ACCREDITATION
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CANADA
Qmentum

Accreditation Report

Bermuda Hospitals Board

Paget, Bermuda

On-site survey dates: May 13, 2019 - May 17, 2019

Report issued: September 17, 2019

About the Accreditation Report

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 2019. Information from the on-site survey as well as other data obtained from the organization were used to produce this Accreditation Report.

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

Confidentiality

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

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

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

A Message from Accreditation Canada

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

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

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

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

We look forward to our continued partnership.

Sincerely,

Leslee Thompson
Chief Executive Officer

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Executive Summary

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.

Accreditation Decision

Bermuda Hospitals Board's accreditation decision is:

Accredited with Exemplary Standing

The organization has attained the highest level of performance, achieving excellence in meeting the requirements of the accreditation program.

About the On-site Survey

- **On-site survey dates: May 13, 2019 to May 17, 2019**

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

  Population-specific Standards

  5. Population Health and Wellness

  Service Excellence Standards

  6. Ambulatory Care Services - Service Excellence Standards
  7. Biomedical Laboratory Services - Service Excellence Standards
  8. Cancer Care - Service Excellence Standards
  9. Community-Based Mental Health Services and Supports - Service Excellence Standards
  10. Critical Care Services - Service Excellence Standards
  11. Diagnostic Imaging Services - Service Excellence Standards
  12. Emergency Department - Service Excellence Standards
  13. EMS and Interfacility Transport - Service Excellence Standards
  14. Home Care Services - Service Excellence Standards
  15. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
  16. Inpatient Services - Service Excellence Standards

17. Intellectual and Developmental Disabilities - Service Excellence Standards
18. Long-Term Care Services - Service Excellence Standards
19. Mental Health Services - Service Excellence Standards
20. Obstetrics Services - Service Excellence Standards
21. Perioperative Services and Invasive Procedures - Service Excellence Standards
22. Point-of-Care Testing - Service Excellence Standards
23. Rehabilitation Services - Service Excellence Standards
24. Reprocessing of Reusable Medical Devices - Service Excellence Standards
25. Substance Abuse and Problem Gambling - Service Excellence Standards
26. Transfusion Services - Service Excellence Standards

- **Instruments**

  The organization administered:

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

Overview by Quality Dimensions

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

Quality Dimension	Met	Unmet	N/A	Total
 Population Focus (Work with my community to anticipate and meet our needs)	84	7	1	92
 Accessibility (Give me timely and equitable services)	159	1	1	161
 Safety (Keep me safe)	900	9	40	949
 Worklife (Take care of those who take care of me)	210	2	1	213
 Client-centred Services (Partner with me and my family in our care)	689	6	8	703
 Continuity (Coordinate my care across the continuum)	151	0	2	153
 Appropriateness (Do the right thing to achieve the best results)	1434	15	26	1475
 Efficiency (Make the best use of resources)	89	1	1	91
Total	**3716**	**41**	**80**	**3837**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	95 (99.0%)	1 (1.0%)	0	145 (99.3%)	1 (0.7%)	0
Infection Prevention and Control Standards	40 (100.0%)	0 (0.0%)	0	31 (100.0%)	0 (0.0%)	0	71 (100.0%)	0 (0.0%)	0
Medication Management Standards	73 (100.0%)	0 (0.0%)	5	62 (98.4%)	1 (1.6%)	1	135 (99.3%)	1 (0.7%)	6
Population Health and Wellness	3 (100.0%)	0 (0.0%)	1	33 (97.1%)	1 (2.9%)	1	36 (97.3%)	1 (2.7%)	2
Ambulatory Care Services	45 (100.0%)	0 (0.0%)	2	76 (97.4%)	2 (2.6%)	0	121 (98.4%)	2 (1.6%)	2
Biomedical Laboratory Services	70 (100.0%)	0 (0.0%)	2	100 (96.2%)	4 (3.8%)	1	170 (97.7%)	4 (2.3%)	3
Cancer Care	76 (100.0%)	0 (0.0%)	5	112 (100.0%)	0 (0.0%)	2	188 (100.0%)	0 (0.0%)	7

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Community-Based Mental Health Services and Supports	45 (100.0%)	0 (0.0%)	0	93 (100.0%)	0 (0.0%)	1	138 (100.0%)	0 (0.0%)	1
Critical Care Services	60 (100.0%)	0 (0.0%)	0	104 (99.0%)	1 (1.0%)	0	164 (99.4%)	1 (0.6%)	0
Diagnostic Imaging Services	65 (98.5%)	1 (1.5%)	2	62 (89.9%)	7 (10.1%)	0	127 (94.1%)	8 (5.9%)	2
Emergency Department	69 (95.8%)	3 (4.2%)	0	104 (99.0%)	1 (1.0%)	2	173 (97.7%)	4 (2.3%)	2
EMS and Interfacility Transport	101 (92.7%)	8 (7.3%)	5	107 (93.9%)	7 (6.1%)	6	208 (93.3%)	15 (6.7%)	11
Home Care Services	48 (100.0%)	0 (0.0%)	0	75 (100.0%)	0 (0.0%)	0	123 (100.0%)	0 (0.0%)	0
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	104 (100.0%)	0 (0.0%)	4	149 (100.0%)	0 (0.0%)	4
Inpatient Services	60 (100.0%)	0 (0.0%)	0	85 (100.0%)	0 (0.0%)	0	145 (100.0%)	0 (0.0%)	0
Intellectual and Developmental Disabilities	54 (100.0%)	0 (0.0%)	0	91 (100.0%)	0 (0.0%)	2	145 (100.0%)	0 (0.0%)	2
Long-Term Care Services	56 (100.0%)	0 (0.0%)	0	99 (100.0%)	0 (0.0%)	0	155 (100.0%)	0 (0.0%)	0
Mental Health Services	50 (100.0%)	0 (0.0%)	0	92 (100.0%)	0 (0.0%)	0	142 (100.0%)	0 (0.0%)	0
Obstetrics Services	71 (100.0%)	0 (0.0%)	2	87 (98.9%)	1 (1.1%)	0	158 (99.4%)	1 (0.6%)	2
Perioperative Services and Invasive Procedures	113 (100.0%)	0 (0.0%)	2	109 (100.0%)	0 (0.0%)	0	222 (100.0%)	0 (0.0%)	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	45 (100.0%)	0 (0.0%)	0	75 (100.0%)	0 (0.0%)	5	120 (100.0%)	0 (0.0%)	5

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 of Reusable Medical Devices	86 (100.0%)	0 (0.0%)	2	40 (100.0%)	0 (0.0%)	0	126 (100.0%)	0 (0.0%)	2
Substance Abuse and Problem Gambling	46 (100.0%)	0 (0.0%)	0	81 (98.8%)	1 (1.2%)	0	127 (99.2%)	1 (0.8%)	0
Transfusion Services	87 (100.0%)	0 (0.0%)	9	70 (100.0%)	0 (0.0%)	6	157 (100.0%)	0 (0.0%)	15
Total	**1545 (99.2%)**	13 (0.8%)	37	2068 (98.7%)	28 (1.3%)	33	3613 (98.9%)	41 (1.1%)	70

* Does not includes ROP (Required Organizational Practices)

Overview by Required Organizational Practices

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

This table shows the ratings of the applicable ROPs.

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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Client Identification (Emergency Department)	Met	1 of 1	0 of 0
Client Identification (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Client Identification (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Met	1 of 1	0 of 0
Client Identification (Inpatient Services)	Met	1 of 1	0 of 0
Client Identification (Long-Term Care Services)	Met	1 of 1	0 of 0
Client Identification (Mental Health Services)	Met	1 of 1	0 of 0
Client Identification (Obstetrics Services)	Met	1 of 1	0 of 0
Client Identification (Perioperative Services and Invasive Procedures)	Met	1 of 1	0 of 0
Client Identification (Point-of-Care Testing)	Met	1 of 1	0 of 0
Client Identification (Rehabilitation Services)	Met	1 of 1	0 of 0
Client Identification (Substance Abuse and Problem Gambling)	Met	1 of 1	0 of 0
Client Identification (Transfusion Services)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Ambulatory Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Cancer Care)	Met	4 of 4	1 of 1
Information transfer at care transitions (Community-Based Mental Health Services and Supports)	Met	4 of 4	1 of 1
Information transfer at care transitions (Critical Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Emergency Department)	Met	4 of 4	1 of 1
Information transfer at care transitions (EMS and Interfacility Transport)	Met	4 of 4	1 of 1
Information transfer at care transitions (Home Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Inpatient Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Intellectual and Developmental Disabilities)	Met	4 of 4	1 of 1
Information transfer at care transitions (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Met	4 of 4	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
Information transfer at care transitions (Obstetrics Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	1 of 1
Information transfer at care transitions (Rehabilitation Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Substance Abuse and Problem Gambling)	Met	4 of 4	1 of 1
Medication reconciliation as a strategic priority (Leadership)	Met	3 of 3	2 of 2
Medication reconciliation at care transitions (Ambulatory Care Services)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	5 of 5	0 of 0
Medication reconciliation at care transitions (Community-Based Mental Health Services and Supports)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Critical Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Emergency Department)	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			
Medication reconciliation at care transitions (Home Care Services)	Met	3 of 3	1 of 1
Medication reconciliation at care transitions (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Inpatient Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Long-Term Care Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Mental Health Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Obstetrics Services)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Perioperative Services and Invasive Procedures)	Met	4 of 4	0 of 0
Medication reconciliation at care transitions (Substance Abuse and Problem Gambling)	Met	3 of 3	1 of 1
Safe Surgery Checklist (Obstetrics Services)	Met	3 of 3	2 of 2
Safe Surgery Checklist (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
The "Do Not Use" list of abbreviations (Medication Management Standards)	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management Standards)	Met	4 of 4	1 of 1
Concentrated Electrolytes (Medication Management Standards)	Met	3 of 3	0 of 0
Heparin Safety (Medication Management Standards)	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management Standards)	Met	5 of 5	3 of 3
Infusion Pumps Training (Ambulatory Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Cancer Care)	Met	4 of 4	2 of 2
Infusion Pumps Training (Critical Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Emergency Department)	Met	4 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
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
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (EMS and Interfacility Transport)	Met	1 of 1	2 of 2
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
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 Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Hospice, Palliative, End-of-Life Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Inpatient Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Long-Term Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Perioperative Services and Invasive Procedures)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0
Suicide Prevention (Mental Health Services)	Met	5 of 5	0 of 0
Suicide Prevention (Substance Abuse and Problem Gambling)	Met	5 of 5	0 of 0

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

Summary of Surveyor Team Observations

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

The Bermuda Hospitals Board (BHB) is responsible for the safe, efficient and effective operations of the King Edward VII Hospital, the Mid Atlantic Wellness Institute and the Lamb Foggo Urgent Care Centre. During the survey onsite visit, 35 priority processes and 26 sets of standards were assessed across the three sites, as well as in one homecare client's home, three group homes, and fire/EMS dispatch.

In 2016 the Bermuda Hospitals Board (BHB) undertook a commendable, comprehensive and inclusive five-year strategic planning process to re-establish its vision and its ways of working and caring for Bermudians. The Vision specifies exceptional care, strong partnerships and healthy community as its aspiration. The Mission to deliver safe, high quality, people-centred, compassionate care every day was understood and very evident to the survey team as dialogues with physicians, staff, patients/clients, families and partners took place, to complete the tracers of both clinical care and administrative processes. People have embraced the Mission and its supporting core values, and staff, as well as community and ministry level partners expressed pride in being asked to help to refine the core values.

In 2017 there was a government change and a new Board was constituted for BHB. At the same time, the BHB Executive Team was restructured and two new Chiefs were introduced. It is impressive that through this change turmoil the BHB Strategic Plan was able to be built upon with an integrated Clinical Services Plan developed in 2018 as well as a Financial Recovery Plan. These plans were effectively cascaded throughout the organization and aligned with operational plans and the establishment of unit-based quality improvement teams. That does not happen by chance but requires focused and intentional Executive Leadership and knowledge of the need to structure, align for effective accountability monitoring, and build the capacity (knowledge, skills and confidence) of the people through effective engagement, to truly be able to effect real and sustainable change. An amazing amount of work has been accomplished in a two year period.

