ACCREDITATION CANADA



Driving Quality Health Services

Accreditation Report

The Bermuda Hospitals Board

Paget, Bermuda

On-site survey dates: May 18, 2015 - May 22, 2015

Report issued: June 12, 2015

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

Accredited by ISQua

About the Accreditation Report

The Bermuda Hospitals Board (referred to in this report as “the organization”) is participating in Accreditation Canada's Qmentum accreditation program. As part of this ongoing process of quality improvement, an on-site survey was conducted in May 2015. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada's President and CEO

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

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

Your Accreditation Specialist is available if you have questions or need guidance.

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

We look forward to our continued partnership.

Sincerely,

Wendy Nicklin
President and Chief Executive Officer

Table of Contents

Section 1 Executive Summary

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

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

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

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

1.1 Accreditation Decision

The Bermuda Hospitals Board's accreditation decision is:

Accredited (Report)

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

1.2 About the On-site Survey

- **On-site survey dates: May 18, 2015 to May 22, 2015**

- **Locations**

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

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

- **Standards**

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

  System-Wide Standards

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

  Population-specific Standards

  5 Population Health and Wellness

  Service Excellence Standards

  6 Cancer Care and Oncology Services
  7 Reprocessing and Sterilization of Reusable Medical Devices
  8 Developmental Disabilities Services
  9 Critical Care
  10 Point-of-Care Testing
  11 Home Care Services
  12 Ambulatory Care Services
  13 Diagnostic Imaging Services
  14 Hospice, Palliative, and End-of-Life Services
  15 Medicine Services
  16 Rehabilitation Services
  17 Substance Abuse and Problem Gambling Services
  18 Emergency Medical Services

19 Community-Based Mental Health Services and Supports Standards
20 Obstetrics Services
21 Mental Health Services
22 Transfusion Services
23 Biomedical Laboratory Services
24 Perioperative Services and Invasive Procedures Standards
25 Long-Term Care Services
26 Emergency Department

- **Instruments**

  The organization administered:

  1 Governance Functioning Tool
  2 Patient Safety Culture Tool
  3 Worklife Pulse
  4 Client Experience Tool

1.3 Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	106	18	0	124
 Accessibility (Give me timely and equitable services)	145	3	1	149
 Safety (Keep me safe)	769	32	25	826
 Worklife (Take care of those who take care of me)	219	5	2	226
 Client-centred Services (Partner with me and my family in our care)	360	4	10	374
 Continuity of Services (Coordinate my care across the continuum)	123	0	4	127
 Appropriateness (Do the right thing to achieve the best results)	1189	144	45	1378
 Efficiency (Make the best use of resources)	88	4	1	93
Total	**2999**	**210**	**88**	**3297**

1.4 Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	40 (95.2%)	2 (4.8%)	0	30 (93.8%)	2 (6.3%)	0	70 (94.6%)	4 (5.4%)	0
Leadership	43 (93.5%)	3 (6.5%)	0	74 (87.1%)	11 (12.9%)	0	117 (89.3%)	14 (10.7%)	0
Infection Prevention and Control Standards	40 (97.6%)	1 (2.4%)	0	30 (100.0%)	0 (0.0%)	1	70 (98.6%)	1 (1.4%)	1
Medication Management Standards	72 (100.0%)	0 (0.0%)	6	55 (96.5%)	2 (3.5%)	7	127 (98.4%)	2 (1.6%)	13
Population Health and Wellness	3 (100.0%)	0 (0.0%)	1	35 (100.0%)	0 (0.0%)	0	38 (100.0%)	0 (0.0%)	1
Ambulatory Care Services	34 (87.2%)	5 (12.8%)	3	71 (92.2%)	6 (7.8%)	0	105 (90.5%)	11 (9.5%)	3
Biomedical Laboratory Services	67 (95.7%)	3 (4.3%)	1	102 (99.0%)	1 (1.0%)	0	169 (97.7%)	4 (2.3%)	1
Cancer Care and Oncology Services	28 (87.5%)	4 (12.5%)	1	68 (91.9%)	6 (8.1%)	2	96 (90.6%)	10 (9.4%)	3
Community-Based Mental Health Services and Supports Standards	16 (76.2%)	5 (23.8%)	1	103 (91.2%)	10 (8.8%)	0	119 (88.8%)	15 (11.2%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Critical Care	29 (87.9%)	4 (12.1%)	1	86 (93.5%)	6 (6.5%)	3	115 (92.0%)	10 (8.0%)	4
Developmental Disabilities Services	34 (89.5%)	4 (10.5%)	1	71 (94.7%)	4 (5.3%)	3	105 (92.9%)	8 (7.1%)	4
Diagnostic Imaging Services	60 (89.6%)	7 (10.4%)	0	62 (92.5%)	5 (7.5%)	1	122 (91.0%)	12 (9.0%)	1
Emergency Department	40 (87.0%)	6 (13.0%)	1	67 (89.3%)	8 (10.7%)	5	107 (88.4%)	14 (11.6%)	6
Emergency Medical Services	39 (88.6%)	5 (11.4%)	5	99 (92.5%)	8 (7.5%)	4	138 (91.4%)	13 (8.6%)	9
Home Care Services	39 (90.7%)	4 (9.3%)	1	48 (90.6%)	5 (9.4%)	1	87 (90.6%)	9 (9.4%)	2
Hospice, Palliative, and End-of-Life Services	28 (87.5%)	4 (12.5%)	1	101 (97.1%)	3 (2.9%)	3	129 (94.9%)	7 (5.1%)	4
Long-Term Care Services	38 (95.0%)	2 (5.0%)	0	91 (97.8%)	2 (2.2%)	1	129 (97.0%)	4 (3.0%)	1
Medicine Services	25 (83.3%)	5 (16.7%)	1	64 (90.1%)	7 (9.9%)	0	89 (88.1%)	12 (11.9%)	1
Mental Health Services	29 (82.9%)	6 (17.1%)	1	83 (94.3%)	5 (5.7%)	0	112 (91.1%)	11 (8.9%)	1
Obstetrics Services	62 (96.9%)	2 (3.1%)	0	76 (96.2%)	3 (3.8%)	1	138 (96.5%)	5 (3.5%)	1
Perioperative Services and Invasive Procedures Standards	91 (92.9%)	7 (7.1%)	2	78 (88.6%)	10 (11.4%)	0	169 (90.9%)	17 (9.1%)	2
Point-of-Care Testing	37 (97.4%)	1 (2.6%)	0	45 (97.8%)	1 (2.2%)	2	82 (97.6%)	2 (2.4%)	2
Rehabilitation Services	28 (93.3%)	2 (6.7%)	1	70 (100.0%)	0 (0.0%)	0	98 (98.0%)	2 (2.0%)	1

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Reprocessing and Sterilization of Reusable Medical Devices	50 (96.2%)	2 (3.8%)	1	59 (96.7%)	2 (3.3%)	2	109 (96.5%)	4 (3.5%)	3
Substance Abuse and Problem Gambling Services	26 (86.7%)	4 (13.3%)	1	68 (93.2%)	5 (6.8%)	0	94 (91.3%)	9 (8.7%)	1
Transfusion Services	81 (93.1%)	6 (6.9%)	8	67 (100.0%)	0 (0.0%)	7	148 (96.1%)	6 (3.9%)	15
Total	**1079 (92.0%)**	94 (8.0%)	38	1803 (94.2%)	112 (5.8%)	43	2882 (93.3%)	206 (6.7%)	81

* Does not includes ROP (Required Organizational Practices)

1.5 Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Safety Culture			
Accountability for Quality (Governance)	Met	4 of 4	2 of 2
Adverse Events Disclosure (Leadership)	Met	3 of 3	0 of 0
Adverse Events Reporting (Leadership)	Met	1 of 1	1 of 1
Client Safety Quarterly Reports (Leadership)	Met	1 of 1	2 of 2
Client Safety Related Prospective Analysis (Leadership)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Ambulatory Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Cancer Care and Oncology Services)	Unmet	0 of 2	0 of 0
Client And Family Role In Safety (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Critical Care)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Diagnostic Imaging Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Home Care Services)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client And Family Role In Safety (Hospice, Palliative, and End-of-Life Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Long-Term Care Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Medicine Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Mental Health Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Obstetrics Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Rehabilitation Services)	Met	2 of 2	0 of 0
Client And Family Role In Safety (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Dangerous Abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Information Transfer (Ambulatory Care Services)	Met	2 of 2	0 of 0
Information Transfer (Cancer Care and Oncology Services)	Met	2 of 2	0 of 0
Information Transfer (Community-Based Mental Health Services and Supports Standards)	Met	2 of 2	0 of 0
Information Transfer (Critical Care)	Met	2 of 2	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information Transfer (Emergency Department)	Met	2 of 2	0 of 0
Information Transfer (Emergency Medical Services)	Met	2 of 2	0 of 0
Information Transfer (Home Care Services)	Met	2 of 2	0 of 0
Information Transfer (Hospice, Palliative, and End-of-Life Services)	Met	2 of 2	0 of 0
Information Transfer (Long-Term Care Services)	Met	2 of 2	0 of 0
Information Transfer (Medicine Services)	Met	2 of 2	0 of 0
Information Transfer (Mental Health Services)	Met	2 of 2	0 of 0
Information Transfer (Obstetrics Services)	Met	2 of 2	0 of 0
Information Transfer (Perioperative Services and Invasive Procedures Standards)	Met	2 of 2	0 of 0
Information Transfer (Rehabilitation Services)	Met	2 of 2	0 of 0
Information Transfer (Substance Abuse and Problem Gambling Services)	Met	2 of 2	0 of 0
Medication reconciliation as a strategic priority (Leadership)	Met	4 of 4	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	7 of 7	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Cancer Care and Oncology Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports Standards)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Critical Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Emergency Department)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Medication reconciliation at care transitions (Hospice, Palliative, and End-of-Life Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Medicine Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures Standards)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Rehabilitation Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Two Client Identifiers (Ambulatory Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Biomedical Laboratory Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Critical Care)	Met	1 of 1	0 of 0
Two Client Identifiers (Diagnostic Imaging Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Department)	Met	1 of 1	0 of 0
Two Client Identifiers (Emergency Medical Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Home Care Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Two Client Identifiers (Hospice, Palliative, and End-of-Life Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Long-Term Care Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Medicine Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Mental Health Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Obstetrics Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Two Client Identifiers (Point-of-Care Testing)	Met	1 of 1	0 of 0
Two Client Identifiers (Rehabilitation Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Substance Abuse and Problem Gambling Services)	Met	1 of 1	0 of 0
Two Client Identifiers (Transfusion Services)	Met	1 of 1	0 of 0
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Cancer Care and Oncology Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Critical Care)	Met	1 of 1	0 of 0
Infusion Pumps Training (Emergency Department)	Met	1 of 1	0 of 0
Infusion Pumps Training (Hospice, Palliative, and End-of-Life Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Long-Term Care Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Medicine Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Obstetrics Services)	Met	1 of 1	0 of 0
Infusion Pumps Training (Perioperative Services and Invasive Procedures Standards)	Met	1 of 1	0 of 0
Infusion Pumps Training (Rehabilitation Services)	Met	1 of 1	0 of 0
Narcotics Safety (Medication Management Standards)	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Met	7 of 7	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Worklife/Workforce			
Client Safety Plan (Leadership)	Met	2 of 2	2 of 2
Client Safety: Education And Training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (Emergency Medical Services)	Met	1 of 1	0 of 0
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Pneumococcal Vaccine (Long-Term Care Services)	Met	2 of 2	0 of 0
Reprocessing (Emergency Medical Services)	Met	1 of 1	1 of 1
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Ambulatory Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Cancer Care and Oncology Services)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Falls Prevention			
Falls Prevention Strategy (Diagnostic Imaging Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Emergency Department)	Unmet	3 of 3	0 of 2
Falls Prevention Strategy (Home Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Hospice, Palliative, and End-of-Life Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Long-Term Care Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Medicine Services)	Unmet	3 of 3	1 of 2
Falls Prevention Strategy (Mental Health Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Obstetrics Services)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Perioperative Services and Invasive Procedures Standards)	Met	3 of 3	2 of 2
Falls Prevention Strategy (Rehabilitation Services)	Met	3 of 3	2 of 2
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Critical Care)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, and End-of-Life Services)	Met	3 of 3	2 of 2

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

1.6 Summary of Surveyor Team Observations

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

Bermuda Hospitals Board (BHB) is comprised of King Edward VII Memorial Hospital (KEMH), Mid-Atlantic Wellness Institute (MAWI) and the Lamb Foggo Urgent Care Centre. BHB offers comprehensive diagnostic, treatment and rehabilitative services in response to Bermuda's full spectrum of medical and mental health needs. BHB serves Bermuda's resident population of approximately 65,000 people, as well as the many visitors who come to the island each year.

BHB developed a strategic plan for the years 2011 to 2015. Recently, BHB has renewed its Mission, Vision and Values. The strategic direction for the organization is based on a vision of "Safe, high quality, people-centered, compassionate care every day". Strategic aims support the vision and act as the mission for the organization. These include:
1. Recognize the patient as the reason we are here
2. Achieve the highest, evidence-based international standards in a safe, caring environment
3. Educate the community, patients, families, other stakeholders and staff using our clinical and professional expertise
4. Structure services to ensure sustainable quality and cost
5. Collaborate with our stakeholders to advocate for health system reforms and improvements
6. Build staff and community confidence in BHB

In order to achieve the vision of "Safe, high quality, people-centered, compassionate care every day", BHB has adopted five strategic priorities.
1. Quality of care
2. Patient experience
3. Workforce experience
4. Financial health
5. Leadership

BHB is moving to align staff to these priorities to drive decision making, resource allocation, and development of programs and services. The values of the organization are respect, accountability, integrity, service and excellence.

The organization has a committed Board of Directors; passionate about the work they do in support of services to support Bermuda. There are well established board processes and protocols in place to ensure effective governance of the organization. Board work is supported by a sub-committee structure that guides business operations, quality and safety, and community engagement. Informal processes are utilized to evaluate the Chief Operating Officer and Chief of Staff performances. The governing body is encouraged to formalize these processes, and has recently implemented an ethics framework and evidence-informed criteria to guide decision making. They have not yet used this tool nor have defined when this tool might be appropriate for use by the Board.

