and improve their outcomes. The team meets weekly to discuss pts.

There are other services, including diabetes program, cardiac program, and other chronic disease mgt services that may be considered under Allied health services to ensure a comprehensive delivery of services for the clients. I encourage the team to focus on care delivery using an integrated approach.

The services are under a new directorate and the services include the rehab day hospital, single service provider consultations as outputs, and rehab beds scattered throughout the facility. The team feels that by being under this new directorate, they have become more cohesive, they are able to provide services to clients on the island where in the past, these clients had to go off island and the community and health care professionals are more aware of what they can offer the clients. They have developed a proposal to the board around what the services should look like for the future and have identified 24 rehab beds are required to meet the needs.

No Unmet Criteria for this Priority Process.

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

Surveyor Comments
The team have access to educational opportunities, they participate in lunch and learns. There is a Research and Audit comm that meet regularly to review practice options and ensure evidence based practice is delivered.

As a result of the outcomes this team monitored and presented, they were able to secure additional staff positions therefore have improved the outpt wait times for their services.

Allied Health Services team is registered with the Council of Allied Health professions (CAHP) and they are required to complete continuing education credits (24 every 2 yrs) to maintain their clinical competency.
The table below indicates the specific criteria that require attention, based on the accreditation review.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Location</th>
<th>Priority for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.</td>
<td>3.5</td>
<td></td>
</tr>
</tbody>
</table>

### Episode of Care

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

**Surveyor Comments**

The rehab equipment is regularly maintained and an inventory of equipment is logged. The goal is by maintaining the equipment, the life expectancy will be improved, and as well they can better plan for equipment replacement.

To improve access to services, clinical referral pathways are implemented for all inpt, outpt, and specialty service with compliance checklists to be completed quarterly starting 2011-12.

The rehab day hospital now has a fully equipped treatment gym separate from the pt wait area to improve pt privacy. There is also a new pt drop off and pick up area to better accommodate pts... This team uses very creative strategies to better meet the pt needs.

The pt satisfaction survey showed a 98-100% approval response to the way they were treated by AHS.

All pts have a falls assessment completed and can be identified if they are risk (orange button).

They have a program "Staying Steady group" that I observed while on site. It assisted pts with exercise and an educational component, as well as assisted them to set their personal and realistic goals, I observed this program to be very interactive, and enhanced their socialization.

No Unmet Criteria for this Priority Process.

### Decision Support

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

**Surveyor Comments**

The AHS has successfully implemented the Point of Service registration and billing so they can register pts for appts on or before the day of service and bill within 24 hrs... They have a centralized record for clients in outpt.

They have implemented a No Show Cancellation policy to address increased nonappearance for appts...

No Unmet Criteria for this Priority Process.
Impact on Outcomes

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

Surveyor Comments

The team has monitored the outcomes for stroke pts and determined that they reduced their length of stay in hospital from 68 days to approx 40 days. This is an improvement that they can be proud of.

The team provides a 48 hrs outpt courtesy call to remind pts of impending outpt appts. They have also implemented an outpt waitlist policy and guidelines to reduce wait times for appts during peak periods.

The team has placed 8 BHB scholarship recipients in fulltime professional posts since 2008. This ensures a good professional and competency base.

This team has done a great deal of work and make numerous improvements to impact their outcomes over the past 3 yrs..

No Unmet Criteria for this Priority Process.

Substance Abuse and Problem Gambling Services

Clinical Leadership

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

Surveyor Comments

see below No Unmet Criteria for this Priority Process.

Competency

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

Surveyor Comments

see below No Unmet Criteria for this Priority Process.

Episode of Care

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

Surveyor Comments

see below No Unmet Criteria for this Priority Process.
Decision Support

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

Surveyor Comments

see below

No Unmet Criteria for this Priority Process.

Impact on Outcomes

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

Surveyor Comments

The Turning Point Programs are well coordinated and are responsive to the needs of the population they serve. The staff is competent and highly dedicated to the objectives of the programs within the context of the Bermuda Board mission. On an ongoing basis the team review best practice models and applied them to their services, eg specialized medications and Quits smart program for smoking. Turning Point staff works hard in establishing and maintaining collaborative initiatives eg with Drug Court and correctional facilities. The Family component of the program is a good example of a progressive program that is helping many improve their lives. Overall good compliance with the standards of accreditation.