Impressively, the BHB has engaged with the Institute for Healthcare Improvement (IHI) to build sustainable system capacity in terms of understanding and use of quality improvement science and related tools. The benefits to the population of Bermuda and the health system cannot be understated. In doing so the BHB adopted the Triple Aim (used worldwide) to improve the patient experience with care, to improve the health of the population in Bermuda, and to reduce the per capita cost of care. The environmental scanning themes and the input of the 350 plus voices heard during the strategic planning process, provided further impetus for the adoption of the Triple Aim. This is seen as a strength towards achieving targeted changes as improvements over time and is envisioned to position BHB and its partners with a revitalized capacity to effectively respond in evidence-based ways to future system-wide challenges and opportunities. This is important as the BHB is legislatively responsible for all diagnostic, treatment and rehabilitative service needs of Bermuda residents and theirs and other strategic imperatives. The BHB CEO and Executive Team have demonstrated excellent "integrator" and "connector" skills that are not only viewed as helpful internally but also in national health system change processes.

Leadership demonstrated by the BHB CEO and the Executive Team has also resulted in the full development and engagement of the BHB Board, the engagement of external partners, staff and physicians to begin to change the models for care and health service delivery, along the continuum of health needs. It is recognized that this requires deliberate strengthening of existing collaborative relationships and the establishment of additional formal partnerships, particularly in the areas of primary care and population health.

Population health demographics point to high rates of risk factors for diabetes, heart disease, lung disease, and kidney disease, to name a few. In addition, the aged population is projected to increase dramatically over the next ten years. As a result, the BHB and its partners have appropriately committed to strengthening capacity to manage chronic disease. The challenge will be to influence change at the government cabinet level as this will undoubtedly require resources beyond the Health Ministry and will require inter-ministerial collaboration and strategy execution to address population health.

In response to the population health community needs assessment and analyses, the BHB has undertaken defined and targeted initiatives since 2016-2017 to change the way they work and provide care. Some examples of the change foundations that have been established since the last survey include: the development and implementation of the Clinical Services Plan (the anchor to the Strategic Plan and people-centred care); development and implementation of a multi-year Financial Recovery Plan; establishment of the Program Management Office to support integrated quality improvement efforts without duplication and in alignment with established directions; attention to the people (staff, physicians and volunteers) who are viewed as the richest resources of BHB, in terms of improving horizontal and vertical communication and active participation; redeveloping the performance appraisal and personal development processes; augmenting workforce and succession planning and talent management; establishing leadership rounds; strengthening reward and recognition opportunities; and significantly investing in quality and patient/staff safety education with over 800 courses completed by leaders and staff through the Institute for Healthcare Improvement (IHI) Open School and participation in the IHI Breakthrough Learning Series Collaborative called “Safety on the Rock”.

When surveyors spoke with staff, teams, patients, families and partners, it was evident that there is a renewed foundation of quality and patient safety science knowledge, skills and tools being adopted organization-wide. There is a sense that most of the organization has embraced “the patient being the core of what they do day by day” and many staff were able to speak to how their roles and work contribute to the strategic and operational success of BHB. The patient, family and community voice is more and more being actively sought in care planning, strategic, operational, quality improvement efforts and in policy development.

Although the reconstituted BHB Patient and Family Advisory Council (PFAC) is still relatively new and it has already achieved results. There is an evident sense that all see the potential to learn from each other’s diverse perspectives and lens. This is what patient and family-centred care is all about, not necessarily the result but harnessing and using the “appreciative learning process and celebrating milestones” along the way, to both shape and embed a renewed culture in the organization. This can only benefit Bermudians in terms of better

health outcomes. Having said this, there is an imperative need to upgrade ageing technological/information systems,to establish a great electronic health record so that each Bermudian has his/her health information available wherever they receive health services and any time of day. The Board and Executive Leaders are very much acknowledged on their current work to develop an Estate Master Plan, as much of the physical environment challenges are no longer appropriate for the complexity of patient needs today, especially the frail elderly with co-morbidities. The cost-benefits of retrofitting some areas to address air quality and such things as mould will need to be included as their health impacts on staff and patients alike are considerable.

The Accreditation Canada Survey Team wishes BHB and its partners every success and trust that the report findings will be useful to you. Thank you for continuing the journey to ensure safe quality care.

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

The organization has met all criteria for this priority process.
Surveyor comments on the priority process(es)

The previous Board with the Executive Leadership team undertook a comprehensive strategic planning process in 2016 resulting in a 5-year plan for the BHB. The plan was well supported by stakeholders and staff who provided input through a variety of means. In 2017 there was a change of government with a new Health Minister, a new BHB Board and two new additions to the BHB Executive Leadership Team (Chief of Staff and Chief Financial Officer).

Impressively the Board was able to describe how the Strategic Plan anchored their development and strengthened their effectiveness. It stood the waves of government change and was used to inform the 2018 Clinical Services and Financial Recovery Plans. Operational and Quality / Patient Safety Plans are well aligned with the strategic directions.

There is an obvious effective and respectful relationship with the CEO and the Executive Leadership Team which is commended. Regular meetings between the Board Chair and CEO occur and there are also monthly meetings with the Minister of Health which affords opportunities to collaborate in "just in time ways".

The Board meeting agendas reflect robust monitoring of fiscal, quality, safety, credentialing and privileges, and risks, to name a few. There are solid Terms of Reference which clearly serve as by-laws, and established board performance review processes which members could speak to.

Dialogue with the Board verified their good understanding of quality and safety and risk mitigation and examples were described about how accountability reports have been used in Board deliberations and decision-making. There was also an impressive ability to reflect on examples of Board deliberations where the values and principles of the Ethics Framework (IDEA) were applied.

The Board was encouraged to continue to strengthen their oversight of BHB effectiveness and achievement of targeted strategic milestones. Planned enhancements to the IT platform and information

systems are intended to support the use of efficient business intelligence tools. There is solid recognition of the absolute need for an Electronic Medical Record which as now at the Request for Proposals Review stage.

This was an impressive Board to interact with and they are very much encouraged to continue their “just in time” development as they continue their governance functions. They are also encouraged to continue to strengthen ways to bring more client and family perspectives to their deliberations and to support continued momentum and accountability reporting on operational and clinical service plan quality improvement aims and targets.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The planning processes deployed at BHB are impressive. The Strategic Plan 2016-2021 was reviewed and validated as still relevant at the midpoint of its life, this year. The original process was inclusive, transparent and had the input of 350 plus staff and partners. There is solid alignment between the Strategic Plan, Clinical Services, Operational and Financial Recovery Plans and QI teams and their targeted priorities. Accountability reporting and timelines are clear and are tabled with the BHB Quality Council. The values of the organization were refined and reduced from 12 to 5 with input from staff. The values are threaded through everything BHB does from education to ethics review, to performance appraisals, to name a few examples.

The Risk Management Framework is applied to planning processes and there is growing comfort with applying risk matrices to new proposals and day to day activities so that risk-benefits can be identified and contingencies considered. All of the standards and criteria associated with planning and service design have been satisfied. Impressively a number of teams and staff indicated that this is the first time that have been able to see how operational plans relate to the directions, and how their unit-specific QI priorities contribute to the whole of the organization. Well done!

Priority Process: Resource Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Resource management protocols and checks and balances are appropriately in place and utilized. There is a government break-even budget expectation. This poses resource management challenges which are being actively addressed. Audited financials for fiscal year '15-'16 have been completed and '17-'18 is in progress. The resource management team is commended for stepping up to the challenge of completing catch-up on financial processes and controls from years prior. Changes have been made to inventory control policies and procedures for medication inventory and procurement, as well as for ambulatory care clinics and the operating theatres as examples.

A quality improvement that has been realized is the addition of post-project evaluation through the new Programme Management Office. This will strengthen the use of future measures as projects are developed to assess the impacts of resource management post-implementation.

The capital budget process has already begun for the next fiscal year. There are impressive and appropriate alignment and use of risk registry data and a standard business case template. Capital budget requests are reviewed by the Decision Support Panel (DSP) before submission and review by the Executive Leadership Team with final approval by the Finance and Audit Committee of the Board.

The resource management electronic systems are a range of older legacy systems, to which some updates have been made. Capital assets and procurement are contained within the general ledger. There is leadership recognition that a significant investment in electronic systems to provide real-time data on budget and revenues is required. Current platforms do not meet this need today or for tomorrow. Majority of processes are labour intensive, inefficient and in some instances redundant as there are multiple layers of manual sign-offs required which pose risk for things falling through the cracks.

The resource management team is located in a separate leased space in the downtown Hamilton area which the executive leaders and the surveyors identify as a challenge and potential barrier to effective resource management and limits staff identifying with and supporting the quality of care as their "reason for being". The team is very much encouraged to use "just in time" opportunities as electronic system enhancements are made to move towards becoming coaches and mentors to organization-wide managers and leaders, as one means of supporting clinical staff to use resource management tools and data, to measure team performance and outcomes. This is a very enthusiastic team commended for establishing the Investment Appraisal Framework and their contributions to the development of the Estate Master Plan draft that is anticipated to be tabled with the Board in July. Well done!

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 Human Capital Team is an impressive group comprised of experts responsible to support key human resource functions and processes such as employee relations, recruitment, new trainee support within their team, compensation, benefits, organizational development, to name a few. The team expressed pride in the " Redesign of Human Resources" which encompassed roles, functions and structure. This is a huge undertaking which has left the team well positioned to provide greater customer support in achieving BHB's strategic imperatives. The team understands that changing the way people work and relate to each other and with the patients and families they serve, is imperative to organizational success and great patient outcomes.

Impressive analysis and response to the Employee Opinion Survey (EOS) were evident. Staff input was sought on three or four occasions to better understand the sources of lower morale and to harness ideas to address them. Some of the frustrations included such things as scheduling, uniforms, perceived poor communication, and harassment and bullying within work teams. Leadership development of approximately 100 managers was completed as well with key work teams. In addition, an effective partnership with the Bermuda Public Service Union (BPSU) was leveraged to action an organization-wide Harassment and Bullying Campaign last summer. Expectations were established with good follow-up and evaluation of expected new work behaviours. Broad employee training and dialogue on the new policy was undertaken and is available in video format on the intranet for any team, staff or volunteer to access in "just in time ways".As a result, there is growing evidence of increased staff reporting of harassment. Kudos to the team and leaders within the BHB for tackling this difficult issue to create greater dignity at work. HR Advisors have also taken training to support the Employee Relations Officers to continue to strengthen the quest for dignity at work. This is an essential component of becoming a true learning organization and does not go without challenges in smaller communities where everyone knows everyone else. You are trailblazing for others with similar realities!

The HR files are now scanned into a computer system and accessible to managers. The team was encouraged to work with their leader and internal partners to find a way to complete the HR file with the addition of ongoing education and competency maintenance records. At this time they are located with organizational development, quality, nursing and other areas in paper format. This will require an IT solution but is worthy of exploration.

The performance review (appraisal) system has been overhauled and is now rolled out to staff and managers for completion organization-wide by June 30, 2019. A good number of completed appraisals have already been received. It will be important to evaluate the process overall and to establish if doing all in one-time frame annually is feasible going forward. Unfortunately, there is no ability to tie annual

increments to performance at this time. 360 performance reviews at the Executive Team has been undertaken, and many expressed how helpful the perceptions of others was for changing their leadership style and behaviours.

The Human Capital Team and the Executive Team are commended for supporting the organization and its people through the adoption of the Prosci Change Management Framework. To date, 6 organizational development staff have been certified and 20 staff have been developed as Change Champions in the MAWI. Evaluation of the impacts and outcomes of this investment in achieving strategic imperatives is encouraged.

The Human Capital Team is very proud of their accomplishments and contributions to the organization including the redevelopment of the Occupational Health Safety components of their functions to better address employee wellness.

There was an invigorating discussion with these individuals who have a renewed spirit of inquiry. Well done!

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Unit-based quality improvement teams have been established and are well supported with quality, risk management and patient safety resources as well as significant education through the Institute for Healthcare Improvement (IHI) Open School. The organization-wide Quality Council has been reconstituted and is commissioned to provide oversight accountability reporting on components of the Quality/Safety Plan to the Executive Leadership Team and the Board. There has been an explicit and purposeful alignment of all improvement priorities and risk matrices with the Strategic, Operational and Financial Recovery Plans. All work together in sync with clear deliverables and timelines.

An appropriate evidence-based step-wise approach has been demonstrated by the Board and the Executive Leadership Team which is applauded. A clear strategy, an enabling structure from board to patient care, immense investment in capacity building, which will lead to better measures of outcomes over time. There is encouragement now for the Board, the Executive leadership team and the Quality Council to keep the momentum going so that the gains already achieved can be sustained and hard-wired into daily practices for the future. Evidence tells us that any reduction in momentum, measurement and accountability monitoring risks the loss of early gains very quickly.