The strong relationship between the Board, CEO and leadership team is evident and will be critical as the organization faces fiscal challenges, increasing service demands and national questions about sustainability of the health care system. Board, Leadership, Management and staff have a strong commitment to the organization's quality and safety agenda. There are many qualitative initiatives led by individuals and teams across the organization and the challenge they face going forward will be to ensure full implementation and the sustainability of the changes. The leadership team has a very strong efficiency focus, and they are committed to

ensuring a balanced budget without sacrificing their focus on the provision of safe, quality patient care and services. Formalization of change management processes and organizational adoption of quality framework will support the organization as it grows into the future.

The Leadership group is to be commended for their visionary approach to care delivery and successes to date. Communication between levels of the organization has been a struggle. Increased focus in this area can assist in leveraging a staff who are already highly focused on quality patient care. There are increasing opportunities and methods for staff, service providers and community input into service planning.

The organization will need to invest efforts in developing a comprehensive Information Management and Information Technology (IT/IM) plan. This will most likely need to be staged toward a fully integrated electronic patient record. Efforts in this area should continue as the benefits will greatly outweigh the costs. The current system of multiple systems that are not necessarily integrated will continue to present challenges, and further addition of systems that are not linked to the desired future state should not be implemented. The information management and technology plan will help to position the BHB to meet the needs of staff and patients into the future and enable not only patient care, but increase the ability to use data for planning and quality initiatives.

There is a very strong corporate business model with well-developed collaborative partnerships. Commitment to the accreditation process and service provision based on standards is unanimous. Services are built around the needs of the people. Further development of a robust quality and risk framework (that is rolled out systematically across the organization) will help to cascade priorities and embed them with staff. Key to BHB success will be harnessing the collective effort of all programs and services in support of the strategic aims/strategic priorities. Strategic thinking and planning with supporting operational and quality plans, and a focus on client safety and quality are supported by the leadership team. The group is actively seeking feedback on areas for improvement.

The culture of this organization attracts professionals, making it an employer of choice. Staff and physicians are invested in the work of the organization and the mission of BHB. In general, there is a sense that staff members are very satisfied in their role in providing patient care. There is a sense of some disengagement present with some staff. Alignment of the program and services activities with the strategic aims of the organization should help to raise employee engagement.

There is evidence of strong inter-professional practice and collegiality across the organization. Staff members appear engaged, knowledgeable, and compassionate in the delivery of care and services. Staff have a general knowledge of ethics and in most cases appear to resolve issues independently on the unit in an informal manner. The organization is encouraged to continue to “rollout” the ethical framework and to educate staff in the use of this tool. Promotion activities related to hand hygiene practices across the organization should continue and efforts to raise compliance in this area should be given consideration.

An integrated quality and risk management model has been developed at the executive level. However, front line staff and managers were not aware of the quality framework and had no knowledge of basis processes like the P-D-C-A cycle. They did not have access to any tools to help or guide the quality work they are starting to do. What is required is the development of the quality framework, and tools that can be shared across the organization to support and grow the quality initiatives. In addition, physician involvement in quality activities is paramount.

Discussions with community partners and agencies indicate a collaborative and respectful working relationship at all levels of the organization. Communication and linkages are strong with the community, Foundation and Auxiliary, and other stakeholders. The organization is working to be transparent. Information is shared broadly and supported by the Communications staff. The Hospital has established linkages with some educational institutions.

Interviews with clients and/or family members across the services visited highlight the gratitude and appreciation felt for the respect and compassion shown by all involved in service and care provision. Clients/patients report that they were very satisfied with the care they receive. The Patient Satisfaction Report indicates significant improvement in access to services, continuity and transition, information and education, and respect for patient preference. The organization is well supported by the Foundation and Auxiliary.

The survey team is unanimous in our acknowledgement that the organization is truly committed to serving the community in a compassionate and respectful manner.

Section 2 Detailed Required Organizational Practices Results

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Communication	
Client And Family Role In Safety The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	· Cancer Care and Oncology Services 15.4
Patient Safety Goal Area: Falls Prevention	
Falls Prevention Strategy The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.	· Medicine Services 15.2 · Emergency Department 16.3
Patient Safety Goal Area: Risk Assessment	
Suicide Prevention The team assesses and monitors clients for risk of suicide.	· Mental Health Services 7.5

Section 3 Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

3.1 Priority Process Results for System-wide Standards

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

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

3.1.1 Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria		High Priority Criteria
Standards Set: Governance		
3.1	The governing body uses the ethics framework and evidence-informed criteria to guide decision making.	!
7.7	The governing body, with the input of the organization's leaders, evaluates the CEO's performance and achievements annually.	
7.8	The governing body has a succession plan for the CEO.	
13.7	The governing body regularly reviews the contribution of individual members and provides feedback to them.	!

Surveyor comments on the priority process(es)

Bermuda Hospitals Board (BHB) is an organization with a governing body that is visionary and committed to “Safe, high quality, people-centered, compassionate care every day”. There is a strong corporate business model with developed collaborative partnerships. Services are readily accessible to those who need them with an emphasis on patient care. There is a strong focus on providing quality patient care in a safe environment.

There is a process in place for planning and service design within the framework of the corporate mission, vision and values. The values are known and used by the governing body. There is an opportunity to align the organization with the 1) mission, 2) vision, 3) values, and 4) strategic aims. Strategic and operational plans are in place with an emphasis on client safety, quality, service volumes and best practices. Alignment of departmental goals and use of best practices with corporate priorities will assist in moving the organization ahead in the future. The governing body ensures appropriate oversight of organizational priorities.

The governing body has a good understanding of their roles and responsibilities and those of senior management. New Board Members are oriented to their role as they join the organization. The mentorship process is practiced. Skills are considered when new Board members are sought. Roles are assigned by the Ministry. Formal processes are utilized to evaluate the governance structure and function. Individual member evaluation is not completed and may be provided informally. The governing body is encouraged to formalize these processes.

There is increased momentum to involve staff and service providers in the development of strategic planning and prioritization. The organization is moving towards gathering input from clients/families, other organizations and the broader community in strategic planning. Communication and linkages are strong with the community, the Foundation and other stakeholders. The Governing Body reported that they are embarking on the development of a succession plan for the Chief of Staff. Similarly, a formalized evaluation process for the Chief of Staff and the Chief Executive Officer is under development.

Feedback from community partners consistently described collaborative and positive relationships with the organization and the governing body. The governing body demonstrated accountability for safety and quality of care and a commitment to quality improvement. Risks associated with operations are shared with the governing body as are financial metrics and utilization statistics. The governing body uses this information to assist in decision making. The governing body considers ethics and evidence informed criteria in decision making but does not appear to use a formalized ethics framework and/or tool to guide decision making. The governing body needs to define when this tool(s) might be appropriate for use by the Board.

The governing body is embracing the challenges of change while sharing an ongoing pride in the health center's success and of the population it serves.

3.1.2 Priority Process: Planning and Service Design

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
4.6	The organization's strategic plan includes goals and objectives that have measurable outcomes that are consistent with the mission and values.	
4.9	The organization's leaders communicate the strategic goals and objectives to leaders throughout the organization, staff, and service providers and verify that goals at the team, unit, or program level align with the strategic plan.	
4.11	The organization's policies and procedures for all key functions, operations, and systems in the organization are documented, authorized, implemented, and up to date.	
6.5	The organization's leaders develop and implement a process to manage change.	
6.6	The organization's leaders select management systems and tools to monitor and report on the implementation of operational plans.	!

Surveyor comments on the priority process(es)

In October 2014, the organization successfully readied and operationalized the new acute care wing. The physical space is quite amazing, all single patient rooms, and environmentally-friendly processes to save energy. The operational readiness committee used the experience to conduct the client safety prospective analysis. As a result, the teams were prepared, having practiced emergency codes and testing equipment. The move of all the patients to the new wing was without incident.

The organization is to be commended for developing a comprehensive strategic plan and a high level operational plan. The executive team needs to ensure that both plans cascade down to the front line. It was consistently noted by surveyors moving throughout the organization that some teams were unable to translate the strategic priorities into meaningful measurable goals and objectives. As a result, there needs to be a connection made between the work at the front line and the direction of the organization from a strategic perspective. Teams would benefit from coaching and mentoring by decision support specialists and the quality and risk associates in establishing a meaningful document where quarterly updates are easily and effectively reported on.

There needs to be an evident change management model in use to guide staff, physicians and the community through the inevitable changes coming. The modernization project can assist in finding opportunities for more efficient and effective provision of care and service. In speaking with front line staff throughout the organization, they welcome more consistent rounding by the executive team including opportunities to express concerns and ask questions in a safe environment.

3.1.3 Priority Process: Resource Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
8.11 The organization's leaders verify that the organization meets legal requirements for managing financial resources and financial reporting, e.g., audit, running a deficit.	!

Surveyor comments on the priority process(es)

There is a centralized finance service that provides financial support to all sites and programs at Bermuda Hospitals Board. The budgeting process is integrated into the planning process. The strategic plan guides the decision making around spending. The organization is operating in constraint and is dealing with 1) decreasing revenues, 2) budget cuts and 3) increasing bad debt. The governing body provides appropriate oversight of resource management and ensures the viability of the organization. It is suggested that the organization consider how to build ethics into non-clinical decision making on a routine basis.

The staff of the Finance Department are very well qualified to manage the finances of this organization and are not only committed to financial sustainability for the organization, but also to ensuring health services are available to meet the needs of the population served by this organization. These staff have implemented processes to ensure accountability for the resources they receive, as well as compliance with all applicable legislation. An external audit is conducted each year. However, the organization reports that there are no audited financial statements for the past few years. The organization is waiting for the auditor (Ministry) to provide audited financial statements. The organization reports that all recommendations are addressed but the audited statements remain pending.

This department is hoping to increase financial insight into decision making. As such, there is a desire to use utilization data to identify opportunities for cost savings without compromising care. The organization is looking to review utilization data to identify opportunities for more efficient use of available resources. The organization is encouraged to continue to pursue this initiative.

Staff report that there is a disjointed IT system in place that hinders day-to-day operations. An integrated system that allows for improved business intelligence would enhance planning and data analysis. Procurement has policies, procedures and processes in place that seek to maximize resources. Product standardization and evaluation is looking to move to increased standardization.

Relationships with managers are being built. It is suggested that the organization continue to involve managers in forecasting on a routine basis and to work with managers to help develop a better understanding of finance reporting. Referral patterns and data mining are starting to be explored in resource allocation. The economic climate is presenting new challenges to the hospital and the organization is working proactively to meet this challenge.

3.1.4 Priority Process: Human Capital

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization is to be commended for supporting the ongoing efforts of the Human Resources team as they continue to support a quality of worklife and healthy and safe work environment.
There are numerous examples of opportunities and activities that are offered to staff. A few examples include: employee discounts at fitness centres, smoking cessation support, periodic physical examinations, pre-employment assessment, tuition reimbursement, staff scholarships, employee assistance program, limiting work hours to 60 for those employees who have secondary employment.

The library staff are very proud of the "Wall of Fame" which recognizes staff who have furthered their education.This is seen as a motivation for others to view education as a "lifelong learning" opportunity.

Staff report that their volunteer-student program which was implemented in 2000 has been very successful and many of these students are now in the healthcare field, educated as nurses, physicians, laboratory technicians and other healthcare disciplines or hospital employees.

The organization employs a variety of employee recognition strategies including the RISE program which is a peer-to-peer recognition opportunity, acknowledging employees on their birthdays and employment anniversary with a small gift, and the "So You Think You Can Save" program.

The team will be introducing the "WOW" recognition in June as well as a managers toolkit. A Wellness Fair is also in the planning stage.

The organization may want to consider the manner in which human resource records are stored. This should be consistent across all departments and services within the organization.

The organization has identified organization-wide and department/service specific mandatory client safety training and education as a high priority. However, the organization should encourage and support the implementation of the electronic human resource record which is intended to store all information, eliminating the need for duplication of a paper copy.

The organization has dedicated staff who prepare physician credentialing applications which are presented to the Chief of Department and Medical Advisory Committee with the final approval the responsibility of the Board of Directors.

The organization is to be commended for an outstanding employee orientation program. Evaluation of the employee performance is done routinely and consistently across the organization. Department/service specific orientation is done with preceptors and a buddy system in place to support the new hire.

3.1.5 Priority Process: Integrated Quality Management

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
3.2	The organization's leaders provide resources to support quality improvement activities.	
3.3	The organization's leaders support leaders throughout the organization to develop the knowledge and skills necessary to carry out ongoing quality improvement.	
3.8	The organization's leaders promote and support the consistent use of standardized processes, protocols, or best practice guidelines to reduce variation in and between services, where appropriate.	
12.5	The organization's leaders evaluate the effectiveness of the integrated risk management approach and make improvements as necessary.	
16.6	The organization's leaders verify that the quality improvement plans and related changes are implemented.	!

Surveyor comments on the priority process(es)

The BHB leadership has developed a Clinical Performance Improvement Plan which includes risk management, patient safety and quality improvement initiatives. Indicators should be specific and measurable in order to compare outcomes and identify opportunities for improvement. There is a goal to enable the organization to benchmark performance internationally. The plan is admirable but has not been operationalized within the organization.

The Patient Safety Culture Survey results warrant continued analysis and additional education with staff and physicians.

There is a benefit to standardize the reporting tool for submissions to the clinical governance committee or the quality counsel. Standardizing the form or tool will ensure that all required information is provided to decision-makers. In the example of harm events or sentinel events investigations submitted it is valuable to include a file number so that the clinical governance committee can ensure that planned improvements are completed and change evaluated in the agreed upon timeframe. The file can then be closed.

The quality team has done an admirable job in communicating the requirements of the required organizational practice (ROP) regarding identifying and reporting a near miss, harm or sentinel event, the process to follow keep the client as safe as possible and the process for disclosure of the error to the patient and family. Roles and responsibilities are clearly delineated but well communicated throughout the organization. Teams seem to think that quality is only the business of the quality staff and not everyone's business. The quality improvement leads so stick to the role of support and facilitation.

The organization does not seem to be aligned in what is exactly expected at each level of the organization in developing quality improvement plans. It appears that teams may see the effort as extra work. When speaking with teams, there are multiple projects or action plans underway that could be aligned with the strategic priorities. All departments have completed a risk register that identifies all potential risk issues. To really demonstrate integrated quality management, action plans related to identified gaps could also be the team's designated quality improvement plan. The frontline staff need to have the knowledge or understanding of basic quality improvement initiatives including PDSA cycles. It is essential the physician leaders actively participate in quality improvement initiatives. Executive sponsors must ensure that education and tools are provided to teams to assist with the identification of meaningful action plans including specific and measurable indicators or outcome measures and detailed evaluation.