No Unmet Criteria for this Priority Process.

Surgical Procedures

Delivery of safe surgical care to clients, from preparation and the actual procedure in the operating room, to the post-recovery area and discharge.

Surveyor Comments

The Operating rooms are well organized and there is effective coordination and linkages with internal and external customers. Good leadership is provided and the competency of the staff in carrying out their functions appears to be working very well. Good mechanisms are in placed when new procedures are introduced to ensure the skills set are updated in order to provide safe patient care. The staff and managers are very proud of the introduction of new surgical procedures which help Bermudians to receive care near their homes but also brings external recognition and could be a source of income to the hospital. The surgical check list is excellent and has been very well implemented. This service has been involved in quality improvement projects that has led to better provision of care. They track key indicators related to quality and the required practices. Overall very good compliance with the standards. There appears to be very good patient and family care with an emphasis in customer services to include the liaison with family members in the discharge process and the call to the patient a day after the surgical intervention is a very good example of excellence in customer service.
The Surgical Care Services provide a very good patient centred approach. Their processes are functioning well. They met all the requirements for the high priority criterias and required organizational practices. The staff have found the ROPs to be very beneficial in the delivery of care. Through various quality improvement initiatives they have implemented activities that are helping to improve communication and enhance team building and cohesion. Examples are the daily huddles and rounds which are open to all members of the team. The evidence manual for the accreditation standards is excellent and it has become a good resource for the staff in the inpatient units. Good opportunities for education are in place. The team uses best practices. The affiliation with renowned health centres in the United States provides many benefits for patients and staff. Cultural diversity among team members is handled well. There appears to be a cohesive team with a healthy working environment. The team monitors quality indicators effectively.

No Unmet Criteria for this Priority Process.
Appendix A - Accreditation Decision Guidelines

The key factor that Accreditation Canada uses to determine an accreditation decision is the degree to which client organizations comply with high-priority criteria and Required Organizational Practices (ROPs). *High-priority criteria* are criteria related to safety, ethics, risk, and quality improvement; *ROPs* are practices that must be in place to enhance client safety and minimize risk.

There are three possible accreditation decisions under Qmentum.

<table>
<thead>
<tr>
<th>Accreditation</th>
<th>Accreditation with Condition (Report, Focused Visit, or both)</th>
<th>Non-accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issued when the client organization has:</td>
<td>Issued when the client organization has:</td>
<td>Issued when the client organization has:</td>
</tr>
<tr>
<td>Met 90 to 100% of high-priority criteria in each applicable set of standards AND</td>
<td>Met 71 to 89% of high-priority criteria in each applicable set of standards OR</td>
<td>Met 70% or less of high-priority criteria in one or more sets of applicable standards AND</td>
</tr>
<tr>
<td>Complied with all applicable ROPs AND</td>
<td>Failed to comply with one or more applicable ROPs OR</td>
<td>Failed to comply with one or more applicable ROPs AND</td>
</tr>
<tr>
<td>Submitted all required performance measure data</td>
<td>Failed to submit required performance measure data</td>
<td>Met 80% or less of the total criteria in all applicable sets of standards</td>
</tr>
<tr>
<td>*CSSS only: obtained 66.6% or more on all CQA indicator questionnaires</td>
<td>*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire</td>
<td>*CSSS only: obtained less than 66.6% on any CQA indicator questionnaire</td>
</tr>
</tbody>
</table>

*CSSS (Centre de santé et de services sociaux) clients in the joint Accreditation Canada/Conseil québécois d’agrément (CQA) program must also administer CQA’s Client Satisfaction indicator questionnaire and the Employee Mobilization indicator questionnaire.

**NOTES**

*Accreditation with Condition* means the organization must meet conditions specified by Accreditation Canada to maintain its accredited status. The nature of the unmet criteria and ROPs determines the timelines for compliance (six or twelve months) and whether the organization must submit a report, undergo a focused visit, or both. If the conditions are not met within the timelines, Accreditation Canada may grant an extension of six months, based on surveyor input, proof of progress, and a plan to meet the criteria.

Failure to comply within the allotted time may result in accreditation being revoked, at the discretion of Accreditation Canada.

*Non-accreditation*: A non-accreditation organization may have its status reviewed six months after the on-site survey if it completes a focused visit within five months. The organization maintains its non-accredited status if the focused visit results are unsatisfactory.