The Quality Council is an enthusiastic and representative group of the organization. It is evident that engaging front-line staff is happening with impact and the majority of teams are "running with the opportunity" to participate and to be contributors to targeted improvements. This is creating a renewed level of curiosity and a spirit of inquiry that promises to fuel innovation. The Quality Dashboard has been established and will be enhanced with use and refinement. It is recognized that more robust and integrated IT, information management, and business intelligence solutions are required, as what exists today are ageing and lack the capacity to speak to each other. While conducting tracers the Survey Team were impressed to hear from auxiliary support staff that they too were very proud to be engaged in unit based Quality Improvement Teams and to be validated as significant members of the patient's team. This is strengthening team relationships and new ways of working with patients and families all around.

A number of impressive quality improvement results were discussed with the Quality Council. In an effort to reduce the average length of stay (ALOS), bullet rounds were introduced on acute care wards in Oct 2018. This would entail the multidisciplinary team convening for focused reviews of patients to address delays and issues that had arisen since the previous day, augmented with the engagement of patients and families in discharge planning preparations. Over a 3 month period, ALOS decreased by 1.4 days over the same time period the previous year, even with 69 additional admissions during the 2018 time period. Given the need to improve patient flow and access, bullet rounds continue and patients and families are engaged day one to expect discharge in a projected time period.

Another initiative had a targeted focus on elimination of avoidable deaths. Weekly review of all deaths at BHB was instituted Nov 2018 to determine if any were potentially avoidable. Over the first months of this improvement initiative, it was determined through the establishment of a mortality database and the reviews of health records that 8.5% of deaths were possibly avoidable. By drilling down further in the review findings it was established that the highest cause of death was sepsis. A" Surviving Sepsis Campaign" was launched encouraging use of an hour one clinical care bundle, which will be tested and measured.

200 patient safety incidents reported through the Quantros Adverse Event Reporting system were also reviewed in an effort to reduce patient harm. Falls and slips were the highest reported category.

There is an encouragement for the Quality Council to consider the inclusion of a representative of the Patient and Family Advisory Council in their membership, as well as the engagement of patient or family member in each of the unit based quality improvement teams. Patient family members of the unit-based teams may well become associate members of the already established Patient and Family Council. There are many options to explore.

In addition, it was suggested that the Quality Council might consider the establishment of an annual " Quality Day" in which unit based QI teams could showcase their storyboards and as a means for celebrating great learning and exchanging ideas between services.

Finally, it would be helpful to the people of the organization to have the Quality Council provide a schematic of the committee structure of the organization and their relationships to the Quality Council and Board Committees as a visual. This could also be useful to patients, families and external audiences. You are structured for success and the fire has been kindled. Job one for all is to keep the fire fueled. Kudos to everyone!

Priority Process: Principle-based Care and Decision Making

Identifying and making decisions about ethical dilemmas and problems.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Ethics Framework has undergone revisions since the last survey in 2015, to broaden inclusions beyond research ethics. Since September 2018 the Ethics Committee has provided and overseen the education of staff and teams organization-wide. Staff interactions during the survey visit and tracers demonstrated solid awareness of the Ethics Framework. People are generally feeling more comfortable about their ability to seek consultation.

Research ethics is addressed through a standing committee of The Ministry of Health. This is referenced in the BHB Ethics Framework. BHB participates in limited research. International Trials in the areas of ophthalmology and hematology were the last undertaken. New overseas Clinical Affiliations for Continuing Medical Education (CME) are anticipated to be inclusive of scientific research components.

The team is very proud of the informal consultation that has occurred since the education blitz. As a result, work has been supported to educate the community about advanced health directives. In addition, the Ethics Committee was instrumental in engaging the Palliative Care Consultant for a session on "having difficult conversations with each other, and patients and families

Two formal Ethics Consultation requests were addressed in the past year. One was reviewed as a tracer. The process was well done and the situation was complex. Having said that a number of quality improvement flags were identified as opportunities for the organization such as review of immediate response and staff/team support requisites post-traumatic incident.

There were ideas exchanged on ways to stimulate greater formal use of the Ethics Framework as system-wide decisions and changes unfold on the island. This was viewed as a potentially useful consideration which lends itself to the use of local social determinants of health data. It will be important to generate more formal consultations to be able to trend issues for policy enhancements or other targeted improvements.

You should be proud of the value you bring to BHB.

Priority Process: Communication

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
11.1 Information management systems selected for the organization meet the organization's current needs and take into consideration its future needs.	

Surveyor comments on the priority process(es)

A Community Partners Focus Group dialogue took place in terms of the effectiveness of BHB Communication processes and to elicit suggestions for improvement. The majority of external partners spoke of their awareness of the website, use of press releases, and expressed they have experienced improved Executive Team communication overall. Where cross appointments are made between partner and BHB Boards communication is generally strengthened and most appreciated.

Suggestions for areas to focus communication process improvements included early and proactive engagement of charitable organization partners as there are 40 charitable organizations on the island when strategic opportunities arise where financial support is required. This allows charitable entities to better plan their campaigns for timely assistance. In some instances, opportunities exist now as other donor campaigns are nearing completion.

Another suggestion related to overall health system reform communication with the expressed desire to have system-wide needs assessment information so as to be able to proactively plan for the numbers and types of housing/accommodations required for specific population types in the future. This was seen to allow coordinated and integrated planning as one system of services beyond the Ministry of Health. This suggestion applies to the broad system rather than BHB alone.

The potential to create a Master Contact List that cluster partner services that support common patients/clients was identified as a suggestion. An example might be Bermuda Cancer and Health Center, BHB oncology services and Friends of Hospice, as all may touch the person at some time in terms of support and service.

Finding timely ways to name and resolve differences between the players whether it be advocacy for mental health and school /public awareness events or resolving confused messaging between the players. It was suggested that when strategic or operational leads bring a number of partners to the same table, that targeted key messages go out to all simultaneously through a group share. Harmony and synergy in messaging are viewed as desirable and possible, to reduce the risk of mixed messaging.

Several of the partners represented their organizations in the discussion rather than as BHB Board members.

There was a healthy discussion of the Bermuda "Health Finance Plan" which poses uncertainty for partners in terms of impact on BHB and on partner services and supports. The Bermuda Health Council representative spoke to the regulatory role of the council and that there is a new strategy for Bermuda in terms of the health system.

Overall it was a wonderful discussion and gave an appreciation for the complexity of partner needs in terms of communication.

Evidence was reviewed to affirm BHB communication with communities and the public in general over the past two years.

The only shortfall in terms of standards being met was the area of Information Management Systems which the Board, Leadership and the Ministry are well aware of. Otherwise, all standards related to Communication were fully met.

Priority Process: Physical Environment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The physical environment at the King Edward VII Memorial Hospital and Mid- Atlantic Wellness Institute (MAWI) meet applicable industry standards. For example, restricted access areas within the perioperative suite comply with the American Operating Nurses Standards. Heating, ventilation, temperature and humidity comply with the Canadian Standard Z32. Strategies to conserve energy include conservation of rainwater and processing sewage on site.

A number of capital projects are underway to address areas in the physical plant needing immediate attention. For example, the kitchen in Mid-Atlantic Wellness Institute is soon to be replaced, and plans are in place to do a major renovation of the laundry at the King Edward VII Memorial Hospital.

Environmental Services is contracted out at MAWI. Cleaning schedules are consistent across both sites. Leadership on both sites are clearly committed to maintaining the physical environment.

Emergency Services have experienced a number of accidents in recent months. Consequently, all drivers have undergone refresher training provided by an outside instructor. The service works with Infection Control to develop policies and procedures for cleaning and decontamination of the vehicles.

The supply of equipment on the vehicles should be reviewed to avoid overstocking and allow for easy retrieval in emergency situations and prevent wastage. A number of unsecured cylinders were observed adjacent to the ambulance bay. These items should be secured to avoid personnel or visitor injury.

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 Bermuda Hospitals Board works closely with and holds a position on, the Emergency Measures Organization (EMO). This close working relationship ensures the communication and integration of healthcare and healthcare providers with the many other vital emergency response organizations involved in planning for, and managing, emergency situations.

The hospital and staff participate in regular tabletop exercises with EMO and with the airport. This helps to familiarize the hospital staff and other organizations with the procedures and improve working relationships with their disaster response counterparts.

Within the hospitals, a lot of work has been done refining the Code RED plan and exercising the procedures with hospital staff. The team is encouraged to continue this excellent work and expand this initiative to other facilities to ensure staff at all locations are comfortable with procedures specific to their workspace.

Reviewing and training with the multiple different Code scenarios is part of the team's ongoing plan as the organization moves forward. Gradually building code capacity and experience and spreading this familiarity through the organization is an ambitious endeavour and the team is encouraged to work towards scheduling Codes of different types on a regular basis and to ensure that they are practised throughout the facility, as applicable.

Code BLUE training is well entrenched in some departments. Running scenarios in a variety of locations within the hospital will provide more staff with Code support experience and help team members prepare for emergency situations wherever they may occur in the hospital.

Priority Process: People-Centred Care

Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

From the Board to the patient and points of care, the BHB has embraced client and family-centred care as an approach that will strengthen their capacity to improve planning, delivery, and evaluation of services. Within the BHB there are mature patient and family advisory structures effectively operating. A few examples include MWI Intellectual and Developmental Disabilities Services and the KEMH Long Term Care (Continuing Care Services) Resident and Family Advisory Council. In addition, the overarching organization-wide Patient and Family Advisory Council was reinvigorated in November 2108. This demonstrates that the Board and Executive Leadership Team is committed to both seeking and using client and family input to all they do as engagement will lead to achieving the mission and strategic vision of the organization and improve patient and family satisfaction with care experiences and outcomes.

Across the organization patients and families described how they were actively engaged in their own care. One example within the acute care units is the establishment of daily bullet rounds and promotion of early discharge planning consistent with the patients care map. Other examples include the implementation of a pilot of post-discharge phone follow-up; allowing a support person to accompany patients during Diagnostic Image (DI) Testing which is in the policy development; DI registration system improved with suggested number system; feedback on the communication policy; and participation in this accreditation survey visit. This is impressive results in 6 short months. Staff who have worked with patients and families in new ways were able to speak to their uncertainty at the outset and to their changed perceptions of the value-adds of engaging and collaborating with patients and families in new ways. Perceptions and understandings of perspectives have influenced both ways. People are learning from each other through engagement.

There is strong encouragement to fully evaluate the functioning of the PFAC on an annual basis; to consider ways to strengthen the profiling of their annual results in the BHB Annual Report and public communication vehicles; to continue to partner in internal and external presentations with PFAC members; and to seek opportunities to broaden patient and family representation in unit based QI/Accreditation Teams, THE BHB Quality Council and the Board.

The organization is well on the journey people-centred care journey and PFAC is encouraged to try new ways using the PDSA model for improvement and learn as you go while keeping this impressive momentum going with the support of the Patient Relations Office and the Executive Sponsor. Thank you to all of the staff and volunteers who make the PFAC one of the most valuable inputs to the BHB.

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)

The organization has put a lot of effort into improving patient flow and the resulting success is apparent. Continuing to evaluate these processes, identify areas of opportunity and continue to monitor outcomes as the hospital moves forward is an ongoing part of the quality journey. Emphasizing and encouraging the involvement of front line staff involved with each stage of the journey may help to provide further insight into ways to further decrease delays.

Environmental cleaning of patient rooms post-discharge is a vital hospital function. Environmental services and infection prevention and control should be engaged to determine best practice in streamlining these processes.

The Predicted Discharge Date (PDD) is assigned by the admitting physician and then is modified as the clinical and/or social situation is further defined in the hospital. It is suggested that the organization look at utilizing standardized measures based on admission diagnosis in order to better benchmark the expected discharge date. This date can then be used to trend outliers to determine the main causes of admission delay and allow the teams to institute plans to mitigate the issues identified.

The team has done excellent work engaging the patient and family and advising of the anticipated discharge date. Ensuring that this is displayed in layman's terms in the room may help with this communication. The plan to also include the time of discharge on the whiteboard will also help facilitate the families discharge plan.

Discharge plans can be complicated by a myriad of social issues. Staff may struggle with discharging patients from the hospital due to many issues including homelessness, substance abuse or other social issues. The teams may wish to engage with their ethicist to work through some of these complex situations.