3.1.6 Priority Process: Principle-based Care and Decision Making

Identifying and decision making regarding ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

BHB has established an Ethics framework that is utilized primarily for clinical ethical dilemmas. The ethics committee is comprised of interested and committed clinicians who are prepared for the work they do. There is not an ethicist on the team but a capacity to consult one at Dalhousie University. If an ethics consultation is required, a request is submitted and a plan is put in place. It is not possible to have the support of an ethicist in an immediate crisis. The chair of the ethics committee is called in to lead the discussion if possible. The Ethics committee provides support to all of Bermuda. The committee reviews all research proposals involving human subjects or financial impact on the organization. Currently the team is struggling with a proposal submitted in which the investigators are not experienced in research methodology. The proposal has been sent to the Caribbean Ethics Committee for consultation.

3.1.7 Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.6 The organization's leaders regularly assess the quality and usefulness of the organizations' data and information, and improve the organization's information systems.	

Surveyor comments on the priority process(es)

The organization has a communication plan established but it does not appear to be operationalized throughout the organization. Staff report that senior leadership is not visible and they do not receive communication regarding the strategic focus or aims of the organization. Staff also report that if they bring concerns forward they are not confident that they reach the senior table or are brought forward in a timely fashion.

3.1.8 Priority Process: Physical Environment

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
9.2	The organization's leaders protect client and staff health and safety at all times and particularly during periods of construction or renovation.	
9.10	The organization's leaders, with partners and the community, participate in initiatives to minimize the impact of its operations on the environment.	

Surveyor comments on the priority process(es)

This is a time of transition for the facilities; the opening of the acute care wing and renovating to provide all utilities from the new acute care wing to the general wing. The roof membrane is also being replaced on the General Wing. This has created a lot of activity in the General Wing as multiple areas are undergoing renovation.

The support areas of the Acute Care Wing which include utilities, data centre, water treatment, heating and ventilation are impressive with redundancy to ensure guaranteed support.

The public and patient care areas of the Acute Care Wing are visually appealing; spacious, clean, light and welcoming. The perioperative area is well laid out and allows for good patient flow for outpatient surgery. The surgical ward is all single rooms that are spacious and patient and family-centered in design. The balcony for emergency evacuation was a novel addition.

The General Wing is also clean and uncluttered in the patient care areas; the critical care unit was renovated about ten years ago and is a well designed space that is very clean and uncluttered.

However, navigating the buildings was challenging and signage for directions needs to be present at junctions.

The distance from the operating rooms and the Critical Care unit and the Sterile Reprocessing (SPD) area is a fair distance and is not restricted to only patient transfer and SPD.

With so many projects underway at the General Wing there was a sense of clutter in many areas and an attempt should be made to organize the clutter and only keep supplies and equipment that is needed in the area. This will be very important as the utilities are decommissioned and removed from the General Wing and the Utilities Building.

Verification of the EMS vehicles preventative maintenance was only by verbal means, as no documentation was seen, and this extended to documentation related to up-to-date licenses, accident logs that have not yet been integrated between the King Edward VII Memorial Hospital emergency medical services and the Fire and Rescue staff.

The Lamb-Fogo Urgent Care Centre warrants comment. The laboratory was closed but not decommissioned. Equipment is still present and reagents and materials are in the refrigerator, and the cupboards. This space should have the equipment removed and the supplies and reagents removed by appropriately trained staff. There is a lot of general clutter and some cardboard boxes on the floor in the storage area. Infection Prevention and Control should assess this facility and make recommendations, and excess and unneeded supplies and equipment should be stored appropriately or removed. Finally, this facility is underutilized, and an innovative approach should be used to determine what other services could be provided for the catchment population.

3.1.9 Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has done a remarkable job of emergency preparedness. The plans are defined and shared organizationally-wide. Teams throughout the organization are well educated and trained with mandatory recertification required of all staff annually. The organization has experienced hurricanes, first hand, two in one week in the past year and plans were put to test.

The Infection Control Program is very robust and staff education and training is evident. The organization should consider proper signage for hand washing stations, particularly in entranceways, waiting areas, etc.

3.1.10 Priority Process: Patient Flow

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Patient Flow does not appear to be a significant problem currently. Initiatives have been put in place to deal with surge and emergency department overcrowding. These include cohorting alternate level of care patients in continuing care beds, and redirecting appropriate patients from the King Edward VII Memorial Hospital Emergency Department to the Lamb-Fogo Urgent Care Centre.

Patient Flow may become more of a problem in the future as a result of the shortage of Long Term Care beds on island, and absence of a single entry point to these beds. Rest homes and retirement homes are very discriminate as to who they will accept, and the continuing care units in the hospital are not admitting any new patients.

It was also noted that there is no organized community access initiative.

3.1.11 Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Diagnostic Imaging Services		
8.6	All diagnostic imaging reprocessing areas are physically separate from client service areas.	!
8.7	All diagnostic imaging reprocessing areas are equipped with separate clean and decontamination work areas as well as separate clean storage, dedicated plumbing and drains, and proper air ventilation and humidity levels.	!
8.11	The team has a process to track all reprocessed diagnostic devices and equipment so they can be identified in the event of a breakdown or failure in the reprocessing system.	
Standards Set: Reprocessing and Sterilization of Reusable Medical Devices		
5.1	The medical device reprocessing department is equipped with hand hygiene facilities at entrances to and exits from the reprocessing areas, including personnel support areas.	
5.2	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.	!
8.8	For each detergent, solution and disinfectant, the team follows manufacturers' recommendations for use, contact time, shelf life, storage, appropriate dilution, testing for appropriate concentration and effectiveness, and required PPE.	!
10.2	The organization limits and monitors access to the storage area to appropriate team members.	

Surveyor comments on the priority process(es)

Staff report that Biomedical Services/Clinical Engineering is responsive to requests and needs. Staff interviewed demonstrated interest in their role and appear motivated. Active communication is evident when speaking with staff. Nursing staff indicated they receive appropriate communication/feedback regarding the status of equipment purchases and repairs.

The organization has a formal and open process for selecting and buying medical devices and equipment, and for selecting suppliers. Procurement processes are in place and many linkages are in place. Capital planning appears to be well developed. Contract management is generally centralized and appears to meet the overall needs of the organization.

With new procedures, products, and technologies, there appear to be basic mechanisms to allow for multidisciplinary collaboration and appropriate input from various stakeholders. Increased involvement in product evaluation and standardization should be considered for such areas as Biomedical, Infection Prevention and Control, and Occupational Health.

The preventative maintenance program uses a risk -ased approach for PM prioritization and rationalization. Biomed is able to monitor performance and, in general, preventative maintenance is completed as planned on an annual basis. In general, equipment appeared to be in good repair. There is a mechanism to monitor Alerts and Recalls and ensure appropriate follow up.

Standard Operating Procedures (SOPs) related to equipment use standardized templates. There is shared content and collaboration for some policy development. Consideration for increased collaboration and standardization with SOPs should result in more aligned care delivery and a decrease in work effort across the organization.

The Sterile Processing Department (SPD) has sound practices in place for reprocessing occurring in the SPD. SPD staff are highly motivated and appear to understand the importance of their role and the link to patient safety. Product recall processes are developed and understood by staff. Loaned equipment appears to be handled appropriately. SPD has a competency program in place. Knowledge sharing and best practice is evident. Staff members are certified.

The handling and reprocessing of scopes is well understood by staff and appropriate processes appear to be in place for this area. Scope processing is organized and able to handle the volume of scopes. Knowledge and skill amongst staff in dedicated scope reprocessing is high.

Outside of SPD, staff advised and it was observed that staff "eyeball" the diluent (For example, preparation of enzymatic). Thus, processes are not in place to ensure team members follow manufacturer's recommendations for detergent, solution and disinfectant for use, contact time, shelf life, storage, appropriate dilution, testing for appropriate concentration and effectiveness, and required PPE.

As part of the quality management system, a formal annual review of reprocessing and sterilization activities should be provided to the organization's senior management. Staff report that they test the eye wash stations. It is recommended that staff document the testing of the eye stations.

Diagnostic imaging reprocessing areas need to be physically separate from client service areas. There is currently a Cidex OPA reprocessing unit in each patient room (ultrasound probes).

Inventory control appears to be appropriate. However, inventory-related process may benefit with the application of LEAN principles. Decontamination, assembly, packaging, sterilization and quality assurance processes are adequate. It is reported that flash sterilization does not occur.

Overall, Medical Devices are well maintained. Clinical Engineering staff were very welcoming and delightful to work with and provided for a very wonderful experience. The SPD is an organizational strength. Staff take pride in their jobs and understand that they make a difference in ensuring quality and safety in patient care delivery.

3.2 Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

3.2.1 Standards Set: Population Health and Wellness

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

Surveyor comments on the priority process(es)
Priority Process: Population Health and Wellness
The Child and Youth Population Program is dedicated to serving children and youth at risk with high needs in both an outpatient and inpatient environment. Highly skilled staff and medical staff are challenged to meet an increasing demand for services within a declining budget. The program works with its partners, mainly education and Child and Family Services to help service users access appropriate services and community resources. Case conferences are held on all children whose families are engaged with one or more agencies in the community. These children are identified through a large community committee of service agencies who meet on a regular basis. The team identifies trends and opportunities for implementation of appropriate services. An example of this is the standard tool developed for schools to use for children at risk for suicide. A trend of increased bullying in the schools was identified and the team provided education and training for teachers. The team identifies social trending with an increase in crime and violence and gang activity impacting the increased need for services for children and adolescents.

3.3 Service Excellence Standards Results

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

Priority processes specific to service excellence standards are:

Point-of-care Testing Services

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

Clinical Leadership

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

Competency

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

Episode of Care

- Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue

Decision Support

- Using information, research, data, and technology to support management and clinical decision making

Impact on Outcomes

- Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes

Medication Management

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

Organ and Tissue Donation

- Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs

Infection Prevention and Control

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

Surgical Procedures

- Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

3.3.1 Standards Set: Ambulatory Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.1	The team works together to develop goals and objectives.	
2.2	The team's goals and objectives for ambulatory care services are measurable and specific.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.3	The team obtains the client's informed consent before providing services.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
18.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
18.5	The team designs and tests quality improvement activities to meet its objectives.	!
18.6	The team collects new or uses existing data to establish a baseline for each indicator.	
18.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
18.9	The team implements effective quality improvement activities broadly.	!

18.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
18.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Bresferod Swan Dialysis Unit has a robust quality program. Goals and objectives are clearly defined and there is alignment with organizations overall strategic plan. The team meets regularly, and tracks and reviews their performance goals.

The quality program appears to be in its infancy in other ambulatory areas. Indicators are tracked and reported but there doesn't appear to be a feedback loop to managers and their staff.

Priority Process: Competency

The teams surveyed in the ambulatory care services all utilized a multidisciplinary approach to service provision

Priority Process: Episode of Care

The teams on both the Dialysis Unit and the Wound Care Unit reported a high level of satisfaction with their work, especially when their patients were stabilized or reportedly improving.

Priority Process: Decision Support

Team members retain their certification and competency through ongoing education and training. This is well supported by the organization education policies.

Priority Process: Impact on Outcomes

The ambulatory care teams are robust in their delivery of care. They are to be commended for their dedication and quality of service.

The staff and physicians on the Dr. Beresford Swan Dialysis Unit are a true example of a well designed multi-disciplined team who provide patients with a coordinated, seamless system of care.

The patients are provided with a Patient Handbook that outlines the units services and expectations as well requires the patient to sign a contract outlining their responsibilities and commitment.

This is a very busy unit which provides over 160 patient interactions over four shifts per day and may have up to 80 or more invasive treatments daily. The unit is actively engaged in quality improvement initiatives which involvea staff at all levels. Indicators are developed and tracked with measured outcomes which are timeframed and aligned with the organization's strategic direction.
The unit is located at the new site and is spacious, modern, colorful and allows patients a beautiful view outside.

The BHB Wound Care Clinic provides an excellent service to a large population of outpatients in their department. They also support wound care for inpatients and share care with Home Care nurses when the unit is too busy to accommodate all of the needed appointments. A weekly clinic is run as well the unit has a hyper-bariatric chamber onsite which services the island.

It is recommended that the organization develop a comprehensive and coordinated approach to quality improvement initiatives which are tied to the overall strategic direction.

It is recommended that sharing of patient information at all points of service be developed and implemented.

3.3.2 Standards Set: Biomedical Laboratory Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Laboratory		
8.2	The layout of the laboratory prevents cross-contamination by separating incompatible activities.	!
26.1	The team has a safety officer who develops, maintains, and monitors the laboratory safety program.	
26.2	The safety officer is authorized to stop any laboratory activities deemed unsafe.	!
27.2	The team labels work area entrances and exits according to risks present within these areas.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Laboratory		

The laboratory staff are to be commended for their tremendous efforts in preparing for this survey, including the development of numerous standard operating procedures and standardization of many processes.

The Laboratory appears to have a well-developed Quality Management Program. Planning is in place to monitor resources, and ensure efficient use. Utilization is examined and results are shared. Medical Staff are engaged in operations and in designing program delivery. In general, laboratory space is well utilized for workflow and laboratory operations. The layout of the laboratory does not prevent cross contamination (separation of incompatible activities). Microbiology activities are not physically separated from the rest of the laboratory. Microbiology is in the corner of an open concept laboratory. Entrances to laboratory areas are not all labelled with bio-hazard signs.

The laboratory is adequately staffed. Consideration of succession planning and human resource planning should be taken to ensure the organization is not at risk for disruption of services and unplanned changes in service provision. Education, training and competency assessment are developed and in place. Processes involved with the introduction of new technology and new equipment appear to be appropriate. Communication methods are in place to ensure laboratory staff, physicians and laboratory users are informed.

Staff are very engaged and there is an overall feeling of team amongst lab staff. In general, lab staff feel supported and are eager to learn. There is a sense that staff genuinely want to ensure they provide quality results. Use of patient identifiers appears to be understood by staff. Staff are client-focused and these sentiments are echoed by the physicians, nursing, and other stakeholders. Hand hygiene practices are well understood and practiced by staff. In general, staff members appear to be aware of policies and procedures. Equipment appears to be in good repair and under appropriate maintenance schedules.

Staff and users of the Laboratory are encouraged to investigate the use and the benefit of increased formalization of reporting and feedback related to utilization, operational trends and outcome measures. The role of the safety officer is not formalized. Staff report that there is no formal description as this role is taken on voluntarily.

In summary, the laboratory has a sound quality program and is well positioned with a solid foundation to further develop a comprehensive program. The staff were very welcoming, eager to learn, and delightful.

3.3.3 Standards Set: Cancer Care and Oncology Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.2	The team's goals and objectives for its cancer care and oncology services are clearly written, measurable, and directly linked to the organization's strategic direction.	
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
	The organization has met all criteria for this priority process.	
Priority Process: Decision Support		
14.1	The team has a process to select evidence-based guidelines for cancer care and oncology services.	!
14.2	The team reviews its guidelines to make sure they are up-to-date and reflect current research and best practice information.	!
14.3	The team's review process includes seeking input from staff and service providers about the applicability of the guidelines and their ease of use.	
Priority Process: Impact on Outcomes		
5.3	The team regularly evaluates the effectiveness of staffing and uses the information to make improvements.	
14.5	The team shares benchmark and best practice information with its partners and other organizations.	
15.4	The team informs and educates clients and families in writing and verbally about the client and family's role in promoting safety.	ROP
15.4.1	The team develops written and verbal information for clients and families about their role in promoting safety.	**MAJOR**
15.4.2	The team provides written and verbal information to clients and families about their role in promoting safety.	**MAJOR**
16.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
16.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!

16.9	The team implements effective quality improvement activities broadly.	!
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Chemotherapy Oncology program is currently up to full medical complement with the addition of a new oncologist three weeks ago. The registered nurses who work on the unit are experienced in cancer care. The team has three clearly stated goals related to timely access to care. The goals are measurable but the team would benefit from organizational support to analyze data collected and evaluate the process.

The unit includes a chemotherapy pharmacy where orders are reviewed, doses are identified and validated based on specific criteria, and then the treatment is prepared and then provided to the nurses for administration. The pharmacist triple checks his/her own work, the nurses perform independent double checks prior to administration. The pharmacy tech prepares the unit and double checks that the process is followed flawlessly.

This chemo unit is the only one available on the island. Radiation therapy is not available in Bermuda.

Priority Process: Competency

The interdisciplinary team includes medicine, nursing, and social work. Other disciplines are consulted when necessary.

All staff and physicians have the required credentials and have completed any mandatory training as evidence by tracking in the HRIS system.

All staff have had a performance review within the last year.

Priority Process: Episode of Care

Patients are referred to the oncologist for assessment. Certain lab and diagnostic results, and the surgeon's post-op report if applicable must be in place prior to booking an appointment with the oncologist. The nurse will contact the patient within two working days after the appropriate referral is received. There are no wait times for chemotherapy since the new oncologist arrived.

The team meets once a week for one hour and reviews any client concerns from a clinical perspective or any process or system concerns related to the flow of the unit. At this meeting patient safety items may be identified.

On the day of the survey three patients were receiving a chemo treatment. All three were properly identified and personal protective equipment was used by nurses when hanging the medication. Two patients were willing to share their experiences of care. One gentleman was very grateful for the care provided. The physician obtained an informed consent for treatment, including showing the client diagnostic images of his tumour and reinforcing his right to stop treatment at any time if he wished. After his first treatment, he felt very comfortable coming back on his own without family members due to the tremendous trust that was built.

Priority Process: Decision Support

Nursing staff informally look to the Oncology Nurses Association and the National Comprehensive Cancer Network for clinical information and guidelines. It is recommended that the organization's nursing and allied health leaders identify a standard process for selecting best practice guidelines across the organization.

Priority Process: Impact on Outcomes

Clients are screened for falls because the potency of the medication and the additional drugs given such as IV Benedryl, result in the client being very drowsy and often unsteady. They are not screened in the chemo clinic for pressure ulcers or VTE as they are active out-patients.

The team members use two client identifiers, (asking the client his name and date of birth) and the clients interviewed confirmed this is a consistent practice.

The team is not aware of any benchmarking exercises comparing services and outcomes with other like programs. Since this chemo unit is the only one in Bermuda, the executive lead would have to determine a comparable program to benchmark against.

3.3.4 Standards Set: Community-Based Mental Health Services and Supports Standards

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
5.4	The team has a process for identifying, managing, and reducing safety risks to staff and service providers while delivering services.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.3	The organization has guidelines to protect staff and service providers that work alone.	
17.4	The organization's leaders encourage staff members to report concerns about safety.	
17.5	Staff and service providers participate in regular safety briefings to share information about potential safety problems, reduce the risk of error, and improve the quality of service.	!
17.6	The organization responds to staff members' concerns about safety issues in an open, fair, and timely way.	
18.5	The organization shares benchmark and leading practice information with its partners and other organizations.	
19.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
19.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
19.5	The team designs and tests quality improvement activities to meet its objectives.	!

19.6	The team collects new or uses existing data to establish a baseline for each indicator.	
19.7	The team follows a process to regularly collect indicator data to track its progress.	
19.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
19.9	The team implements effective quality improvement activities broadly.	!
19.10	The team shares information about its quality improvement activities, results, and learnings with individuals, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
19.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The MAWI Community Mental Health Service provides a variety of programs within its mandate.

The Support Services Outpatient clinic has 400 plus service users. Individuals from the island attend the clinic to receive their medications. This ensures compliance for many of these individuals who are homeless and or hard to serve. There is a pharmacy on site, medication reconciliation is done, patients are identified by a photo on their chart and their name and birthdate.

Service users drive the programs. There are excellent examples in the Vocational Rehabilitation Program. It was noted by the Support Services Outpatient Clinic that service users arriving on the morning bus were exhibiting high blood sugar levels. This was investigated and it became evident that there was a bakery across the street and service users were eating sweets. A breakfast program was initiated and operated by three service users. Forty-five to sixty individuals now attend and are charged $1.00 each. The program has expanded to include lunch and a healthy snack and blood sugar levels have gone down. Other services which have evolved for the same reasons are to name a few, a laundry program which is affordable at $2.00 each to wash and dry clothes and a storage depot for same. A Personal Hygiene program for those who don't have access to shower facilities is another example. Barber services provided by one of the staff, nicknamed "Ali Barber" who provides hair cuts and shaves on his free time, another.

The Vocational Rehab Program also provides job opportunities for service users who at one time could be employed in Bermuda in jobs through the "People Employing People" (PEP) program but due to the economic situation in Bermuda these jobs are no longer available. A Day Labour Program has been initiated where clients can wash cars, cut grass, etc. Other onsite programs such as guarding, aerobics, cooking, carpentry, communications etc. are in place. Many of the clients attend these programs and "hang out" in the facility as they have no where else to go.

General Case Management is provided through an outpatient clinic setting which is supported by two full-time psychiatrists and two residents. The case managers encourage clients to attend the clinic for appointments but do go out to the community when necessary.

The Intensive Case Management Program consists of a team of three individuals who provide service off-site to clients who have had dual diagnosis. Many of these individuals have past criminal records and many are substance abuse users. The team is often exposed to high risk activities which puts their personal safety at risk. The staff is to be commended for the development and implementation of the "Traffic Light Board".

Priority Process: Competency

Students from the secondary school system are hired to work in the service during the Easter break and summer holidays.

Priority Process: Episode of Care

The teams in the mental health services work in an ever changing environment. Their client numbers are increasing while funding has decreased. The clients they serve have increasing needs and pose many challenges for the team, including non-compliance with medication, drug and alcohol abuse, weapons, and other related high risk activities, as well as homelessness, to name a few.

Recruitment and retention is a concern for managers of the service due to an aging workforce, the economic situation in Bermuda and competition with other overseas countries.

Priority Process: Decision Support

The organizations staff document in a satisfactory manner. The service user records are organized and up-to-date.

Priority Process: Impact on Outcomes

The staff in all of the services including the medical staff are dedicated and committed to providing services in a caring, compassionate manner.

3.3.5 Standards Set: Critical Care

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
10.2	The interdisciplinary team conducts daily rounds.	
Priority Process: Episode of Care		
10.9	The team uses a delirium screening tool to assess clients for delirium.	
12.7	Following transition or end of service, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning.	
Priority Process: Decision Support		
13.1	The team maintains an accurate and up-to-date record for each client.	
Priority Process: Impact on Outcomes		
15.4	The team shares benchmark and best practice information with its partners and other organizations.	
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
17.5	The team designs and tests quality improvement activities to meet its objectives.	!
17.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.9	The team implements effective quality improvement activities broadly.	!
17.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Critical Care Unit at the King Edward VII Memorial Hospital is the only Critical Care unit on the Island, has 8 beds for adult and pediatric population with one dedicated pediatric bed and two isolation rooms. The unit also functions as a step down or intermediate care unit, and has an average occupancy of about 50%. The unit is also used for delivering specialized care such as red cell exchange for sickle cell and hemodialysis during the times the main hemodialysis unit is not open, and a connection to the reverse osmosis water treatment system is available in each room.

The anesthetists are all trained in critical care and the Chief of Anesthesia is the Medical Director for the Critical Care Unit. Hospitalists can also admit patients to the Critical Care Unit after discussion with the anesthetist covering the unit.

The nurse manager and the medical director meet regularly together and with staff to plan and implement new initiatives. It was not clear how often the head of the hospitalists is involved in planning given their ability to admit to the unit.

Priority Process: Competency

The Critical Care Unit has established a multidisciplinary team that provides comprehensive care to the patients. There is no respiratory therapist on the team. A British model is followed where the anesthetists and nurses manage the ventilated patients. A pharmacist is also on the team and participates with the antimicrobial stewardship program.

The team has recently undergone a formal evaluation of the function of the team and additional work will continue in this area.

While the attending anesthetist rounds daily with the team, the hospitalist admitted patients do not always receive care from the anesthetist and do not have the physician attending the rounds. Understanding that each hospitalist may only have one patient admitted to the Critical care Unit, flexibility of both the team and physician should enable combined rounding.

Priority Process: Episode of Care

The type of patients admitted to the Critical Care Unit varies, and the unit is used as an intermediate level care area. Many processes are standardized, and some, like the delirium screen, are still under development. A care plan is not used, but a tool to document the daily activities and concerns is used to communicate.

Developing more standard care maps and pathways that are evidence-based and updated on a regular basis would further increase standard approach to care.
The nurses hold regular journal clubs and these could be used to update and develop new care pathways.

Priority Process: Decision Support

There is ongoing work to update policies and procedures. The antimicrobial stewardship program has been recently implemented and has already shown cost savings. There has been work on a delirium screening tool that now requires the physicians to provide input regarding their role.

When reviewing charts the documentation is usually complete, however, there are some areas where duplication of documentation is done, and one chart reviewed was missing a VTEP sheet and the Braden scale and Falls Risk Assessment had not been completed.

Priority Process: Impact on Outcomes

The quality improvement process for critical care appears to be informal, and a consistent process does not seem to be followed. Infection Prevention and Control collects, analyzes and presents data on line related to infections, and antimicrobial stewardship work has started recently.

However, a standard knowledge to action (KTA) or PDCA (Plan - Do - Check - Act) approach is not consistently seen. Although there are multiple indicators that should be tracked at the unit level, thoughts of developing a balanced score-card with key indicators to report up to the senior leadership and board should be considered.

Priority Process: Organ and Tissue Donation

The organization has partnered with the New England Tissue Bank for organ and tissue donation. If a potential donor is identified, a donor coordinator arrives to manage the donor.

Most donors are identified were for solid organs, while consideration of tissue donation is not done routinely. The Anesthetists are trained to determine neurological death.

The New England Tissue Bank does audit charts on a regular basis, and apparently has not felt that significant numbers of potential donors are being missed. The actually written assessment was not reviewed.

3.3.6 Standards Set: Developmental Disabilities Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.2	The team's goals and objectives for its developmental disabilities services are measurable and specific.	
Priority Process: Competency		
4.2	The team supports student and volunteer placements.	
4.3	The team ensures that new team members, including students and volunteers, undergo criminal background checks.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
15.1	The organization has a process to select evidence-based guidelines for developmental disabilities services.	!
15.5	The team shares benchmark and best practice information with its partners and other organizations.	
Priority Process: Impact on Outcomes		
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
17.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The team has an exceptional understanding and knowledge of the community which they serve. The clientele at present are both male and female and between the ages of 22 and 74 years. Seventy per cent of the clients have no family interaction. The group homes managed and supported by the team provides the family support that is missing for some.

Priority Process: Competency

The development disabilities inter-professional team includes a psychologist, a family representative, a clinical educator, a recreational therapist, clinical supervisors, clinical managers, registered nurses, and activities coordinator. The team has well defined roles and clear understanding of scopes of practice among team members. The team is comfortable consulting with the ethics committee when there are complex client issues. Safety of clients is foremost in everyone's mind.

Most of the team is mobile and spend a good deal of time moving between the group homes.

Priority Process: Episode of Care

The team recently reassigned clients in group homes by cohort, common challenges, and like behaviours. There were thirty-two clients moved within the homes. The team developed a social model of care focussing on helping the clients have as full a life experience as possible. While planning the changes, the homes were reviewed for safety including a risk assessment with regard to the impact of each move plan. In addition, a new house was opened which increased capacity. The move has been completed and the impact is being evaluated. Many clients have adjusted well.
The team provides a program called 'New Dimensions'. About fifteen to twenty-five clients come in from the group homes to participate in structured activities focussing on work skills, living skills and behaviours.

A visit to one group home provided an opportunity to speak to some clients who were very proud to show their bedrooms and personal belongings. There were five clients present at the time of the visit. The four bedroom home provided outside living space where a number of clients enjoy having meals. A second kitchen provides opportunity for cooking and baking activities.

Priority Process: Decision Support

The team keeps a current thinned client record at the group home for ease of access. The record includes day-to-day documentation, the annual plan of care and any incidental behavioural incidents or other issues. The full chart is situated at MAWI and can be accessed at any time. The team is skilled at identifying best practices but would benefit from an organizational approach.

Priority Process: Impact on Outcomes

The most significant quality improvement project has been the cohorting of patients to achieve some efficiencies and promote compatibilities among the clients within a given group home. There needs to be ongoing evaluation of the new initiative. The team is skilled at identifying and reducing risks to client and staff safety.