The organization has done a lot of work with improving the utilization rates of operating rooms and preventing cancellations. Continuing this excellent work is encouraged to further maximize usage and continue to smooth the surge impacts of visiting surgeons.

Priority Process: Medical Devices and Equipment

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The Sterile Processing Department (SPD)team presents as enthusiastic, knowledgeable collegial and very professional. The team is extremely committed to providing excellent service and supporting patient care and clinical services. The team takes time to celebrate their improvement success and continuously plan for new ways to develop their department and improve the service they provide.

The department has adequate space for their work needs with defined spaces separating each component of the workflow. A high level of quality control aligned with industry standards was evidenced throughout the tracer, enabled with bar coding and real-time monitoring and tracking capabilities. For example, the flow of instrument sets through the perioperative process is displayed on the Sterile Processing Management System (SPM), which allows for timely pick up of instruments at the end of the surgical procedures. The sterilization process in SPD is also uploaded to SPM. Work is underway to onboard the endoscopy reprocessing record to SPM.

The SPD works effectively with programs and services across the organization. The manager is a member of the Product Evaluation Committee and Infection Control Committee.

The preventive maintenance program is well established. Equipment repair and maintenance history is tracked in the Mainspring system and reported monthly to leadership.

There is a very comprehensive departmental orientation and training program. The Sterilization and Reprocessing Technicians are cross-trained to work throughout the department, including endoscopy. Technicians obtain their certification through the International Association of Healthcare Central Services. Six staff members are enrolled in a leadership development program.

The MDR team report that no reusable devices or equipment is reprocessed and does not contract or outsource cleaning and reprocessing. Perioperative Services equipment and devices are transported to reprocessing area in closed containers and cart.

Performance monitoring informs quality improvement plans. Improvement objectives for this year are the maintain 100% accuracy in surgical tray assembly, case cart preparation, and steam sterilization.

Priority Process Results for Population-specific Standards

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

Priority processes specific to population-specific standards are:

Population Health and Wellness

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

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

Unmet Criteria	High Priority Criteria
Priority Process: Population Health and Wellness	
7.3 The organization consults regularly with its partners to collect information, identify gaps in the continuum of care, and improve services for its priority population(s).	
Surveyor comments on the priority process(es)	
Priority Process: Population Health and Wellness	

The Child and Adolescent Care Team provides a range of psychiatric care for children and adolescents ranging from 4 years to 18 years of age with Attention Deficit Hyperactivity Disorder, Depression and Anxiety and other mental health conditions. The program is unique in that it offers a range of inpatient, outpatient and day program services. The intake process is unpredictable as to the number of new clients and the type of service.

The team includes consultant psychiatry, clinical psychologists social work, registered nurses art therapist, family therapy, experiential therapist, occupational therapist speech-language therapist. While addressing the immediate needs of patients referred to the program, this team has adopted a multi-modal approach, primarily working with the schools, community organizations and the ministry to address the needs of this challenged population and build a more integrated community-based outreach care for a very challenged population.

The service can accommodate four inpatients. Use of limited space is maximized with the capacity to adjust the configuration and furniture depending on the age range of the inpatients.

The patients participate in care planning to enable self-management focused on understanding and managing the illness and symptoms. Patents receive education on the management of symptoms and violent behaviour.

This team is leading the way to build partnerships in order to meet the needs of a growing population estimated at 13, 500 on the island of Bermuda. A key success factor will be dependant on the availability of resources to support this very important work.

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 direction to teams providing services.

Competency

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

Episode of Care

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

Decision Support

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

Impact on Outcomes

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

Medication Management

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

Organ and Tissue Donation

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

Infection Prevention and Control

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

Diagnostic Services: Imaging

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

Diagnostic Services: Laboratory

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

Transfusion Services

- Transfusion Services

Standards Set: Ambulatory Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
9.7 Access to spiritual space and care is provided to meet clients' needs.	
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	
15.10 Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)	
Priority Process: Clinical Leadership	

The Ambulatory Clinics visited at King Edward VII Memorial Hospital included the Patient-Centred Medical Home, Dialysis, Wound Care/Hyperbaric and DREAM clinic. Established processes are in place to plan and ensure services are available to meet current and future needs of the populations served. Data are drawn from multiple sources to drive the plans including populations served, comorbidities, emergency room and inpatient visits and clinic volumes. Physicians are engaged in assessing what services are needed.

The patient voice was evident in the planning processes and discussions with teams across the clinics. Formal and informal information sources are used to incorporate the patients' perspective including patient satisfaction surveys and patient identified opportunities for service improvement. For example,

patient feedback was recently used to reconfigure and standardized the patient call centre for the second floor clinics in the acute wing. The change plans were further validated with a target group of patients before implementation.

The Patient-Centred Medical Home is a one-year government-funded pilot project to improve the population health of underinsured and uninsured patients and decrease emergency room utilization and inpatient admissions. The clinic is operated by a Nurse Practitioner and Registered Nurse with part-time support of a General Practitioner. Patient-centred, visits and technology-enabled “touch points”, such as email, are used to sustain engagement and support self-management based on current evidence. To date, emergency room visits and inpatient admissions have decreased by 50%, and the current patent satisfaction score is 95%. Work is currently underway to secure permanent funding for this excellent program.

Staff skill mix is customized for each clinic. Considerable work has been done to move to bring a nursing perspective, and improve efficiency in the clinics in the acute wing. Daily huddles are taking place and staff are cross-trained to work in the clinics within the cluster.

The Dialysis Clinic serves 137 hemodialyses and 21 peritoneal dialysis patient compliment. The service is managed by a highly engaged and knowledgeable team. Patients spoke highly of the staff and the care they were receiving.

The DREAM clinic offers a range of programs to assist people with diabetes to live healthy lives and control the complications of diabetes. This team is encouraged to establish a measurement system to evaluate the excellent work.

The Wound/hyperbaric clinic is challenged for space. The current layout does not allow for patient privacy. There is also a risk of cross-contamination due to the limited space between the beds. Plans are in place to expand the space but have been put on hold.

Priority Process: Competency

New staff receive a comprehensive orientation to the hospital followed by a customized onboarding to the clinics assisted by Nurse Educators. Infusion Pump training is completed every two years. Compliance is monitored through the adverse events; competency checks (maintained by the manager) and smart pump data. There is evidence of a strong cohesive team approach to care in all areas visited. Staff spoken to were knowledgeable and project a very positive team-oriented approach to patient care.

Priority Process: Episode of Care

The teams have established processes to facilitate timely access for patients based on priority needs in the areas visited. Standardized assessment tools are used and care plans are well done and updated at each visit. There is a monitoring process for no shows and cancellations.

Medication reconciliation is done by physicians in all areas. The Medication Reconciliation Form-Outpatient Services is used except for the second-floor clinics in the acute wing and the dialysis. It is recommended that the documented medication reconciliation be standardized in these areas.

Priority Process: Decision Support

The clinic records are standardized, accessible and well maintained. Patient privacy is evident through the clinics. Patients can assess a hard copy of their record upon request. Plans are underway to create a patient portal

Priority Process: Impact on Outcomes

While no corporately established process was identified to select evidence-informed guidelines, an evidence-based approach to care is evident in all the ambulatory areas visited. For example, the Dialysis clinic has adopted the KDOQI Clinical Practice Guidelines to guide practice. Evidence-based pathways are under development for the management of chronic conditions in the patient-centred Medical Home. The teams are encouraged to strengthen and further standardize the process for selecting evidence-based guidelines with input for patients, teams and partners.

Safety incidents are reported analyzed for improvement purposes. There was strong evidence of the use of quality indicators in all areas visited.

Standards Set: Biomedical Laboratory Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Diagnostic Services: Laboratory		
1.2	The team collects information at least every two years from laboratory users and clients about their needs for laboratory services.	
1.3	The team meets at least every two years to review information collected from clients and laboratory users to identify strengths and areas for improvement in service needs, and makes changes accordingly.	
4.2	The team works with laboratory users to identify and remove where possible barriers that prevent clients and laboratory users from accessing services.	
29.16	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
Surveyor comments on the priority process(es)		
Priority Process: Episode of Care		

The laboratory services follow the organization's falls prevention program. They serve the outpatient community and are cognizant of those at risk for falls when providing services to this population.

Priority Process: Diagnostic Services: Laboratory

The Biomedical Laboratory team provides a range of services to the hospital and to the community and are the primary laboratory providers in the country.

The laboratory is clean and well laid out with defined areas to accomplish the different tasks within their mandate. The department is small, but the team have established an appropriate workflow that mitigates the risk of cross-contamination or delays in processing samples.

The team actively collects data to identify trends, workflow issues and ordering patterns as part of their ongoing quality improvement processes. The team does not specifically collect information from laboratory users except as part of the generic hospital patient experience survey. There may be an opportunity to survey their population with specific questions pertinent to the laboratory and how care is delivered. Surveying community medical providers may also be considered to determine whether there

are opportunities to streamline the process from their perspective and to ensure that the laboratory is continuing to service their diagnostic requirements.

The laboratory team does excellent work and should consider sharing this work with clients, families, the community and other organizations. The team may choose to share their successes in more public areas such as the waiting room, newspaper or on social media to highlight the excellent services provided.

The organization does have logistical challenges with referral laboratories due to the geographic distances, but these have been mitigated. Most laboratory services are provided within the country and they have back up systems to maintain these services. Formal MOUs exist with these overseas partner laboratories to provide the supplemental services and verifications that the organization requires.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It is evident that the Cancer Care team at Bermuda Hospital Board (BHB) are passionate about the care and services they provide to their patients. This was supported by the feedback received from a patient who was interviewed during this visit and by direct observation of the interactions between staff and other patients who were in the clinic during the survey visit.

Patient input into programs and services is obtained on a one to one basis and by patient satisfaction surveys. There is a suggestion/comment box available for patients however, it is rarely used.

The cancer care clinic is located in the new Acute Care Wing (ACW) of the King Edward VII Memorial Hospital (KEMH). It is spacious and bright. The windows are large and provide nice views for patients receiving treatments. One patient commented on her first session at this site. She noted that there was soft music playing, she was offered a warm blanket and treated like she was very special. She noted that she feels like her input into her care and services are welcomed.

There are strong strategic partnerships such as the partnership with the palliative care team and with the radiation clinic.

Priority Process: Competency

There are three (3) RNs which work in the Cancer Care Unit. They are each trained in oncological nursing and are required to maintain their competency in this area. Each of the nurses are affiliated with their individual universities and have access to current information.

The chief oncologist has been with the organization for five (5) years. Together with two (2) part time oncologists, they are able to attend to a larger volume of chemotherapeutic treatments thus decreasing the number of patients needing to travel outside the country for therapy. This is commendable.

The clinic also has access to a pharmacist who prepares and oversees the individual patient treatments.

Priority Process: Episode of Care

There is evidence to support a culture of patient focused care within the cancer care unit.

Patient assessments are completed and recorded in a manner which is unobtrusive for the individual. Attention to the person as a whole is positively noted.

Patients are provided with information relevant to their treatment and are supposed in their decision-making. Access to other service providers is made available as required.

The patient's wishes are respected with respect to family involvement in their care.

Both written and verbal safety information is provided to the patient. This information is specific to their individual needs and is presented in an easily understandable format.

Before discharge the patient is provided with assistance for follow-up care as required and given contact information should he/she have questions.

The revitalization of the multidisciplinary Tumor Board Rounds is positively noted. The input from the radiologist, surgeons, pathologist, nurses, oncologists etc. has proven beneficial in providing patients with information to make informed decisions related to ongoing treatment plans.

The availability of Radiation Therapy in Bermuda is welcomed addition to the country. It has provided access to a much needed service for the residents. BHB Cancer Care speaks well of the close working relationship that has been developed with the Radiation Centre.

Priority Process: Decision Support

The patient record is paper-based in the cancer clinic. There are plans to move to an organization-wide electronic record. It is felt that this will be beneficial in creating a fully integrated interdisciplinary chart making it easier to follow the information flow.

The paper record being kept by the cancer care clinic is comprehensive and captures the treatments provided and the patient's response to the treatments.

Records are kept for seven (7) years and then destroyed in accordance with organizational policy and appropriate legislation.

Privacy and confidentiality of patient information is protected. The private rooms on the cancer care unit also provides privacy for patients should they feel the need to be alone while receiving their treatment.