3.3.7 Standards Set: Diagnostic Imaging Services

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
2.1	The team tracks wait times and average response times for elective, urgent and emergent requests for diagnostic imaging services.	!
4.1	The physical environment has clear signage in place to direct clients to the imaging service.	
12.2	The team evaluates whether it is meeting the timeframes set for interpreting diagnostic imaging results and makes improvements if needed.	
12.3	The team informs the referring medical professionals immediately following unusual, unexpected, or urgent findings.	!
16.3	The team conducts and reports on repeat/reject analysis monthly, as part of its quality control program.	!
16.4	The team documents all repeat/reject analysis including corrective action taken.	!
16.5	The team retains repeat/reject records for the period set by the organization's policy.	!
17.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
17.10	The team collects new or uses existing data to establish a baseline for each indicator.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The Diagnostic Imaging staff are to be commended for their work and efforts in preparation for this visit. There is a breadth of imaging modalities provided including: CT, mammography, ultrasound, bone mineral densitometry, MRI, nuclear medicine, and general radiography. There is strong technical knowledge and staff are proud of the services that are provided.

Staff advise that there is a process to identify the resources needed to deliver efficient and timely diagnostic services. Staff report that timeframes for interpreting diagnostic imaging results can vary significantly depending on the schedule of the radiologists. Staff advised that images may be read within minutes of the exam or may take up to two weeks depending on vacation schedules. Contingency plans for major downtimes have been considered. Evidence was not found that the team tracks wait times and average response times for elective, urgent and emergent requests for diagnostic imaging services. Staff reported that all signage in the new building is not yet installed. It was observed that way-finding was challenging.

There is a small group of radiologists supporting Diagnostic Imaging. Back up is arranged for when radiologists are unavailable after hours (for some procedures). It is reported that there is good informal access with the medical director. Evidence of a formal process for the team to identify the indicator(s) that will be used to monitor progress for each quality improvement objective was not seen. Many elements of this process are started, but formalization of the process is pending. A formal medical liaison meeting/process to discuss such items as future planning, service delivery, quality improvement projects and issues affecting the department, areas served and/or radiologists may be helpful.

There appears to be a good understanding regarding the use of patient identifiers. Staff are client-focused and these sentiments are echoed by the physicians, nursing, and other stakeholders. There is a general feeling of responsiveness and teamwork within Diagnostic Imaging. Hand hygiene practices and equipment cleaning are well understood and practiced by staff. Policies and procedures are in place. In general, staff members appear to be aware of policies and procedures. Staff report that there is not a formalized, consistent process for the team to conduct and report on repeat/reject analysis monthly, as part of its quality control program.

Access to all Diagnostic Services is very good. Wait times are low. Formalized reports and analysis of such data is limited. Consideration of a standardized list of instances when the team will immediately inform the referring medical professionals of unusual, unexpected, or urgent findings should be pursued. The department is fully digital with CR, DR and a PACS system.

Equipment appears to be in good repair and under appropriate maintenance schedules. Reprocessing of ultrasound probes is occurring in Medical Imaging. This process should be reviewed against the standards. For example, reprocessing of probes should be moved out of the patient care room and into a dedicated room with a dedicated sink (of proper size). Ultrasound gel is not topped up, but is heated for patient convenience. The increased risk of infection was discussed with staff.

3.3.8 Standards Set: Emergency Department

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.1	When delivering emergency department services, the team has access to equipment and supplies appropriate to the needs of the community or catchment area.		!
Priority Process: Competency			
4.5	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.		
Priority Process: Episode of Care			
9.8	The team has timely access to urgent medications and pharmacy staff 24 hours a day, 7 days a week.		!
Priority Process: Decision Support			
The organization has met all criteria for this priority process.			
Priority Process: Impact on Outcomes			
15.5	The team shares benchmark and best practice information with its partners and other organizations.		
16.3	The team implements and evaluates a falls prevention strategy to minimize the impact of client falls.		ROP
	16.3.4	The team evaluates the falls prevention strategy on an ongoing basis to identify trends, causes, and degree of injury.	**MINOR**
	16.3.5	The team uses the evaluation information to make improvements to its falls prevention strategy.	**MINOR**
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.		!
17.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.		
17.5	The team designs and tests quality improvement activities to meet its objectives.		!
17.6	The team collects new or uses existing data to establish a baseline for each indicator.		
17.7	The team follows a process to regularly collect indicator data to track its progress.		

17.9	The team tracks and benchmarks data on wait times for services, the length of stay in the emergency department, and the number of clients who leave without being seen.	
17.10	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.11	The team implements effective quality improvement activities broadly.	!
17.12	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
17.13	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Priority Process: Organ and Tissue Donation

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The King Edward VII Memorial Hospital Emergency Department (ED) is busy, with about 40,000 visits last year. There are some times of the year when large cruise ships can result in increased ED use.

The space is new with 15 rooms plus four trauma rooms, and has a dedicated pediatric room and pediatric trauma room. However, access to the Orthopedics Clinic, which could function as a rapid assessment unit is no longer possible. Ambulance and street access are very separate and there is good security. The space is light and clean with large treatment rooms, and the focus is on bedside charting rather than a large central station.

The Lamb-Fogo Urgent Care Centre is located near the airport and has a Fire and Rescue Centre located approximately five minutes away. It was a new build about eight years ago and was to provide emergency services with laboratory and diagnostic imaging support.

The Urgent Care Centre is staffed by two RNs, an Emergency Physician and a Diagnostic Imaging Technologist. All staff rotate from the King Edward VII Memorial Hospital. The small laboratory that was included in the original space was closed and only selected Point of Care testing is available.

Priority Process: Competency

Staffing of the emergency departments of the King Edward Memorial Hospital and the Lamb Fogo-Urgent Care Centre are from the same pool. Therefore the expertise from the main emergency department is available at the urgent care centre.

The team works well to provide care and the Medhost program for documentation, orders and viewing of laboratory and other data and reports enables collaborative care.

Priority Process: Episode of Care

The staff at King Edward VII Memorial Hospital (KEMH) are RNs supported by an auxiliary worker and the EMTs that can porter for diagnostic imaging. Point of care testing is used for urinalysis, pregnancy testing and stool for occult blood, and a pneumatic tube system is used to transfer to the laboratory. Laboratory services are available 24/7, as are DI, but may require a call back after midnight. Medical consultants are available, except for ENT, CV surgery and Neurosurgery.

Patients at both the KEMH and Lamb Fogo-Urgent Care Centre (LF -UCC) receive care from an appropriate interdisciplinary team. The Medhost program is a key enabler including discharge and faxing appropriate information to the primary care provider.

The medication area at the LF-UCC should have pharmacy staff visit to assess and replace expired medications.

Priority Process: Decision Support

The Emergency Department has implemented the Medhost Emergency Department Information System (Medhost EDIS) program which is used at the bedside to document the nursing and physician assessment, create a best possible medication history to enable medication reconciliation, and can be used to generate a summary of the encounter.

The staff are RNs supported by an auxiliary worker and the EMTs that can porter for diagnostic imaging. Point of care testing is used for urinalysis, pregnancy testing and stool for occult blood, and a pneumatic tube system is used to transfer to the laboratory. Laboratory services are available 24/7, as are DI, but may require a call back after midnight. Medical consultants are available, except for ENT, CV surgery and Neurosurgery.

The Lamb-Fogo urgent Care Centre also has the Medhost system that enables collaborative care. However, a comprehensive plan for information Management and Information Technology was not seen, and integration of multiple systems will increase cost.

Priority Process: Impact on Outcomes

The leadership and staff are committed to providing excellent care to patients that present at the emergency facilities, and work continues on standardizing protocols, policies and procedures and integrating with emergency medical services.

However, it was not evident that a comprehensive quality framework has been developed that will ensure that quality, safety and sustainability of emergency services are evaluated to continuously improve.

Priority Process: Organ and Tissue Donation

The organization partners with the New England Organ and Tissue Bank for Organ and Tissue Donation. Any potential donors that are identified in the Emergency Department are admitted to the Critical Care Unit. The focus appears to be on solid organs and the potential in the area of tissue donation should be explored.

3.3.9 Standards Set: Emergency Medical Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.3	The team evaluates its functioning annually, identifies priorities for action, and makes improvements.	
7.3	The team has access to injury prevention programs and ergonomic strategies to reduce employee injuries.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
22.1	The team collects information and feedback from patients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
22.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
22.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
22.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
22.5	The team designs and tests quality improvement activities to meet its objectives.	!
22.6	The team collects new or uses existing data to establish a baseline for each indicator.	
22.7	The team follows a process to regularly collect indicator data to track its progress.	
22.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!

22.9	The team implements effective quality improvement activities broadly.	!
22.10	The team shares information about its quality improvement activities, results, and learnings with patients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
22.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There has been work accomplished thus far and is still in progress, to integrate emergency services between the Fire Fighters, which have been trained as Emergency Medical Technicians (EMT) and are now first responders, with the emergency medical services provided by the EMTs from the King Edward VII Hospital. The 80 staff of Fire and Rescue report up to the Minister of National Defense, while the Emergency Medical Services provided by the King Edward VII Hospital Staff report up through the organization to the Minister of Health.

Although there has been work to develop an Emergency Medical Technicians Council with representation from both Ministries, a formal governance structure has not been implemented. Legislation is required to move toward a fully integrated program with the same training, standards and maintenance of competency evaluations.

Priority Process: Competency

There has been standardization of training within this program. The fire fighters were all trained as Emergency Medical Technicians, and the Dispatch staff all have APCO (Association of Public-Safety Communications Officials) Certification, and have a six week orientation.

The EMTs did not recall any initial or ongoing injury prevention programs and stated that the injury rate of the staff was very low. They were also not aware if ergonomic consultation was available.

Priority Process: Episode of Care

The focus of EMS is to collect and transport the patient to the King Edward VII Memorial Hospital Emergency Department (KEMH). The dispatch centre is located in Fire Station, with thoughts of moving to a facility where national defense security is housed. The Dispatch staff are well trained and oriented and the office is setup for collaborative teamwork with ready access to information to support transfer.

The scope of the Bermuda Fire Department increased with all staff being trained as EMTs and work is underway to fully integrate with the EMS staff of the KEMH.

Standard tools are used to document the initial and ongoing assessment, as well as to alert the emergency department of the arriving cases. Forms are being updated to include additional information like oxygen saturation and a pain assessment.

The scope of the EMTs is limited, and the ambulances do not have narcotics and infusion pumps are not used.

Priority Process: Decision Support

There has been a massive amount of work done to update and standardize about 100 policies and procedures, and this has been from March to May 2015. Massachusetts General Hospital is the trauma partner.

The next steps are to implement the updated policies and procedures, and develop a way to ensure they are be consistently applied.

Priority Process: Impact on Outcomes

Data is entered into the Dispatch System related to response times and the Emergency Department Ambulance Report form recordes times from call received to arrival at the emergency department.

Although a lot of work has been done to integrate the Fire and Rescue Service with the EMS services at KEMH, it was not apparent that quality framework was in place to evaluate the program and its initiatives.

Priority Process: Medication Management

The focus and priority of the emergency medical service is to retrieve and transfer. Narcotics and high risk medications are not available on the vehicles.

Priority Process: Infection Prevention and Control

Application of the policies and procedures of infection prevention and control were seen, including hand hygiene, appropriate disposal of linen, and terminal cleaning.

Hand Hygiene audits are not done on the emergency medical services staff.

Opportunities for further standardization will follow the integration of the KEMH emergency medical services with Fire and Rescue.

3.3.10 Standards Set: Home Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
3.4	The organization develops procedures to improve teamwork and minimize duplication.	
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
	The organization has met all criteria for this priority process.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
15.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
15.5	The team designs and tests quality improvement activities to meet its objectives.	!
15.6	The team collects new or uses existing data to establish a baseline for each indicator.	
15.7	The team follows a process to regularly collect indicator data to track its progress.	
15.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
15.9	The team implements effective quality improvement activities broadly.	!
15.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
15.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Home Care Program is to be commended for providing a high quality of wound care to patients in the community. Patients report a high level of satisfaction with the care they receive and the support provided by the home care nurses. Patients report that they are well informed about the status of their wound site and educated about signs, symptoms and best practices.

It is recommended that the hospital develop a client record that supports a continuum of care between care givers. This would include the wound care clinic, home care program and inpatient unit.
The team is very supportive of one another and ensure that all staff have reported back at the end of the shift or visit.

During the on-site visit with management and staff, the topic of budget constraints was raised. A consideration might be given to the manner in which supplies are ordered and distributed. Nursing staff currently order supplies based on past practices. This could potentially become a non-nursing function.

Standard protocols need to be in place to prevent the transmission of communicable disease. As an example, scissors in Home Care used between patients are cleaned with alcohol.

Priority Process: Competency

Staff performance appraisals are done annually. Professional staff are required to submit evidence of 24 hours education within two years.

The organization should consider reviewing nursing staff job descriptions and realigning the non-nursing functions of the position.

Priority Process: Episode of Care

Medication management is well done by the Home Care nurses. Staff are very safety conscious. The nurses sign in and out and carry cell phones when on a home visit. A safety check is performed in the home environment before and during the visit.

Priority Process: Decision Support

Client records are maintained on site, nurses document on the client file when they return from a home visit.

Priority Process: Impact on Outcomes

There is evidence of quality improvement initiatives, however, a quality improvement framework is not in place at this time.

3.3.11 Standards Set: Hospice, Palliative, and End-of-Life Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
3.5	The organization provides sufficient workspace to support interdisciplinary team functioning and interaction.	
4.9	The organization supports learner and trainee placement on the team.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
15.1	The organization has a process to select evidence-based guidelines for hospice palliative and end-of-life populations.	!
Priority Process: Impact on Outcomes		
17.5	The team designs and tests quality improvement activities to meet its objectives.	!
17.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.9	The team implements effective quality improvement activities broadly.	!
17.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		
BHB is very fortunate to have the calibre of dedicated physician leadership in palliative and end-of-life care. One physician is community-based and the other hospital-based.		
Priority Process: Competency		
The hospice team is made up of a highly functioning, interprofessional, passionate group of clinicians, support staff and volunteers.They are very knowledgeable and comfortable with the various scopes of practice, professional experience. The team is very clear on each member role and responsibility and as a result meshes well together.		

The team meets all mandatory organizational training requirements and is very actively participating in available educational opportunities. The team shares information obtaining through elective learning opportunities related to palliative and hospice care.

Priority Process: Episode of Care

The Agape hospice was opened in 1991 to provide end-of-life care for persons with AIDS and HIV. As AIDS has become a chronic disease, the hospice began to accept palliative cancer patients and those who are at end of life with kidney, cardiac, and otther terminal illnesses. Currently about 20% of patients may stay at Agape to get pain management controlled and effective and then be discharged home. The team can access specialists such as the rehab, oncology, and the lymphodemia teams.

The hospice provides care to a maximum of nine in-house clients. The team provides exceptional nursing care 24/7 provided by registered nurses and auxillary aides, while meeting the physical, spiritual, cultural and emotional needs of the client and family. The inter-professional team provides a specialised and holistic approach to dying with dignity. The team also includes social work, physio, nutrition, and medicine. The challenge is the cramped physical space. The three client bedrooms are the same size as a single patient room in the new acute wing but each room beds up to three patients. Unless there is an empty bed there is no place for family to stay at the bedside when death is imminent. The team is as flexible as possible and so may move the patient into the hospice living room where the family can have more physical and emotional comfort.

A client and his son provided insight into the experience. The client is very grateful for the service because he no longer feels alone and afraid.

The hospice works with a charity called 'Friends of Hospice' that conducts significant fundraising and currently provides a chef, food, a counsellor, and a day hospice program. The group interviews and selects any potential volunteers prior to them being processed through BHB voluteer on-boarding process.

Priority Process: Decision Support

The organization does not have a standardized approach to best practice guidelines and therefore the team has little guidance in deciding whether to align with Canadian, American, British, Australian experts. This issue is persistent across the organization.

Priority Process: Impact on Outcomes

The team is very client focused and passionate about palliative and hospice care. The team does collect data with regards to the program but has not had a lot of support in designing, developing, implementing and evaluating quality improvement activites. At this point the team identifies a gap or a barrier, brainstorms solutions and uses a quick PDSA (plan, do, study, act) to trial a potential change. The team would benefit from assistance in analysis of data and evaluation of activities.

3.3.12 Standards Set: Infection Prevention and Control Standards

Unmet Criteria	High Priority Criteria
Priority Process: Infection Prevention and Control	
2.9 The organization seeks input from the IPC team to maintain processes for selecting and handling medical devices/equipment.	!
Surveyor comments on the priority process(es)	
Priority Process: Infection Prevention and Control	

The Infection Prevention and Control (IPAC) program has grown since the last survey and is becoming integrated into clinical practice. IPAC staff support the organization in providing safe and quality patient care. The Infection Prevention and Control staff are engaged and are working to become active throughout the hospital.

Strategic planning is mainly driven by Required Organizational Practices (ROPs). Formalization of strategic planning for the IPAC program to expand on and to support organizational priorities and associated operational plans is recommended. Linkages with a number of external bodies are developed. Linkages to the medical staff and a medical champion for the program are in place.

Education, training and orientation for staff and volunteers are in place. Active communication and dialogue between IPAC staff and other areas is evident. A process to ensure policies and procedures are reviewed and up to date is in place. Resources for patient education have been developed and nursing report that these are shared with patients.

Some compliance audits have been initiated and appropriate follow-up is in place. IPAC is represented on various teams and committees across the organization. Representation and engagement would be welcomed and beneficial in additional areas such as product evaluation. The organization monitors appropriate indicators such as: hand hygiene, MRSA, VRE, C-diff and focused surgical infection rates.

A vaccination program and influenza campaign are in place. However, the organization has a low influenza vaccination rate (27%). Continued initiatives to increase influenza vaccination rates across the organization should be pursued. It is suggested that vaccination for Neisseria meningitidis be offered to staff who might work with live cultures of this organism.

An antimicrobial stewardship program is in its infancy and has had some early successes. Formalization of the program will benefit the organization. A surveillance program is in place and appropriate monitoring is evident. Staff and service providers appear to be aware of the infection rates and/or recommendations from outbreak reviews. Operating Room staff members were generally aware of surgical infection rates.

IPAC staff take a proactive approach to cluster and outbreak investigation. Signage related to precautions (contact, droplet, airborne) appears to be consistently adhered to and understood by staff. Outbreak procedures are in place and outbreak stations have been developed to allow easy access to PPE.

Sanitizer was not always readily found in patient care areas. The organization is encouraged to increase the number of reminders/posters about the proper techniques for hand-washing and using alcohol-based hand

rubs. Similarly, increasing the availability and sanitizer throughout the organization should be explored. Hand hygiene audits are limited to eight areas. Expanded audits accompanied with reporting and education should be considered to help increase hand hygiene compliance.

Staff appear to understand the need to clean equipment and ensure that this is completed after and between patient use. Clean and dirty items and processes appear to be appropriately segregated. Cleaning and reprocessing is almost entirely centralized. This decreases many risks that are present in an un-centralized model. Staff report that flash sterilization does not occur. It was reported that there is no re-use of items sold as single use devices.

Transportation of dirty equipment requires review. Clean and dirty equipment has the same flow. In addition, patients move through the SPD corridor. Visual inspection of the sharps containers identified appropriate use of sharps containers. The organization uses safety engineered devices for sharps and other high-risk materials in some instances. There are instances where safety engineered devices for sharps are not in use. It is unclear if there is a plan to fully implement safety engineered devices across the organization.

Overall, IPAC is providing support and guidance for improved patient and staff safety. The program is seen as proactive and valuable. In general, IPAC staff are viewed as very engaged, collaborative, and knowledgeable.

3.3.13 Standards Set: Long-Term Care Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
4.15	Each team member's performance is regularly evaluated and documented in an objective, interactive, and constructive way.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.4	The organization shares benchmark and best practice information with its partners and other organizations.	
20.5	The team designs and tests quality improvement activities to meet its objectives.	!
20.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The long term care or continuing care units have recently moved to the new acute care wing. The front line managers and director are enthusiastic, committed highly skilled clinicians with a passion for the care of the elderly and those with significant care needs. There is one patient with a ventilator on the Perry unit and prior to his arrival all registered nurses received education and training regarding the care of a chronic ventilated patient.

The continuing care units were moved from the oldest part of the hospital to the new acute care wing. Unfortunately the space was not planned for continuing care. As a result, a previously assigned ward room is now the dining room and space used for recreation therapy. There need to be large shower rooms to bathe patients in wheelchairs or enough space for toileting patient with physical disabilities.

Priority Process: Competency

The inter-professional team includes nursing, medicine, physiotherapy, occupational therapy, dietician, recreational therapy, auxillary aides and unit clerks. All the professional staff provide unique and complementary contributions to the care of the patient within their own scope of practice including case management meetings. A nurse takes primary lead for the patient and the management of the care plan.

Nursing staff are involved in the NICHE initiative (Nursing Improving Care for the Elderly). The program provides guidance and evidence-based best practice protocols. The whole team is committed and excited about this opportunity.

Priority Process: Episode of Care

The units appear to be well staffed which provided the opportunity to effectively conduct case management meetings for each patient over the year. The consistent round the clock caregivers are registered nurses and auxillary aides. Allied health professionals round out the team. The number of continuing care beds have decreased over the years from 120 to 66 as the organization reviewed its mandate to provide acute care to Bermuda. As a result there has been almost no turnover of patients in the last two to three years. There are a couple of patients who have lived their whole life at the King Edward site.

The staff address patients as they prefer and with tremendous respect. The unit feels quite peaceful and calm most of the time. One patient was exhibiting threatening behaviour and even assaulted staff and one patients. The team used a unique approach to monitor and document all interactions with the patient for two weeks to try to identify what triggered his outbursts. The team reviewed the documentation, put a plan in place that all agreed on and the patient has been much calmed since.

The continuing care unit staff, being situated within an acute care hospital, are very skilled at managing any changes in a patient's condition with an effort to prevent a transfer to an acute bed.
Consultant physicians provide support when required and the health team has access to all diagnostic services the hospital provides.

Priority Process: Decision Support

Many of the patients receiving care in the long-term care or complex care units have been living there for a number of years. The team uses inter-professional team case conferences to review each patient at regular intervals or in the event of a change in condition. Guidelines, policies and procedures guide any decision-making. There has been a concerted effort to review and update the policies and procedures and the most critical ones have been updated between 2011 and 2015.

Priority Process: Impact on Outcomes

The team is participating in the NICHE program which includes an evaluation component. The leaders have incorporated two strategic objectives into the employee performance plan. The manager and the employee will identify an action plan whereby the employee will contribute to meeting the goal in a manner relevent to the job level and capacity.

3.3.14 Standards Set: Medication Management Standards

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
9.2	The organization purchases commercially manufactured medications when available to minimize compounding.	
25.4	The interdisciplinary committee provides staff and service providers with regular feedback about medication errors and near misses, and risk reduction strategies that are being implemented.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

There are five pharmacies in BHB. The out-patient pharmacy is a retail operation supporting primarily dialysis and oncology patients and is open for limited hours. There are also pharmacies in Oncology, Methodone clinic and in In-patient psychiatry.

The pharmacy department is lead by a highly competent and energetic pharmacy manager who ensures all aspects of medication safety is in place or in the process of being in place. She is extremely knowledgeable about the nuances of managing medication procurement for the island and works closely with the Ministry of Health. The team consists of thirteen pharmacists and eleven pharmacy techs. The manager has worked at ensuring that the pharmacy techs are trained and competent to work to their full scope.

After a review by Price Waterhouse, the pharmacy procurement function was moved to the purchasing procurement department. The work continues to the be done by a pharmacy professional. The move has been advantageous to the efficiency of the function. A new assistant manager has been approved to focus on reviewing par levels in pharmacy.

There is a pharmacist trained to monitor medication error trends and drug utilization.

The Pyxis system is extremely impressive using bar codes, patient profiles and linked to the medication administration record. The only awkward, time consuming factor is that the nurse can only administer medications to one patient at a time and must return to the Pyxis station to obtain the medication for the next patient. On a unit with thirty patients there may only be one Pyxis station.

3.3.15 Standards Set: Medicine Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
10.1	The team identifies who is responsible for prescribing, storing, handling, and disposing of medications, as well as who is responsible for recording medication information in the client record.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
14.5	The team shares benchmark and best practice information with its partners and other organizations.	
15.2	The team implements and evaluates a falls prevention strategy to minimize client injury from falls.	ROP
15.2.4	The team establishes measures to evaluate the falls prevention strategy on an ongoing basis.	**MINOR**
16.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
16.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
16.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
16.5	The team designs and tests quality improvement activities to meet its objectives.	!
16.6	The team collects new or uses existing data to establish a baseline for each indicator.	
16.7	The team follows a process to regularly collect indicator data to track its progress.	

16.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
16.9	The team implements effective quality improvement activities broadly.	!
16.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The medicine units at the King Edward VII Memorial Hospital moved into two floors of the acute care wing in September 2014. There are 30 beds on one floor and 15 beds on the other floor, with these patients intermixed with surgery patients.

Staff provided their input into the unit design. The unit is well laid out into two 15 bed areas with medication rooms, clean and dirty supplies and storage. Patient rooms are all single with adequate space for mobility. The supply areas are well stocked. There are separate entrances for staff versus patients and families. The units were built and stocked with all new equipment.

However, it was not clear if the bed map was based on occupancy rates and if the current space will be adequate for future needs.

Priority Process: Competency

Medicine services has a dedicated Nurse Educator that is also responsible for the general nursing orientation. After a three-day general orientation there is a competency day when nurses go from station to station to demonstrate competency in various areas, including assessment and use of equipment.

A medicine specific clinical skills and procedures log book that is dated and signed with an anniversary date of the employee on the front is used. Documentation was fully complete for six books reviewed and includes Falls Prevention, Point of Care Glucose Testing, and Pressure Ulcer Prevention.

Infusion pumps are standardized across the organization and competence is first evaluated at initial orientation, and then yearly. All staff questioned had demonstrated to the educator their competency with infusion pumps within the last year.

The Nurse Educator is up and about on the wards and does mostly one-on-one education, training and evaluation of competency. Managers are given the names of staff whose competencies need to be updated to ensure staff maintain competency.

The hospitalists also provide education sessions for the nurses and the multidisciplinary team, which includes social work, dietary, occupational therapy, speech therapy, physiotherapy.

Priority Process: Episode of Care

Each patient has a comprehensive assessment by the team, and all the required organizational practices are well documented. The care of the admitted patients is by a general internal medicine specialist working as a hospitalist, paired with a house officer. In June, each fifteen bed unit will have one hospitalist and one house officer for all of the patients on that unit and this will enhance the continuity of care by the team and enable more frequent rounding of the physicians with the team.

Priority Process: Decision Support

The Medservice 4 Clinical Suite is used along with the Pyxis system and barcoding and scanning of the unit dose and patient wristband for medication distribution and management. Through this system there is access to laboratory and diagnostic imaging results and information form emergency and operative reports can also be viewed.

The bulk of documentation is done through paper charting, and preprinted and standardized forms. Processes do appear to be streamlined and consistent, which will be important prior to implementation of an electronic medical record.

Priority Process: Impact on Outcomes

The staff on the Medicine Unit reviewed have started to take an interest in quality initiatives and have started a Quality Care Committee. They have started with pressures ulcer assessments and use of additional initiatives to decrease or mitigate pressure ulcer morbidity and mortality. Another initiative is to watch and score the completeness of the bedside handover to ensure all elements are completed.

Unfortunately, as in other areas, there does not seem to be a consistent organizational framework, process or tools to support these activities. Staff were unaware of the PDSA (Plan-Do-Study-Act) cycle that is commonly used in quality improvement.

The organization should develop a quality framework and the tools needed to enable and empower staff to take a role in initiating quality improvements.

3.3.16 Standards Set: Mental Health Services

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
2.2	The team's objectives for mental health services are specific and measurable.		
4.9	The organization has a strategy to reduce stigma of mental illness among staff and service providers.		
4.10	The team supports and monitors student, resident, intern and volunteer placement on the mental health team.		
Priority Process: Competency			
The organization has met all criteria for this priority process.			
Priority Process: Episode of Care			
2.7	The team protects the physical security of clients and staff in the service setting.		!
6.9	If the organization is unable to meet the particular needs of a client, the team refers the client to another organization.		
7.5	The team assesses and monitors clients for risk of suicide.		ROP
	7.5.1	The team assesses each client for risk of suicide at regular intervals, or as needs change.	**MAJOR**
	7.5.2	The team identifies clients at risk of suicide.	**MAJOR**
	7.5.3	The team addresses the immediate safety needs of clients who are identified as being at risk of suicide.	**MAJOR**
	7.5.4	The team identifies treatment and monitoring strategies to ensure client safety.	**MAJOR**
	7.5.5	The team documents the implementation of the treatment and monitoring strategies in the client's health record.	**MAJOR**
Priority Process: Decision Support			
15.1	The organization has a process to select and update evidence-based guidelines to inform its mental health service delivery.		!
Priority Process: Impact on Outcomes			
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.		!