Priority Process: Impact on Outcomes

The cancer care team has identified, through the Medical Director and the Oncology Nurses, the National Comprehensive Cancer Network (NCCN) and the Oncology Nurses' Society (ONS) guidelines as the standard for the BHB cancer unit. While these are the team's recommended guidelines, there needs to be a standardized and organization-wide process established for selecting these guidelines. It is recommended that this process address how the guidelines will be used and how they can be integrated into service delivery.

There are good processes in place to address patient safety and risks. Patients are provided with education on how to minimize the risk of falls, carry our good hand washing techniques, and how to recognize signs of infection.

The incident reporting system is in place and reported incidents are followed up through the Quality and Risk Department with feedback provided to the cancer care team.

There is evidence of indicator tracking for cancer care services. The organization-wide quality framework is in the early stages of formalizing processes related to analysis of data, trending, and evaluation of outcomes.

Priority Process: Medication Management

The policies, procedures and processes in place for preparation and administration of chemotherapeutic agents are clearly defined and closely monitored by the pharmacist and the RNs administering the treatment.

Patients are watched for signs of toxicity and in the event of such a reaction protocols are followed in accordance with BHB policies.

Attention to safe handling of cytotoxic medications and management of spills is noted.

Personal Protective Equipment is available and used by staff appropriately.

Protocol for disposal of chemotherapeutic agents is established and clearly defined.

It is recommended that a copy of the Do Not Use Dangerous Abbreviations, Dosages and Symbols be prominently displayed in the work area are on easily accessible for physicians when writing medication orders.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Person-centred care is the focus of these programs areas. The goal of these programs is to realize a service user driven process with guidance and assistance from staff.

While there was no formal strategy observed to address the stigma associated with mental health, there were many examples of staff involvement in addressing this on an ongoing basis. Examples such as staff presentations at educational and community events, engaging college students in work placements, supporting the Family Support Group and the Client Council in their roles as service user advocates, and using positive media coverage for special events demonstrate the commitment to reversing the mental health stigma.

There are many well established community partnerships. Strategic alliances with the Bermuda Housing Corporation and the Bermuda Police Service as well as other stakeholders help to facilitate service delivery.

Priority Process: Competency

The team is comprised of a group of dedicated professionals which include representation for several disciplines. There have been some challenges associated with recruiting and retaining staff such as nurses,

councillors etc. This has started to improve for this area and staff is hopeful that they will soon see a period of stability.

There is evidence to support ongoing training and education and, professional development is supported organization-wide.

Attention to workplace safety is positively noted.

Priority Process: Episode of Care

The Community-Based Mental Health Services and Supports team is recognized for its commitment to patient focused care. This energized team is innovative and creative. They are persistent in finding opportunities to enhance the quality of life for the service users.

At present the Support Services Outpatient clinic provides services to over 800 people. The number of service users has doubled since the last survey and additionally, the acuity and complexity of service requirements are also putting demands on these services.

The Intensive Case Management team provide off-site services for service users with dual diagnosis. Safety measures such as sending the two (2) staff on a site visit and the use of panic buttons are in place.

The Vocational Rehabilitation Program provides job opportunities for many of the service users. The goal of this program is to build skill sets where possible and enable service users to reach their full potential. This is commendable.

The recent introduction of the 'Mindful-Based Stress Reduction Group' for service users and their families is applauded. This program is still in its early stages but is being well received.

The recent establishment of a 'Client Council' which brings its suggestions and concerns to the staff meeting for discussion is a great example of person-centred care.

Priority Process: Decision Support

Service user records are well maintained and audited for compliance with BHB policy and in accordance with legislative requirements.

There are clearly established processes for service user to access their records in a timely manner.

Policies and procedures are in place to guide staff in care and service provision.

Priority Process: Impact on Outcomes

The work done to provide a safe work environment is recognized. Staff note that the addition of security guards, video surveillance cameras and access to personal panic buttons has decreased their level of

concern in potentially volatile situations. They feel less vulnerable.

Indicator measures are in place for this service. There is a need however, for an organization-wide approach to continued development of the quality improvement process.

Guidelines for practice have been identified for this program area. It is recommended that the organization establish a standardized process for the selection of guidelines across all program areas.

Standards Set: Critical Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
11.9 The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
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 Intensive Care Unit King Edward VII Memorial Hospital serves adult and pediatric patients with critical care needs. The major sources of patient referral are transfers from the internal patient areas, emergency department and operating room. The team serves as a critical care resource and the cardiac service to the other clinical areas.

There is a staffing complement of registered nurses, an orderly and clerk, clinical pharmacist, social work, occupational therapy, physiotherapy and dietician services. The medical management is provided by intensivists and hospitalists.

Notable strategies to engage patients and families include bedside rounds handover, thus bringing the patient and family into the care decisions in real time. The “Speak Up” campaign is an initiative intended to more fully establish the patient and family in open dialogue to inform improvement work. The team should consider developing a more formal implementation and evaluation plan for this initiative. Frequent patient and family meetings take place to further engage the patient and family in care decisions and

preparation for transition from service.

Data are trended monthly to plan for services. Goals and Objectives are aligned with the Strategic priorities and Operating Plan. Improvement priorities include Catheter-Associated Urinary Tract Infection (CAUTI), Pressure Injuries (PI), Falls, and Medication Safety.

Priority Process: Competency

A collaborative engaged team approach is evident. Team members project a learning environment centred on patient care needs. There was a strong physician presence during the visit. Positive collaborative interdisciplinary team functioning was observed.

Team members participate in a range of professional development opportunities, including attendance at conferences. All staff complete the hospital orientation program. Nursing staff complete all required Nursing Skills Competency assessments, which are accessed through the internet-based Learning Management System (LMS), “Relais”.

A number of team members are participating in the IHI Open School.

Performance appraisals are currently underway for this year.

Priority Process: Episode of Care

The Intensive Care Unit environment is clean and welcoming. The intake process and assessment process is well documented. Patients receive a comprehensive assessment including risks of falls, venous thromboembolism, and pressure injuries. The Best Possible Medication History and Reconciliation is completed by the admission physician. Care plans are well done with clear evidence of implementation and evaluation of the goals of care.

The medication room is clean and well organized to promote safety and efficient use of resources. Nursing staff are knowledgeable about the medications in frequent use and safe medication practices, including high-risk medications.

Patients are prepared for transition back to the referring clinical area or home in the community. There is no standardized process for follow up evaluation of the transition plan post transfer. Patients spoke highly of the services provided.

Priority Process: Decision Support

The patient chart is in paper format.

The team mentioned that the number of steps required to process medication orders with the current system is prone to errors. Some challenges have been encountered overlooking medications with predefined stop dates resulting in the medication order not being renewed. Steps are being taken to address this issue.

Priority Process: Impact on Outcomes

The Intensive Care team presented a strong culture of quality improvement and commitment to evidence-based practices. Required Organizational Practices are embedded in the clinical care process. The team is actively participating in the IHI Open School. Trended performance results are posted for a broad range of indicators with demonstrated improvement. As this work progresses the team should consider using storyboards to maximize the learning and gain broader input to the change ideas.

Priority Process: Organ and Tissue Donation

The team have well-established processes in place to work with the New England Organ Bank for organ procurement.

Annual assessment indicates sustained performance and few lost donation opportunities.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
1.1	The team collects information at least annually about service volumes, wait times, client perspectives on services, and trends in service needs across different groups such as age or condition-specific populations.	
1.2	The team collects information at least annually from referring medical professionals about their needs for diagnostic imaging services.	
1.3	The team meets at least annually to review information collected from clients and medical professionals to identify strengths and areas for improvement in service needs, and make changes accordingly.	
2.3	The team regularly seeks input from referring medical professionals about how to improve access to diagnostic imaging services and address delays in reporting diagnostic imaging results.	
11.1	The team, in consultation with the referring medical professional, chooses the least invasive diagnostic imaging technique necessary to achieve the desired results.	
12.2	The team evaluates whether it is meeting the timeframes set for interpreting diagnostic imaging results and makes improvements if needed.	
15.4	The team prepares for medical emergencies by participating in simulation exercises.	!
17.1	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.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

BHB offers a full range of diagnostic imaging services. MRI, CT, ultrasound, x-ray, mammography, nuclear medicine and cardiac imaging are offered by the organization. The teams offering the different modalities are enthusiastic and knowledgable about their respective areas and the services they provide to their community.

The imaging team regularly conduct internal audits on pertinent data related to their services including wait-times, cancellations, no shows and ordering indications. There may be an opportunity to formally

collect information specific to Diagnostic Imaging clients on client perspectives, real and perceived barriers to care access and suggestions which may help improve care from the patient perspective. The team has done this informally and made changes based on this feedback but more formally gathering data may assist in identifying priorities and gaining support in making changes. The organization may consider centrally holding tablet technology that teams can sign out to conduct focused surveys with patients and families in their areas.

The Diagnostic Imaging team may also choose to survey medical professionals on their perceptions of access, quality and availability of diagnostic imaging modalities to help address these concerns and gaps. Tablet technology can also be used to conduct brief surveys on clinicians when they gather for meetings or educational events.

There is an opportunity within the department for increased oversight by radiology consultants to review requisitions and to recommend if a different diagnostic modality is more appropriate. This could be incorporated further into education sessions for referring physicians to help improve utilization and decrease unnecessary imaging to protect patients from radiation and secondary testing resulting from incidental findings.

Performance appraisals are completed in the department on an annual basis. It is noted that the team feels the requirement to complete all appraisals at the same time of year decreases the quality and utility of these evaluations. The organization may consider staggering these performance appraisals (by hire date or birth date, for example).

The team would benefit from running simulation exercises within their department including, but not limited to, Codes Brown, Blue, Pink and White. It is suggested that these codes be scheduled to occur monthly in rotation and should vary in departmental location so the team is aware of the logistics in running Code procedures in different locations.

The two Code Carts in the department were locked and fully stocked. It is noted that although no medications were expired, some were close to this date. The pharmacy team should be engaged to rotate crash cart stock to higher volume areas wherever possible to minimize the cost of discarding expired medications. It is also noted that there are numerous medical supplies on the cart that are past the expiration date. These supplies should be verified as still being viable and a sticker noting the new expiry/review date added so that these supplies are managed appropriately. Stocking levels of medical supplies should also be reviewed with the appropriate teams, as packaging is more likely to be compromised if drawers are crowded. Further, a review of whether two Code carts within the department is required. With responders coming from the Emergency Department during a Code Blue, a second cart could be delivered from that location with the team in a Code situation for a secondary back up, if that is deemed to be necessary.

Reports are run daily to review the timeliness of diagnostic imaging review and reporting by radiology. It is noted that in mammography specifically, there is an opportunity to improve the timeliness of report completion. The diagnostic imaging team currently outsources a significant proportion of after-hours

imaging through teleradiology. These processes and workloads could be reviewed to ensure that resources are being used appropriately and effectively to meet the needs of the department and the community that they serve.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
17.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
17.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
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 Emergency Department at KEMH includes 15 general and four resuscitation beds plus access to an additional four beds which can be utilized for fast track during high volume periods. The Lamb Foggo Urgent Care Clinic is bright, clean and well laid out for the intended purpose. The Urgent Care Clinic provides evening and weekend clinician access, x-ray and Point of Care Testing.

Recruiting qualified staff due to immigration delays is an ongoing issue as well as retaining trained staff. The organization may choose to investigate partnering with the local College to train Enrolled Nurses (ENs) to close some of these staffing gaps. Inadequate staffing results in overtime, staff fatigue and adversely impacts front line clinical care and the patient experience.

The four resuscitation areas at KEMH are fully equipped with the necessary emergency supplies and one room is designated for pediatric emergencies. A review of the five adult carts in the department is suggested. It was noted that none of the carts were locked and that there were numerous supplies on the cart that were non-standard and, in some cases, expired. Medical supplies may be approved for extension beyond their expiry date but should be labelled (stickers) to identify that these supplies are still viable. Locking the carts would prevent removal, tampering or additions of medication and equipment which could impair the team's ability to respond in an emergency. A review by the Critical Care team may also be considered to determine the appropriate number of carts given the department size and staffing for concurrent code response.

The Lamb-Foggo Urgent Care Centre has one code cart. This cart was unlocked. The quantities of supplies stored should be reviewed to ensure that quantities are appropriate and to lessen the crowding of supplies. It was noted that some supplies were in packaging that had yellowed and otherwise appeared compromised.