17.5	The team designs and tests quality improvement activities to meet its objectives.	!
17.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.9	The team implements effective quality improvement activities broadly.	!
17.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Mental Health services are a holistic continuum of care provided by a highly skilled inter-professional team. The team is extremely knowledgeable of the community needs. Clients and families are actively involved in care through to the recovery stage and transition to the community. The discharge planning begins at admission. If a patient in ER at KEMH requires a psychiatric consultation, there is a very quick response and transfer to MAWI.

Priority Process: Competency

The mental health services employs a clinical educator with a Masters degree in Psychology. He has developed a competency checklist for the mental health nurses to ensure they remain knowledgeable about best practices.

There is a focus on training and development of staff to ensure they can work to their full scope. The different professional groups have defined roles and responsibilities via a job description. The orientation program is detailed and ensures a comfortable onboardering experience.

Priority Process: Episode of Care

All in-patient units were visited during the tracer activity including the Reid unit for patients requiring chronic long term care, the PICU, the in-patient acute unit and the recovery unit. The team in each area works well together and promotes a continuum of care for mental health clients. The team ensures that informed consent is obtained while identifying the patient's consent capacity. Each patient is assessed on admission and a plan of care is created. The team uses clinical judgement as to determine when the patient is well enough to participate in the care planning process. There is an emphasis on activities provided through recreational therapy and occupational therapy.

The team has done an admirable job at ensuring use of two client identifiers is well embedded in practice. The suicide risk assessment ROP was not met. In a review of four charts, the PICU documented only one assessment of suicide risk for each patient but there was no evidence of further assessments within a two week period. The in-patient unit was diligent in documenting whether there was any suicide ideation on each shift and this trend was evident on multiple chart reviews.

On the chronic unit, most patients will likely stay for life as they have an intractable mental illness. The staff deal with aggression on a daily basis. A notification button system is required to ensure staff and physicians can access assistance when threatened. The recovery unit prepares patients for returning to the community and identifying the cues for relapsing including medication management.

Several patients agreed to provide their view of care. One woman was able to talk about the great care provided. The staff has assisted the other patient to appeal to a tribunal in order to change his medication.

Priority Process: Decision Support

The team has ready access to the patients' complete medical records. Many clients have multiple admissions and the charts get 'thinned'. The team keeps the remainder of the chart readily accessible if reference is required, The team is very diligent about maintaining and preserving a client's right to privacy. In such a small community, the staff are often approached by friends, family and others outside the hospital for information about a specific client. The staff are diligent at ensuring the client's privacy.

Priority Process: Impact on Outcomes

While there is evidence of work being done on quality improvement plans, there is little organizational support to ensure alignment with the organization's strategic plan. The goals and objectives are not measurable or specific. The team is willing and eager to devote time to this purpose but need quality improvement tools to guide them in the right direction.

3.3.17 Standards Set: Obstetrics Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
19.8	The team follows a process to regularly collect indicator data to track its progress.	
19.9	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
19.10	The team implements effective quality improvement activities broadly.	!
19.11	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
19.12	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The team reports that one of their initiatives to address funding shortfalls was to streamline consumables. This was done through audits, trending and evaluating outcomes. Staff are cross-trained between pediatrics and the special babies unit and maternity to special baby unit. This requires the staff to maintain competencies in many nursing skills and they are to be commended for their commitment.

Priority Process: Competency

There is a robust orientation program for all staff recruited to the Obstetrics Service.

Priority Process: Episode of Care

Patient Care Maps are well developed and utilized as evidenced by the Cesarean Section and Vaginal Delivery.

The team uses a standardized procedure for all planned C-sections. The patients are seen two to three days before the surgery in a pre-assessment clinic where they meet with the nurse, anaethestist and surgeon.

The patients are provided with excellent information both orally and written regarding their labour, delivery, postpartum care, breast feeding, etc. Patients are provided with a "Speak Up" pamphlet explaining the organizations process for reporting issues.

A social worker is assigned to the obstetrical services and provides emotional support, counselling and bereavement services to patients and their families when required.

Priority Process: Decision Support

The team utilizes a multidisciplinary approach to care which involve many of the island agencies and services.

Priority Process: Impact on Outcomes

The Obstetric Services provide a high quality of care to the patients they serve. The unit is staffed by registered nurses who must hold a midwifery certification upon hire and four years experience.
New nursing staff are preceptored and buddied with an experienced nurse and evaluated at one and three month intervals. Staff are required to maintain competency in an extensive number of skills. The staff are supported in their ongoing education and training through many organizational funding opportunities.

The unit has recently added two new state of the art operating theatres where cesarian sections are performed. The building of these operating room theaters was implemented as a patient safety initiative to avoid a lengthy travel to the relocated general operating room theatres.

The obstetrical patients are provided with pre-natal, labour and delivery and post-natal support through unit services. There is a well coordinated transition of services for mom and babe to the community. The unit also supports a high risk neonatal unit.

Quality initiatives are in place but the overall quality framework is not implemented.

3.3.18 Standards Set: Point-of-Care Testing

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
5.4	The organization follows written procedures to store, handle, clean, and disinfect POCT equipment.	!
5.8	The organization monitors and verifies that health care professionals delivering POCT use only the unique identification numbers assigned to them.	

Surveyor comments on the priority process(es)

Priority Process: Point-of-care Testing Services

Point of Care Testing (POCT) program is well developed and integrated into clinical practice. Laboratory staff have a breadth of knowledge and expertise regarding Point of Care testing.

Oversight of the POCT is appropriate. A quality management/improvement program has been initiated. There is an interdisciplinary committee in place to oversee this program and ensure improvements. Promotion of increased reporting for POCT incidents to Quality and Risk will allow for POCT trending, enhanced quality and mitigation of risk.

POCT is in place for glucose, urinalysis, drugs of abuse, pregnancy testing, occult blood and a few other analytes. Staff performing POCT receive appropriate training. Documentation of orders and test results is appropriate and staff are aware of associated practices. Informed consent and positive patient identification are completed. Staff are required to enter patient information into the glucose meter manually. Bar coding could be considered in future years. A few staff members report that there have been instances when staff delivering POCT use another staff member's code (when using glucose meters).

Standard operating procedures are in place. The organization has written procedures to store, handle, clean, and disinfect POCT equipment. It was observed on a few occasions that staff do not always clean the equipment after patient use (even though equipment is used on more than one patient).

Adverse events and recalls are handled appropriately. Procurement and inventory control is formalized. Reporting is appropriate. The ability to integrate results from POCT for glucose meter devices into the electronic patient record is in place.

Overall, this is a well-managed program that is overseen by a dedicated and knowledgeable group.

3.3.19 Standards Set: Rehabilitation Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
8.3	The team obtains the client's informed consent before providing services.	!
Priority Process: Decision Support		
14.1	The organization has a process to select evidence-based guidelines for rehabilitation services.	!
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)
Priority Process: Clinical Leadership
Rehabilitation services are provided at several different physical locations across the organization. Staff meet on a regular basis to review services and implement activities according to client needs.
Priority Process: Competency
Staff maintain competencies through yearly mandatory certification with their professional bodies.
Priority Process: Episode of Care
Patients and families report a high level of satisfaction with the rehabilitation services. The teams are truly multidisciplinary in their approach to patient care.
Priority Process: Decision Support
The organization should direct the rehabilitation team to an established set of best practice guidelines.

Priority Process: Impact on Outcomes

The Rehabilitation Services provide an extensive, high quality of care to both inpatient and outpatients. The volume of outpatients far exceeds the capacity of the service which results in a wait list particularly for physical therapy and dietetic services. The team employs a variety of strategies to address these wait times and utilizes the quality improvement process to track, monitor and develop strategies. Staff report sending a letter to family physicians alerting them to the wait lists and suggesting an alternative of referring patients to private clinics on the island, however, this has not had any impact on the referral pattern.

The physical space poses challenges as well. The outpatient services are provided in three different locations which can be challenging when trying to utilize staffing resources.

The new inpatient unit houses patients in private rooms and boasts of a colorful, bright and spacious environment. Staff and patients report a high level of satisfaction with the new space and well equipped unit.

Patients interviewed by the surveyor in both the inpatient and outpatient unit report a high level of satisfaction with the service they receive and compliment the staff for their dedication and commitment to providing care.

The services employ Best Practice Guidelines and Practices but there is not a formalized process or policy to guide the disciplines. The Bermuda Health Council determines the service needs and the Board of Disciplines sets the standards.

The team members maintain their competencies though ongoing education and training which is supported by the organization.

An annual performance appraisal is done and well documented.

The team meet every two weeks and review their quality indicators, determine action plans and opportunities for improvements.

The Social Worker meets quarterly with the staff from the National Office For Seniors and the Physically Challenged where they discuss discharge and transitioning strategies.

The team has implemented an eight week "Staying Steady Group" for individuals at risk for falls. This is a group event led by members off the rehab team. The team has employed a variety of tools to address patients at risk for falls including "Humpty Dumpty" for pediatrics; "SAFE" for inpatients and "WHICH" for outpatients.

It is recommended that the team follow the organizations policy for obtaining written consent for admitted patients.

3.3.20 Standards Set: Substance Abuse and Problem Gambling Services

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
16.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
16.5	The team designs and tests quality improvement activities to meet its objectives.	!
16.6	The team collects new or uses existing data to establish a baseline for each indicator.	
16.7	The team follows a process to regularly collect indicator data to track its progress.	
16.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
16.9	The team implements effective quality improvement activities broadly.	!
16.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
16.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a team concept throughout the program. The leadership team ensures adequate staffing levels at this time although there is concern expressed about future funding.

Quality improvement initiatives are evident through tracking, monitoring and evaluating, however, there is still much work to be done in this area.

Priority Process: Competency

The team reports that they are recognized and valued for their commitment in a variety of ways.

Priority Process: Episode of Care

The team does a remarkable job of coordinating services for their clients with the agencies and programs on the island. This is often complex as many are privately or government funded through different branches and often the client's insurance does not cover the cost.

Priority Process: Decision Support

The program boasts a paperless system as they chart on the electronic record. They continue to keep a paper copy as the entire organization is not electronic at this time. Physician orders are still hand written.

Priority Process: Impact on Outcomes

The Substance Abuse and Problem Gambling Program has done an excellent job of providing staff and clients with a safe environment.

The access is controlled with a swipe card, monitoring system is in place and two staff are on the unit at all times.

Service users report the staff support all their recovery efforts in a respectable manner and include them in developing their care plans.

3.3.21 Standards Set: Transfusion Services

Unmet Criteria		High Priority Criteria
Priority Process: Transfusion Services		
14.3	The team verifies that specific precautions have been followed for red blood cells prepared for recipients with anti-IgA.	!
16.1	The organization follows SOPs for storing each type of blood component and blood product within acceptable temperature ranges and storage conditions, including in the event of power failure.	!
16.6	The team isolates blood products and blood components from donor and recipient samples, tissues for transplantation, or blood centre reagents.	!
17.1	The team visually inspects each blood bag and documents that it is free from leakage or abnormalities, and is within the expiration date.	!
18.7	The team stores blood components that do not meet criteria for release in an identified and secured quarantine location until they are released from quarantine or are disposed of appropriately.	!
20.10	In situations where delaying transfusion may cause harm to the recipient, the team follows SOPs for releasing blood components for which infectious disease testing and/or pre-transfusion compatibility testing is incomplete.	!
Surveyor comments on the priority process(es)		
Priority Process: Transfusion Services		

Transfusion laboratory staff have a breadth of knowledge and expertise. The team collects information about the demand for transfusion services including services volumes, wait times, client perspectives, and trends in service needs. A Transfusion Committee is in place and meets quarterly. Staff are aware of policies and procedures. Quality control is adequate. An orientation program is established for new staff. A formal program to maintain team members' competence is in place.

The Hospital provides oversight for the walking blood donor program across the country. Donor samples are collected and processed on site. Donor samples are sent off shore for testing prior to being available for transfusion. Directed donations are not an option.

Staff report that a formal process is not established to verify that specific precautions have been followed for red blood cells prepared for recipients with anti-IgA. It was observed that blood components and blood products were not stored in acceptable storage conditions. For example, 1) blood that was not fully tested and approved for use was stored in the same fridge as blood that is in active use for patients, 2) staff indicated that blood under quarantine would be stored in the same fridge as blood that is in use for patients, and 3) patient samples (and potentially reagents) are being stored in the same freezer as fresh frozen plasma.

Transport of units appears to be appropriate. Nursing staff appear knowledgeable in policies, procedures and processes related to transfusion. Two patient identifiers were consistently utilized. Look back procedures are in place and record handling is appropriate.

3.3.22 Priority Process: Surgical Procedures

Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge

Unmet Criteria		High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures Standards		
3.6	The interdisciplinary team follows a formal process to regularly evaluate its functioning, identify priorities for action, and make improvements.	
9.3	The team ensures that all of the client's jewelry, body piercings, contact lenses, prostheses, dentures, and eyeglasses have been removed prior to surgery.	!
10.1	The physical layout of the operating and/or procedure room(s) and equipment are designed to consider client flow, traffic patterns, the types of procedures performed, ergonomics, and equipment movement logistics.	
10.8	Rooms where surgical and invasive procedures are performed have at least 20 complete air exchanges per hour.	!
10.11	The organization posts a regular and comprehensive cleaning schedule for the operating/procedure room and supporting areas in a place that is accessible to all team members.	!
27.5	The team shares benchmark and best practice information with its partners and other organizations.	
29.1	The team collects information and feedback from clients, families, staff, service providers, organization leaders, and other organizations about the quality of its services to guide its quality improvement initiatives.	
29.2	The team uses the information and feedback it has gathered to identify opportunities for quality improvement initiatives.	
29.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
29.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
29.5	The team designs and tests quality improvement activities to meet its objectives.	!
29.6	The team collects new or uses existing data to establish a baseline for each indicator.	
29.7	The team follows a process to regularly collect indicator data to track its progress.	

29.8	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
29.9	The team implements effective quality improvement activities broadly.	!
29.10	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
29.11	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Perioperative and Invasive Procedures are done exclusively at the King Edward VII Memorial Hospital in the public healthcare system of Bermuda.

The Acute Care Wing was recently opened with a pre-admission clinic and area, five operating rooms, a post anaesthetic recovery unit (PACU), discharge lounge and surgical inpatient beds on two floors. All the facilities are state of art. The new facilities were originally built for outpatient surgery, and the flow of inpatients is not optimal, especially those who require admission to the Critical Care Unit, which is at a significant distance.

A comprehensive range of surgery is available and visiting specialists provide additional ability in areas such as hemodialysis vascular access surgery, and total knee arthroplasty. In addition, endoscopy and interventional radiology procedures are performed in the OR.

A central booking office is in place and is used to coordinate block bookings. There are no wait lists and flexibility in the block booking schedule is used to ensure that all available time is used to ensure there is no wait list. Collection of absolute wait times is not formally done.

A well run pre-admission clinic ensures that a comprehensive nursing assessment and best possible medication history is completed, a pre-operative anesthetic consult is done and the required admission documentation is completed by the surgical associate. Patients are given verbal and written instructions regarding safety in the hospital, VTE Prophylaxis, patient controlled analgesic pumps as well as information related to the specific surgery.

The operating rooms run smoothly with well-trained teams and there is good flow of staff, patients, equipment and materials. All areas are secure with controlled access. The Medservice 4 Clinical Suite is used to access emergency department information, laboratory results, diagnostic imaging and operative reports. Unfortunately, other important information, including discharge summaries and consultations are not in this application.

Care Pathways were seen for gynecological surgeries, and some work has been done to formalize one for knee surgery. Additional care pathways should be developed as much as possible in other areas.

Quality indicators for the perioperative program are being collected and monitored, including compliance with the safe surgical checklist, and VTE Prophylaxis. Hand hygiene audits are done randomly and the most recent posting was 69 %. It was not clear if the quality initiatives are being done with a focus on continuous

improvement as action plans to increase towards a goal were not seen. A more robust quality program that also compares to similar organizations would be informative.

Transitions for the operating room to the PACU and to the ward or discharge lounge are done with formalized transfer of information. All discharged patients are contacted at 24 hours to assess status.

The surgical wards are all single patient rooms with state of the art systems including the medication distribution and management systems (Pyxis and bar coded and scanned unit dosing via the Medseries4 clinical suite) which also allows the dispensing RN to review laboratory parameters. There has been some initial work done by frontline staff on quality initiatives and these should continue to be encouraged and supported.

Staff meetings are held on a regular basis and the ward had minutes of the meetings. Analysis of patient safety incidents have included root cause analysis. Performance evaluations are being done on a regular basis; most yearly. Succession planning is challenging given the large number of expatriate staff, as well as the decline in the economy.

Section 4 Instrument Results

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

4.1 Governance Functioning Tool

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

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

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

- **Data collection period: March 10, 2014 to April 1, 2014**
- **Number of responses: 13**

Governance Functioning Tool Results

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	15	8	77	93
1	We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	15	8	77	93
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	8	15	77	95
2	Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	8	15	77	95
3	We have sub-committees that have clearly-defined roles and responsibilities.	15	0	85	97

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
3	We have sub-committees that have clearly-defined roles and responsibilities.	15	0	85	97
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	23	0	77	95
4	Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	23	0	77	95
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	8	0	92	92
5	We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decisionmaking.	8	0	92	92
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	8	0	92	95
6	Disagreements are viewed as a search for solutions rather than a “win/lose”.	8	0	92	95
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	8	0	92	98
7	Our meetings are held frequently enough to make sure we are able to make timely decisions.	8	0	92	98
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	15	0	85	96
8	Individual members understand and carry out their legal duties, roles and responsibilities, including sub-committee work (as applicable).	15	0	85	96
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	8	15	77	94

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
9	Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	8	15	77	94
10	Our governance processes make sure that everyone participates in decision-making.	8	15	77	94
10	Our governance processes make sure that everyone participates in decision-making.	8	15	77	94
11	Individual members are actively involved in policy-making and strategic planning.	8	23	69	89
11	Individual members are actively involved in policy-making and strategic planning.	8	23	69	89
12	The composition of our governing body contributes to high governance and leadership performance.	8	23	69	93
12	The composition of our governing body contributes to high governance and leadership performance.	8	23	69	93
13	Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	15	0	85	96
13	Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	15	0	85	96
14	Our ongoing education and professional development is encouraged.	8	46	46	88
14	Our ongoing education and professional development is encouraged.	8	46	46	88
15	Working relationships among individual members and committees are positive.	8	0	92	97
15	Working relationships among individual members and committees are positive.	8	0	92	97
16	We have a process to set bylaws and corporate policies.	8	38	54	95
16	We have a process to set bylaws and corporate policies.	8	38	54	95

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	8	0	92	97
17	Our bylaws and corporate policies cover confidentiality and conflict of interest.	8	0	92	97
18	We formally evaluate our own performance on a regular basis.	38	38	23	82
18	We formally evaluate our own performance on a regular basis.	38	38	23	82
19	We benchmark our performance against other similar organizations and/or national standards.	15	38	46	72
19	We benchmark our performance against other similar organizations and/or national standards.	15	38	46	72
20	Contributions of individual members are reviewed regularly.	23	54	23	64
20	Contributions of individual members are reviewed regularly.	23	54	23	64
21	As a team, we regularly review how we function together and how our governance processes could be improved.	23	46	31	81
21	As a team, we regularly review how we function together and how our governance processes could be improved.	23	46	31	81
22	There is a process for improving individual effectiveness when non-performance is an issue.	31	38	31	64
22	There is a process for improving individual effectiveness when non-performance is an issue.	31	38	31	64
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	23	31	46	80
23	We regularly identify areas for improvement and engage in our own quality improvement activities.	23	31	46	80
24	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	25	25	50	84

		% Disagree	% Neutral	% Agree	%Agree * Canadian Average
		Organization	Organization	Organization	
24	As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	25	25	50	84
25	As individual members, we receive adequate feedback about our contribution to the governing body.	8	54	38	69
25	As individual members, we receive adequate feedback about our contribution to the governing body.	8	54	38	69
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	8	15	77	96
26	Our chair has clear roles and responsibilities and runs the governing body effectively.	8	15	77	96
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	15	8	77	84
27	We receive ongoing education on how to interpret information on quality and patient safety performance.	15	8	77	84
28	As a governing body, we oversee the development of the organization's strategic plan.	8	0	92	95
28	As a governing body, we oversee the development of the organization's strategic plan.	8	0	92	95
29	As a governing body, we hear stories about clients that experienced harm during care.	8	0	92	85
29	As a governing body, we hear stories about clients that experienced harm during care.	8	0	92	85
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	15	0	85	92
30	The performance measures we track as a governing body give us a good understanding of organizational performance.	15	0	85	92

	% Disagree	% Neutral	% Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	9	36	55	87
31 We actively recruit, recommend and/or select new members based on needs for particular skills, background, and experience.	9	36	55	87
32 We have explicit criteria to recruit and select new members.	20	70	10	84
32 We have explicit criteria to recruit and select new members.	20	70	10	84
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	50	25	25	90
33 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	50	25	25	90
34 The composition of our governing body allows us to meet stakeholder and community needs.	15	0	85	94
34 The composition of our governing body allows us to meet stakeholder and community needs.	15	0	85	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	17	33	50	94
35 Clear written policies define term lengths and limits for individual members, as well as compensation.	17	33	50	94
36 We review our own structure, including size and subcommittee structure.	8	25	67	89
36 We review our own structure, including size and subcommittee structure.	8	25	67	89
37 We have a process to elect or appoint our chair.	22	44	33	95
37 We have a process to elect or appoint our chair.	22	44	33	95

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2014 and agreed with the instrument items.

4.2 Patient Safety Culture Tool

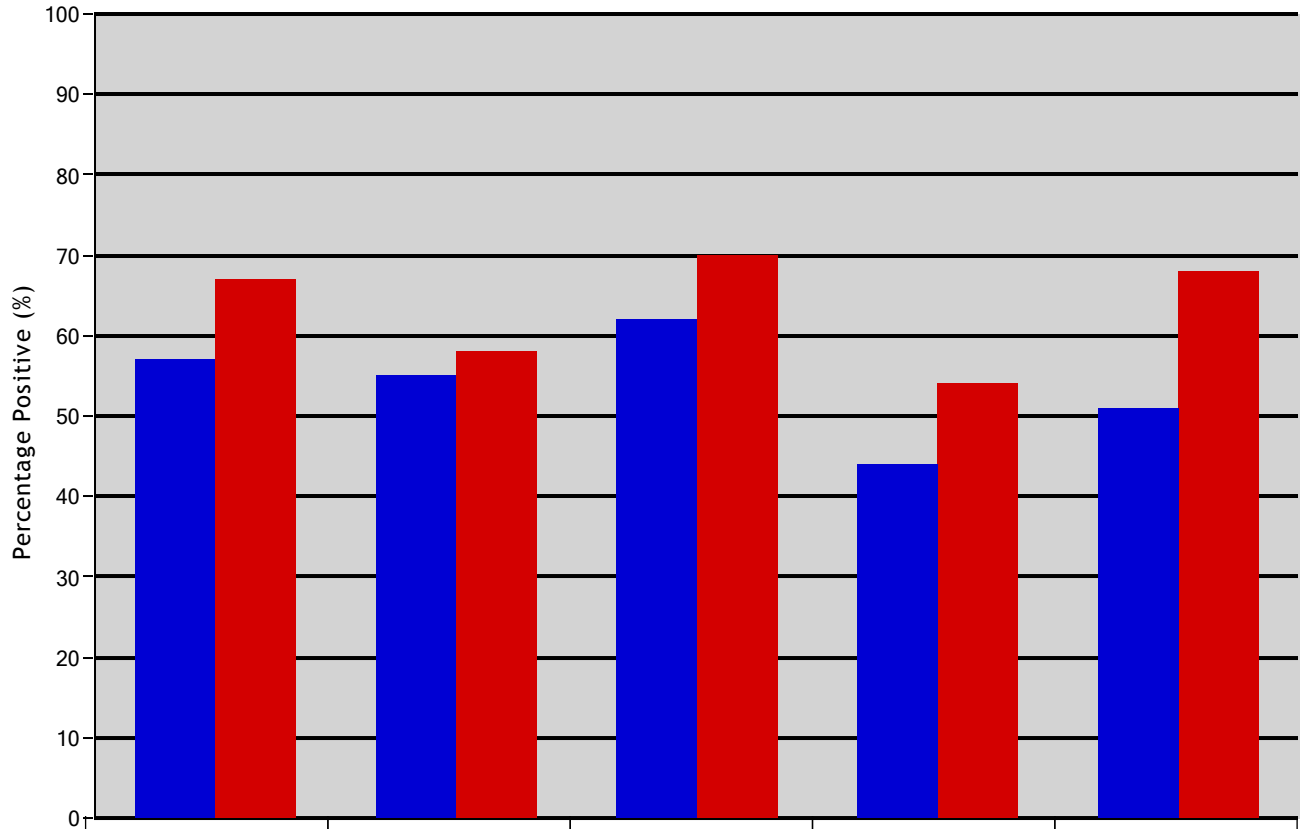
Organizational culture is widely recognized as a significant driver in changing behavior and expectations in order to increase safety within organizations. A key step in this process is the ability to measure the presence and degree of safety culture. This is why Accreditation Canada provides organizations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

Results from the Patient Safety Culture Tool allow the organization to identify strengths and areas for improvement in a number of areas related to patient safety and worklife.

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

- **Data collection period: February 1, 2013 to March 6, 2013**
- **Minimum responses rate (based on the number of eligible employees): 299**
- **Number of responses: 880**

Patient Safety Culture Tool: Results by Patient Safety Culture Dimension



	Senior leadership support for safety (valuing safety)	Supervisory leadership support for safety	Patient safety learning culture	Communication barriers/talking about errors	Overall perception of patient safety
	57%	55%	62%	44%	51%
	67%	58%	70%	54%	68%

Legend

The Bermuda Hospitals Board

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2013 and agreed with the instrument items.

4.3 Worklife Pulse

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

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

The organization used an approved substitute tool for measuring quality of Worklife. The organization has provided Accreditation Canada with results from its substitute tool and had the opportunity to identify strengths and address areas for improvement. During the on-site survey, surveyors reviewed actions the organization has taken.

4.4 Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A Qmentum

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

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 10 business days.

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

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

Action Planning

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

Evidence Review and Ongoing Improvement

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

Appendix B Priority Processes

Priority processes associated with system-wide standards

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

Priority processes associated with population-specific standards

Priority Process	Description
Chronic Disease Management	Integrating and coordinating services across the continuum of care for populations with chronic conditions
Population Health and Wellness	Promoting and protecting the health of the populations and communities served, through leadership, partnership, innovation, and action.

Priority processes associated with service excellence standards

Priority Process	Description
Blood Services	Handling blood and blood components safely, including donor selection, blood collection, and transfusions
Clinical Leadership	Providing leadership and overall goals and direction to the team of people providing services.
Competency	Developing a skilled, knowledgeable, interdisciplinary team that can manage and deliver effective programs and services
Decision Support	Using information, research, data, and technology to support management and clinical decision making
Diagnostic Services: Imaging	Ensuring the availability of diagnostic imaging services to assist medical professionals in diagnosing and monitoring health conditions
Diagnostic Services: Laboratory	Ensuring the availability of laboratory services to assist medical professionals in diagnosing and monitoring health conditions
Episode of Care	Providing clients with coordinated services from their first encounter with a health care provider through their last contact related to their health issue
Impact on Outcomes	Identifying and monitoring process and outcome measures to evaluate and improve service quality and client outcomes
Infection Prevention and Control	Implementing measures to prevent and reduce the acquisition and transmission of infection among staff, service providers, clients, and families
Medication Management	Using interdisciplinary teams to manage the provision of medication to clients
Organ and Tissue Donation	Providing organ donation services for deceased donors and their families, including identifying potential donors, approaching families, and recovering organs
Organ and Tissue Transplant	Providing organ transplant services, from initial assessment of transplant candidates to providing follow-up care to recipients
Organ Donation (Living)	Providing organ donation services for living donors, including supporting potential donors to make informed decisions, conducting donor suitability testing, and carrying out donation procedures
Point-of-care Testing Services	Using non-laboratory tests delivered at the point of care to determine the presence of health problems

Priority Process	Description
Primary Care Clinical Encounter	Providing primary care in the clinical setting, including making primary care services accessible, completing the encounter, and coordinating services
Public Health	Maintaining and improving the health of the population by supporting and implementing policies and practices to prevent disease, and assess, protect, and promote health.
Surgical Procedures	Delivering safe surgical care, including preoperative preparation, operating room procedures, postoperative recovery, and discharge