The clean holding area has recently been tidied and reorganized and a review of stocking levels is in progress. The organization is encouraged to continue this process to ensure that procedures are in place to prevent inadvertent excess ordering. There are also multiple storage areas - several rooms identified as clean storage, the medication room, portable cupboards in halls and rooms, each treatment room and the EMS storage area all hold medical supplies and should be consolidated wherever possible to prevent overstock and expiration of supplies.

Priority Process: Competency

Education and training of staff is a priority for Bermuda Hospitals Board. Orientation of new staff to the hospital, their department and competency-specific training are completed for new hires, and annual training completed for all staff thereafter. The Emergency Department is a busy department and leadership should be proactive in identifying areas for further education or refresher training.

A specific area of concern noted during the survey was the narcotic management practice within the department. This, and practice related to all high-risk medication should be reviewed and monitored to ensure that practices following hospital policy are re-implemented and embedded.

Priority Process: Episode of Care

The KEMH Emergency Department is clearly labelled and includes an alarm system from the parking lot to enable patients to signal that they need assistance. The LFUCC is also clearly signed with accessible entrances.

The organization utilizes the ESI (Emergency Severity Index) to triage all patients. Ongoing education and audits may be useful to confirm that the ESI is being used appropriately (and not assessing too high or too low) in order to standardize benchmarking measures with similar organizations.

The medication room at Lamb Foggo UCC does not have an Automated Dispensing Unit for holding and dispensing medication. Due to the relative isolation and lack of continuity of staff, this location should be considered a priority. Providing a Pyxis or equivalent system would improve management of stock quantities and expiry dates and better secure high-risk medication such as narcotics.

Phone calls post discharge from the emergency department could be considered to evaluate the discharge process. Evaluation of transition from the emergency department to an inpatient unit could also be considered, in conjunction with patients and families.

Priority Process: Decision Support

The KEMH Emergency Department has an electronic health record for all staff and physicians. This is transitioned to a paper chart if the patient is admitted. Information such as EMS records are scanned into the system. The Lamb Foggo Urgent Care Clinic employs the same electronic health record platform and information can be reviewed at the larger site.

Priority Process: Impact on Outcomes

The Emergency Department is busy and overcrowding is an ongoing issue. Much work has been done to improve bed management in the emergency department and patient flow. The organization is encouraged to continue in these efforts.

Narcotic management has become a significant topic with the escalation of the opioid crisis internationally. Narcotic management and verification procedures for high-risk medications require ongoing education and monitoring throughout the organization.

Auditing of incident reports to ensure that they are reported to the patient and documented appropriately in the chart should be completed periodically to confirm that organizational policy is followed.

Priority Process: Organ and Tissue Donation

The Bermuda Hospitals Board is supportive of organ donation and collaborates with the New England Organ Bank (NEOB) to fulfill this mandate and identify, refer, and recover anatomical gifts where possible.

While the Critical Care unit is the lead for the program, the role of the Emergency Department is defined in the policy as there is an opportunity to identify potential donors in this department. Staff within the Emergency Department were aware of the policy and had taken part in organ donation awareness training.

Standards Set: EMS and Interfacility Transport - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
27.5	The results of ongoing retrospective case reviews are used to improve care.	!
Priority Process: Competency		
5.14	Training on how to maintain the integrity of equipment throughout transport is provided to the team.	!
5.15	Training and education is documented in personnel files.	
6.2	The team members' knowledge and experience is appropriate to the patient and the patient's condition.	!
7.1	The workload of each team member is assigned and reviewed in a way that ensures patient and team safety and well-being.	
Priority Process: Episode of Care		
14.4	The communication centre uses standardized processes and tools to identify and track infectious events at calls, and communicates this information to partners and other organizations.	
20.3	Treatment protocols are consistently followed to provide the same standard of care in all settings to all patients.	!
Priority Process: Decision Support		
23.7	Policies and procedures for securely storing, retaining, and destroying patient records are followed.	!
Priority Process: Impact on Outcomes		
25.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from patients and families.	!
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from patients and families.	
27.11	Information about quality improvement activities, results, and learnings is shared with patients, families, teams, organization leaders, and other organizations, as appropriate.	

27.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from patients and families.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Priority Process: Infection Prevention and Control

8.3	The IPC program is regularly reviewed to ensure currency.	
8.5	There are policies for IPC practices.	!
13.12	Sterile supplies are appropriately stored to maintain the integrity of packaging, and damaged or opened packages are discarded.	!

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Emergency Medical Services (EMS) work closely with the Fire Department with whom they share 911 dispatch. The Advanced and Basic level Emergency Medicine Technicians (EMTs) work predominantly out of the KEMH facility with two other teams (one staffed by the Fire Department) providing service for either end of the country. During the day, there are four ambulance crews available with three available at night. During periods of high demand, the fire department EMTs assist to provide additional manpower and responding units when needed.

The EMS services also offer interfacility transfer and transfer to home following discharge when available. These services are booked in advance but are bumped as required due to 911 calls which remains the organizational and medical priority.

The hospital-based EMS team are the only ones offering this service in the country. The St. John Ambulance does provide site coverage for specific events and will transport from events at which they provide care but they are volunteers who do not respond to 911 calls or provide patient transportation services.

The EMS team has recently considered implementing retrospective case reviews as part of the EMT team meeting. These learning opportunities are valuable and all team members should be encouraged to submit interesting or challenging cases.

The team is encouraged to review the medical supplies stored within each ambulance to limit the quantity and type of supplies carried in each vehicle.

Priority Process: Competency

The Emergency Medical Service consists of both Advanced and Basic Level EMTs. The majority of the EMTs are hospital employees while one ambulance is operated by the Fire department with Basic and Advanced qualified EMT Firefighters.

Consideration may be given to evaluating the acuity of ambulance calls to determine the levels of care required to confirm the skill sets required to adequately meet the clinical needs of the population. It is noted that the current scheduling process does not ensure that Basic and Advanced trained EMTs are paired when they go out on a call and, during the survey, it was noted that two Basic EMTs were often paired. When reviewing acuity levels of ambulance calls, confirming that the skill level of EMTs is appropriate for the needs of EMS patients should be considered. The clinical requirements of patients should determine the skill sets of the EMS teams responding.

It was noted that EMS team members frequently work overtime, extending long shifts considerably. Opportunities to employ rested EMTs from the casual pool where possible will decrease the risk to patient safety that may be created by fatigued and potentially compromised drivers and care providers.

The medical supplies were noted to be overcrowded within the bins which could compromise the sterility of packaging. Medications frequently have temperature limits and it is challenging to maintain these medications with confidence when stored on the ambulance. Evaluating other options for medication storage and transport should be reviewed.

Priority Process: Episode of Care

Emergency Medical Services is dispatched through a centralized 911 system shared with the Fire Department. When the disaster management plan is activated, EMS crews are distributed to locations collated with partners to prepare for potential requirement to respond to emergencies.

Infectious disease is not formally screened through the dispatch system. Informally, 911 dispatchers identify potential concerns to communicate to front line staff but this is not formally addressed through standardized processes. The EMS team are trained to utilize personal protective equipment when dealing with a potential communicable disease.

The EMS team does not consistently include an EMT advanced, thus limiting the services that can be provided to that patient. Changing protocols to ensure that this level of care is provided may be considered by the organization.

Priority Process: Decision Support

The EMS medical chart is paper-based and it is scanned upon completion to be included in the electronic health record. For admitted patients, the EMS record is included in the paper inpatient chart. It is important to ensure that the EMS records for discharged patients are consistently managed and controlled as per hospital policy so that patient confidentiality is not compromised.

Priority Process: Impact on Outcomes

The EMS collects a significant amount of data as part of their patient record. Currently, this data is contained in a spreadsheet. The team has the potential to mine this data to identify trends or problem areas to direct additional resources. For example, response times could be tracked to determine geographic or temporal outliers which could then be mitigated. Level of acuity could also be reviewed to determine a profile for ambulance calls and services required by EMS and whether the skill sets and equipment are appropriate. Benchmarking this data and sharing results with the organization and partners may help to direct future MES programs.

Priority Process: Medication Management

The medications utilized by EMS services are limited as they do not have paramedics within the organization. Narcotics and high alert medications are beyond their scope of practice.

The ambulances do carry a stock of medication on each of their platforms. It is recommended that these stocks be reviewed for appropriateness, quantity and to ensure that storage is in line with parameters such as temperature control.

Medications beyond the scope of EMT Advanced should be removed completely and included only in the transport bag utilized by nurses or physicians when they are required for patient support in the ambulance. This bag should be kept in the medication room and stock rotated and verified on a schedule.

Medications that are within the scope of EMT Advanced should be reviewed to ensure that quantities are minimized and procedures put in place to protect these medications from temperature extremes. The organization may consider removing all medications from the ambulance stock and having the on-duty EMS teams carry a medication bag that is kept in a climate controlled building when not utilized on an ambulance call. Spare bags that can be swapped following utilization should also be kept in the medication room and regularly verified by qualified staff.

Priority Process: Infection Prevention and Control

The Bermuda Hospitals Board has an IPC program that extends to all departments and personnel. As the staff of the hospital, EMTs receive training from IPC. Although the Fire Department falls under a different ministry, IPC has been involved in training those EMTs as well.

The EMS teams follow procedures to clean the ambulance following transportation of each patient, as per the protocols. They would benefit from a periodic review of procedures to ensure that IPC practices continue to be followed with audits of high-risk areas.

It was noted that sterile medical supplies in the ambulance are overstocked in crowded compartments. This can cause damage to the packaging of supplies and impact the ability of the team to check or otherwise verify stores held within the ambulance or in the EMS storage room. There were supplies in the ambulance that were found in compromised packaging.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

In terms of clinical leadership, the Home Care Services Team has fully met the standards. The team is a mix of very experienced RNs who work extensively with and on behalf of clients and families on a daily basis and for whom effective collaboration with partners such as patient assistance, district nursing and home health services is imperative.

Comprehensive attention and improvements have been made in home safety as the team is fully aware and experienced with the realities that workplace safety risks often mirror those in society generally. Particular attention has been given to gun violence and ways to ensure access to services within the BHB walls rather than the home in those situations

Priority Process: Competency

Competency development and maintenance processes are well established and adhered to. The team described check-in protocols with the manager at specified times to ensure safety and provided examples of recent training in community-based nursing advances. It would be most helpful to have the benefit of an electronic health record and to eventually be able to document care in handheld devices at the point of care. There was good discussion on the importance of continuity of care, wound care management as one example, with the associated patient and family self-care teaching.

The competency level of this seasoned nursing team is impressive.

Priority Process: Episode of Care

Referrals average approximately 300 annually with an average of 37 days of services per client, and 4000 plus annual home visits. Referral criteria are clearly defined and largely come from an acute care surgical ward, primary care physicians, outpatient clinics and the wound care clinic. The budget is managed in a decentralized way and visits and duration with identified supply use are co-signed by the patient for billing purposes. The home health database is used. Vehicles are owned and maintained by the BHB.

Client and family feedback is sought and used and the client on the surveyors home visit with the home care nurse expressed she felt respected and informed and was an active participant in her care.

Priority Process: Decision Support

Effective record keeping practices are in place and the team is sufficiently small that client information is exchanged well and privacy considerations are adhered to. Issues are addressed in real time within the workgroup and there was demonstrated evidence that the team functions and communicates well. File storage and retention practices are good although the temporary office space is tight for the office-based functions of the team. Standards in relation to decision support are fully met and the opportunity to have an electronic health record will be readily embraced.

Priority Process: Impact on Outcomes

There are established evidence-based care practices within the service. As an example, a common wound management protocol is used between services at BHB. The staff could readily speak to those practices and it was evident in a home visit with a client that good teaching has been conveyed to clients and families and details of wound healing are recorded and commented upon by referring physicians in the follow-up.

The team is very much encouraged to use their outcome measures to demonstrate the outcomes of standardized care practices and to share with the organization. It is important that the team uses the information on their own team performance outcomes to know how well they are doing and to make adjustments.

Standards Set: Hospice, Palliative, End-of-Life Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Teams members demonstrated passion and commitment to enhancing the quality of life for their patients. This was evident during a discussion with staff and in observing the interactions with the patients.

Staff receive education and training through BHB nurse educator and through Relius. Additionally, training is accessed via the Centre to Advance Palliative Care (CAPC). Educational events are also funded by the Friends of Hospice, a funding raising organization for Agape.

There are 50+ volunteers who are an integral part of the hospice team. These volunteers are screened closely for an appropriate fit. Criminal reference checks are required. Volunteers who want to become designated patient companions must complete seven (7) weeks of training before assuming this role.

Staff are very excited about the new hospice which is about to be built on BHB grounds. This state of the art facility has been designed to maximize the quality of life for its patients and will provide eight (8) private rooms with views of the ocean. This project is being funded through the fund-raising efforts of the Friends of Hospice and is expected to commence construction in the very near future. The new hospice will replace the ageing Agape facility. You are wished well in this much-anticipated journey.

Priority Process: Competency

There are two (2) RNs and two (2) auxiliary staff on the day shift and one (1) RN and one (1) auxiliary staff on the night shift to provide care to eight (8) palliative care patients.

At present, there are only four (4) patients due to the temporary closure of the four (4) downstairs beds. This closure is a result of an air quality problem created by mould. The area has been properly secured to ensure no harm to patients, staff or visitors. It is expected that renovations will take three (3) to four (4) weeks. This has been well communicated both internally and externally. During this temporary decrease in the census, an auxiliary staff from days has, on occasion, been deployed to the long-term care area of the hospital.

This team collaborates with each other and with its partners in the community to ensure the best possible care and services for its patients. These partners include but, are not limited to, Friends of Hospice (FOH Charity), Patients Assistance League Service (PALS), Bermuda Cancer and Health Centre etc.

The commitment to education and professional development within the Bermuda Hospital Board is commendable.

Priority Process: Episode of Care

This patient-focused team considers the individual and his/her family as part of the continuum of care. Consideration for the patient's rights, including the right to refuse family involvement, is respected.

The patient 'Bill of Rights' is prominently displayed at each patient's bedside.

There is a clearly defined process for informed consent and/or substitute decision-making/ power of attorney.

Social events such as Friday Tea Time and holiday celebrations are just two (2) examples of how this team attempts to promote family for those who choose to participate. It was noted that sometimes these events are attended by past family members who want to remember their loved ones.

Attention to diversity and spirituality is noted.

An individual's goal is paramount with this team. They will strive to ensure the patient is able to enjoy his/her one last wish wherever possible. An example of this is in noted in a patient's desire for a lobster supper. The FOH Charity was able to make this happen however, the patient was unable to eat the meal.

There are many well established partnerships with the community. Examples of these, include but are not limited to, Bermuda Cancer and Health Centre, Patients Assistance League Service (PALS), and Community/District Nurses.

Priority Process: Decision Support

The organization is moving towards an electronic patient record. There is much anticipation regarding this endeavour. The ability to have a multidisciplinary reporting system is anxiously anticipated by staff.

The hospice team has worked diligently to develop an admission assessment tool, flow sheets, and they are working on the development of a care plan that reflects the accreditation standards for palliative care. They are commended for their progress to date.

Record keeping practices are in accordance with legislation and organizational requirements.

Patients have access to their records in a timely process.

Priority Process: Impact on Outcomes

Patient quality of life is at the centre of the Agape program. Staff are passionate about their work and promote their program within the community and within BHB. Their standards and their expectations are high.

Attention to safety for both patients and staff was evidence during this survey visit.

It has been noted during this survey that the leadership team has focused a great deal of attention on quality and risk management. These efforts are commended.

The next steps in this journey are the continued development of the organization-wide quality framework and standardization of related processes across all program areas. This will include formalizing processes related to indicator refinement, collection and analysis of data, trending, evaluation of outcomes and, benchmarking activities.

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

Unmet Criteria	High Priority Criteria
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: Infection Prevention and Control

Governance oversight for the Infection Prevention and Control program is provided by a multidisciplinary committee with a direct reporting relationship to the Medical Staff Committee. The team is comprised of a manager and 1.5 Infection Preventionists (IP). The manager and one of the IPs have achieved Certification in Infection Control (CIC). The third team member is working towards certification. Medical scientific input and support is provided by the Chief of Medicine, Infectious Diseases, who also chairs the Medication Management Committee, and a microbiologist. Public Health is an active participant in the program. The Chief of Medicine and Manager attend the Disaster Preparedness meetings and work closely with the health department.

The tracer included a interdepartmental meeting, and visits to the laundry, kitchen, and Emergency Management Services. There is an opportunity to build more cohesive working relationship between IPAC, Environmental Services, Laundry, and Food Services in order to ensure evidence based standards are followed consistently.

Policies and procedures are based on current evidence and standardized across inpatient and outpatient sites. The team conducts regular audits and a carries out a comprehensive surveillance plan to evaluate compliance with established policies and procedures.

The surveillance plan is updated annually. Reporting includes, Methicillin Resistant Staphyloccus Aureus (MRSA), Clostridium difficile, (C diff). Central Line Associated Bloodstream Infections (CLABSI), Catheter Associated Urinary Tract Infections, and Ventilator Associated Pneumonia (VAP). Post Operative Surgical Site (SSI) Infections surveillance is done for Colon , Cesarean Section, Hip Prosthesis, and Knee Prosthesis. Hand Hygiene is audited and reported the each clinical area. There is a plan to commence reporting all hospital acquired infections in the incident reporting system.

The physical infrastructure, including plumbing, and integrity of environmental surfaces were observed to be significantly compromised, in the General wing. This presents as significant challenge from an infection control perspective. For example, large containers of soiled laundry were observed in the corridor outside the main laundry area. There is minimal separation of soiled laundry to the clean laundry in the main area, presenting a risk of cross contamination. The overall cleanliness of the area and ease of workflow, and availability of hand hygiene facilities requires attention.

Similar observations were made in the food services areas with regard to physical space to support efficient workflow and environmental cleanliness. Equipment in both areas appears to be very old. Staff in both areas were extremely helpful and willing to explain the operations.

The organization is also experiencing significant challenges with mould due to leaking water pipes. Current efforts are focused on early assessment and containment and procuring mould resistant dry wall.

A range of food safety quality control checks are in place. The department of health conducts inspections once or twice per year. The team should consider sharing the reports with the Infection Control Committee.

The cleaning of air ducts and routine filter changes is a contracted service. CSA Z32 standard is followed for construction and renovations.

Staff spoken to throughout the survey were well informed about the infection control practices and reported easy access to the team and policies and procedures. Use of PPE and hand hygiene was observed. Staff practices putting on and removing personal protective clothing and equipment varied in terms of technique.

The team have adopted the IHI approach to improve hand hygiene drawing on the improvement solutions for the front line staff . The best performer receives a small trophy . Early results are promising, however overall improvement is slow. Consideration may be given to making hand hygiene a designated organizational Key Performance Indicator.

Standards Set: Inpatient Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Bermuda Hospitals Board has 90 inpatient medical and surgical inpatient beds between the Catlin Lindo and Ascendant Partner Wards, all of which are single rooms. There are an additional 20 beds on the Curtis Ward which were re-opened in the original building with the plan to increase by an additional six beds once staffing levels have been established. The pediatrics program is supported by 17 beds in the Gosling ward which is also located in the older part of the hospital.

The Catlin-Lindo and Ascendant Partner Wards are bright and have wide corridors and large rooms which include convertible beds to allow for family members to stay with loved ones overnight. Each floor is divided into two modes, which each have a medication room, crash cart and which share a clean supply room. Overall, these areas are clean, organized and readily support their intended purpose. It is noted that the number of crash carts could be reviewed to determine if one Crash Cart per floor would be sufficient. If so, this would save significant costs in pharmaceuticals, medical supplies and capital equipment as well as staff time in checking and verifying stocks daily.

The Curtis Ward is located in the older part of the building and has rooms for one, two and four patients. Although dated, clinical areas are clean and well organized to provide staff with the tools and space in which to provide client care. The staff note they have benefited from teaching sessions specific to geriatrics and management of the elderly and look forward to having access to more resources in this specialty.

Pediatrics is situated on the Gosling Ward which is dated but is also clean and comfortable. While the children's playroom is bright and cheerful, IPC should be engaged in future remodelling plans of this area to ensure that the area conforms to best practice to prevent the spread of infection. Pediatrics is an area that tends to have significant fluctuations in usage and the floor is utilized, when required, for surge situations as per hospital policy.

The inpatient teams on all the units impressed with their professionalism. There have been a number of changes and initiatives over recent years and staff seem to have embraced new programs. Interviewed staff expressed pride in the improvements they have made to patient outcomes with reductions in restraints, decreases in falls and pressure ulcers and the work done in involving patients and families in their own care. Some of these successes are proudly and prominently displayed to share with staff, patients and families.

Priority Process: Competency

The inpatient teams on Gosling, Curtis, Catlin-Lindo and Ascendant Partner have a comprehensive training program which includes general hospital training as well as training specific to maintenance of clinical competencies.

Exceptional work has been done in many areas (such as education surrounding the use of restraints) and subsequent data review has supported the success of these initiatives. Ongoing efforts on education around workplace violence are commended and the organization is encouraged to keep moving forward with education, encouraging reporting, monitoring and investigation of incidents and trends.

Priority Process: Episode of Care

The inpatient teams have successfully implemented programs to improve falls and pressure ulcer rates. Individual team members are aware of these priorities and are proud of how their efforts have made a difference in patient outcomes. The organization is encouraged to capitalize on these successes to maintain momentum as everyone continues to strive to improve care.

The recent addition of a formal stroke program is a point of pride for several staff and they are determined to meet their goal to have this program fully accredited, in conjunction with their partner, Johns Hopkins Hospital.

Pediatrics is a pediatrician led program which includes both inpatient and outpatient services. The Pediatrics team may consider developing a policy to better define processes and procedures for transitioning patients from pediatrics to adult care as well as define exceptional circumstances for care extension.

Bullet rounds and multidisciplinary rounds are other improvements highlighted by the inpatient teams.

Interviewed staff have found them to be very helpful to aid communication, inform on priorities and to identify barriers to discharge. They are proud to note their successes in decreasing the length of stay and return of patients to their home environment sooner.

A lot of work has been done in implementing clinical care pathways and standardized order sets. These were consistently used throughout the hospital and are valuable tools for improving the consistency of care.

Code BLUE response is important but providing expertise and medical support to patients to prevent the Code is even more valuable. The inpatient team were very happy with the guidelines for early identification of a deteriorating patient and the ability to activate the Code team expertise to help stabilize a patient. Quantifying these efforts and ICU avoidance may help to support this program and the necessary resources.

The team has implemented a discharge phone call to survey the patients' experience of their hospital stay and discharge. The team has done a lot of excellent work in developing a standardized SBAR transition form as well. Evaluating the success of the SBAR transition process, especially if changes are being made to the procedure, may be considered.

Priority Process: Decision Support

The charting on inpatient services is paper-based and the teams look forward to a comprehensive electronic charting system. It is noted that the system of utilizing different pen colours for different services in the progress notes is a simple and effective tour to aid communication and assist in rapidly finding the required information from team members.

Errors in charting are a reality in every charting system and the teams need to be encouraged to report errors, omissions and "wrong patient" to identify trends and put plans in place to mitigate these mistakes.

Priority Process: Impact on Outcomes

Bermuda Hospitals Board has done extensive work to standardize care throughout the hospital. The Hospitalist teamwork with the nursing staff and allied health professionals to provide a multidisciplinary team approach to patient care. Utilization of clinical care pathways and standardized order sets also assists to standardize care and support evidence-based medicine.

The implementation of electronic incident reporting has improved reporting rates. Continuing to educate and support staff on reporting "good catches" as well as incidents is encouraged to help identify trends and areas of risk so they can be addressed.

Standards Set: Intellectual and Developmental Disabilities - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

It is evident that the Intellectual and Developmental Disabilities team members at Bermuda Hospitals Board (BHB) are passionate about the care and services they provide to their service users. The small, but engaged multidisciplinary team, demonstrated strong commitment to the provision of a high level of individualized and diverse programs.

Social inclusion was noted to be high on the list for the team. Examples of activities which demonstrate commitment to this include, but are not limited to, participation in the Special Olympics, community outings, bowling, fishing trips, arts and crafts etc. It is noteworthy that three (3) clients were selected to travel to Dubai in 2018 to participate in the Special Olympics. Congratulations on this great achievement!

A Service User Council election was held recently, late 2018. This is positively noted.

Families are encouraged to participate in decision-making with the service users whenever possible. A Family Support Group has been active for 30+ years and, although small in numbers, are quite involved in supporting the Intellectual and Developmental Disabilities team. Regular meetings occur which can see attendance of 4 -15 members. At these meetings the team provides updates on from staff meetings including new things that are being planned for Mid Atlantic Wellness Institute and the Bermuda Hospitals Board (BHB) as a whole.

Priority Process: Competency

Four (4) nurses provide clinical oversight for thirteen (13) group homes, or sixty-nine (69) service users during the day shift with one (1) manager on call during the night. Additionally, there are six (6) respite beds which are utilized in accordance with demand. There is one support staff person housed in each home 24/7.

The team has identified a gap between the homes and management making it sometimes challenging to ensure consistency in approach and service delivery across the program. To address this concern, a proposal was prepared and submitted to senior leadership for approval of a new level of staff, a supervisor or senior support worker, to bridge the gap and provide greater supervision. Position descriptions are in progress and plans are being made to prepare job postings.

There is access to education and training as well as professional development for all staff. It is strongly suggested that regularly scheduled fire drills be included as part of emergency preparedness for all group homes. This will ensure that staff working alone are well prepared to evacuate their service users in a timely manner in the event of such action is required.

Attention to safety for both service users and staff is noted at BHB. As part of the commitment to a safe work environment, it is recommended that panic buttons be provided to all staff who work alone in community settings.

Priority Process: Episode of Care

During this survey, two (2) group homes, as well as the New Dimensions program area, were visited. Staff interaction with users was noted to be respectful and bonding was evident. The laughter and sense of openness spoke to a warm and inclusive culture.

This program is challenged in its ability to expand its services due to the lack of sufficient government funding to create additional housing for individuals waiting for placement. As well, several of the current users are 'ageing in place' which is creating a need for more accessible environments, especially in 1-story homes. All thirteen (13) group homes are rental properties making it somewhat difficult to do major infrastructure modifications to address this challenge. The property owners have allowed minor renovations such as grab bars however, to be installed. This has been appreciated.

The team is hopeful that, through Project 100, there may be an opportunity to have a custom built bungalow built to better meet the accessibility requirements of some of the current users. If this becomes a reality, BHB would be able to rent this property. It was noted during the discussion that building a BHB owned home using current government funding would not be feasible.

Priority Process: Decision Support

There are processes in place for the sharing of information. Change in shift report is used to communicate pertinent changes and/or new initiatives related to each service user.

Confidentiality and privacy of information protocols have been established.

Current education and training materials are available to staff to allow them to stay informed.

Policies and procedures, as well as the intranet, are available to all staff who work in the group homes.

Priority Process: Impact on Outcomes

The team is recognized on receiving an 80% satisfaction rating from the most recent family survey. The information gained from this survey will be used to make improvements where possible.

Team members have worked hard to decrease the use of narcotics by 40%. This is a notable achievement and encouragement is given to continue with this quality initiative.

An Advocacy Group, spearheaded by parents of service users, formed in January 2019. This group in recruiting community members and plans to seek political opportunities to advocate on behalf of the Intellectual and Developmental Disabilities group. They are wished well.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The LTC Services Team demonstrated enthusiastic and responsive clinical leadership from the geriatrician, nursing staff and all of the allied health and support professionals, including the Residents and Family Council. Active work is being done with KPMG Consultants to assess staff to resident ratios based on case complexity and supplemented with use of the Resident Assessment Instrument (RAI).

There is a Resident and Family Council in place that provides key inputs to quality improvement initiatives including those being undertaken with the Institute for Healthcare Improvement (IHI) through BHBs first participation in a Breakthrough Learning Collaborative known as "Safety on the Rock". Residents and families are part of the team, as are housekeeping and other support staff. Staff and families are energized by what they have learned in the Collaborative and spoke to ways they could apply the methodology to other improvements.

Priority Process: Competency

This impressive multi-disciplinary team has really gone the extra mile to ensure service-specific education and training for all staff is available. Staff were able to describe programs and protocols to identify escalation of resident behaviors and speak to ways to effectively intervene and reduce aggressive episodes and calm the resident. Of significant note is how well each staff knows each resident as individuals so that care approaches can be customized. Good attention is paid to reducing and eliminating the use of pharmacological and physical restraints for resident safety. Risk matrices are reviewed with family members when restraint options are reviewed and the family contributes to the decision of choice.

Priority Process: Episode of Care

The Long Term Care Service has clearly defined referral criteria and processes which largely are received from inpatient services within BHB. In accordance with the National Strategy for Seniors, the comprehensive Resident Assessment Instrument(RAI) is used and scored to determine level of care. There is comprehensive geriatrician assessment upon referral and families are engaged in the intake and treatment planning process at all points of time.The values of the BHB are visible in resident staff interactions, as there is an explicit positive physical approach to care. Two staff are certified as trainers in Teepa Snow Dementia Care methodology which is applauded. An impressive end of life approach has been established and supported by an end of life checklist for staff to use with residents and families. Kudos to the team for looking at the whole person along the life cycle.

Priority Process: Decision Support

All of the requisites for standards compliance were fully met by the Long Team Care Service Team. A family member spoke to her ability to obtain access to to health record information as needed about her loved one. Having said that, she also indicated that because of her involvement in the care plan and progress reviews with the team that likely would not be necessary.

Policies and procedures related to secure storage,retention and destruction of health records are in place in accordance with an umbrella policy for the organization. Audits of charts and record keeping practices are taking place and very much encouraged due to the long stay nature of the complex resident

The team is very much encouraged to review record keeping practices on an annual basis to ascertain if quality improvements can be made. The availability of an electronic medical record would lesson the burden of manual record keeping for staff and an organization-wide Request for Propoasals (RFP) is in progress.

Priority Process: Impact on Outcomes

There are impressive multi-disciplinary evidence based guidelines applied in the program. The team is encouraged to formally define the process for introduction and review of emerging evidence and to document both the process and the selection or changes that impact clinical practices for annual review and validation as a team and to share with the Quality Council.

The teams results with IHI Learning Collaborative in terms of pressure ulcer prevention are remarkable. This team is leading in quality and patient safety in this regard and are positioned to help the system with spread of the pressure ulcer prevention bundle when readiness for spread is established.

Standards Set: Medication Management Standards - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Medication Management	
27.4 The interdisciplinary committee regularly and comprehensively evaluates its medication management system.	
Surveyor comments on the priority process(es)	
Priority Process: Medication Management	

The Medication Management tracer included meetings with the Pharmacy and Therapeutics Committee, Pharmacy Leadership Team, tours of the main pharmacy at King Edward VII Memorial Hospital and visits to a the Oncology Clinic area and the surgical patient care unit.

The oversight structure includes the Pharmacy and Therapeutics (P&T) Committee which reports to Medical Staff Committee (MSC). The P&T Sub committee and Antimicrobial Stewardship Committee report to the P&T Committee. The pharmacy team is comprised of 13 Pharmacists, 3 Pharmacy Technicians, a Director, Manager and Clinical Coordinator. The service reports to the Vice President, Hospital Services. A number of clinical pharmacist positions were recruited this year to meet the needs of all clinical areas.

The pharmacy team provides 24x7 coverage. There was evidence of establishes clinical engagement between pharmacy staff and the clinical teams during the designated tracers.

Pharmacy and Therapeutics is a multi-stakeholder committee with evidence of a comprehensive, robust, approach to the development and evaluation of KEMH's medication management system. There is a structured process for adding and removing medications from the formulary. While mechanisms exist to ensure policies, procedures, guidelines and protocols are evidence based, the committee does not follow and established process to monitor the literature on a regular basis to update the medication management system.

Policies and procedures are readily available on line and in hard copy in clinical areas. Staff spoken to in clinical areas were aware of the website and reported they were kept informed when items were added or removed.

The Antimicrobial Stewardship program is well established. The program has evidence of good results both in terms cost and decreased use of antimicrobials. The High Alert Medication Policy has undergone recent review.

While mechanisms are in place to evaluate the Medication Management System, there is an opportunity for the committee to adopt a more strategically focused system level performance evaluation and improvement approach. For example, consideration should be given to establishing a more standardized reporting schedule for P&T to receive results of audits conducted on the availability heparin, narcotics, and concentrated electrolytes in clinical areas. Medication related Adverse Events and Adverse Drug Reactions are reported in the hospital system and reviewed at many levels within the organization, including the Quality Committee. There is also an opportunity to provide a more fulsome adverse event report and breakdown of drug reactions directly to the P&T on a regular basis.

A number of cardiac arrest carts were found to have inconsistency in the expiry date on the tray and the expiry dates in the medication packages. Carts were also found to be overstocked and unlocked in some instances. It is recommended that the process for maintenance of the carts be established across the organization.

At Mid-Atlantic Wellness Institute the documentation process used to order new drugs is unsafe as medication list provided is currently incomplete and the pharmacy check may not include all the medications which are continuing.

The current pharmacy is part of the original building and presents significant space and environmental challenges. The service is scheduled to move to a new space by June 30th, 2019.

Indicators monitored by the P& T Committee include safety events, drug utilization and antimicrobial resistance. However, the committee does not have a standardized process to regularly and comprehensively evaluate the medication management system in order to inform a focused improvement plan and maximize the excellent work of the committee.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Bermuda Hospitals Board (BHB) is the single mental health service provider for the country. Services are provided through acute care, community-based care and rehabilitation. Inpatient and outpatient services are offered through these program areas.

The team is made up of professional staff who are passionate about their program and the people they serve. They work collaboratively to ensure the best use of resources in the delivery of high-quality care and services.

There are many well-established community partnerships which help the team to achieve identified goals for the individuals they serve.

Mental Health Services (MHS) has identified the following as some of the current challenges faced by the team:
> increasing costs to meet the needs of the growing mental health services,
> challenges related to dealing with the stigma associated with mental illness,
> ability to educate the general population on mental illness and,
> the bed flow situation and limited housing availability.

Service users are encouraged to participate in their care and family input is welcomed as appropriate.

Priority Process: Competency

Education and training are provided to all team members. An emphasis on safety training is noted.

The plan to move to Prevention of Violence and Aggression from the Non-Violent Crisis Intervention program currently used is noted. The new program will be geared more towards de-escalation techniques and less physical intervention.

EAP program, as well as other forms of support, is available for employees should they require it.

Priority Process: Episode of Care

Inclusion of service users and families (as appropriate) in service user care planning was evident throughout mental health services. Service users rights regarding developing their goals were acknowledged and respected.

The crisis safety plan is well done and provides clear direction to address triggers for the individual service user.

Plans for Devon ward to become smoke-free is commended. You are wished well is this venture.

Staff are aware of and use the IDEA Ethics Framework frequently in their day-to-day work. This tool has also been said to be used on a personal level on occasion.

Teams meetings and huddles are ways in which the team shares information and is considered a good communication venue.

Staff recognition events are noted with approval as are the opportunities provided for staff to take time to de-escalate.

Offering mental health first aid to the service users, families and the community is a new practice which should help to promote health and well-being.

Priority Process: Decision Support

Service user records were well maintained to allow for privacy and confidentiality of individual information.

Policies and procedures are readily accessible to staff.

Priority Process: Impact on Outcomes

It has been noted during this survey that this team has focused a great deal of attention on quality, safety and risk management. These efforts are commended.

The next steps in this journey include further development of the organization-wide quality framework and standardization of related processes across all program areas. This will include formalizing processes related to indicator refinement, collection and analysis of data, trending, evaluation of outcomes and, benchmarking activities.

Standards Set: Obstetrics Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
9.12 Access to spiritual space and care is provided to meet clients' needs.	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Obstetrical Services planning is projected with consideration for demographic shifts in the populations served. Trends over the last two years show a mixed age range with an increase in primigravidas, comorbidities and multiple gestation deliveries. The service had ~ 600 births last year. Volumes and budget are reviewed by the leadership

The team has established internal and external partnerships to support a comprehensive, integrated suite of maternal and newborn services comprising of antepartum, labour and birth, postpartum, and a level 2 Special Care Baby Unit.

The interprofessional team includes nurses with midwifery qualifications, obstetricians, pediatricians with neonatology training, and anesthesia. The nurses from the main operating room and post-anesthetic care unit provide support for Caesarian Sections.

The Maternity and Special Care Unit Based (SCUB) Quality and Safety Team has been established and a number of staff are currently enrolled in the IHI Open School. Examples of improvement initiatives underway include surgical site infection reduction, and the Baby Friendly Hospital initiative. Patient participation and input to program design are in the early stages of development. Consideration should be given to including a patient advisor to support his work.

The unit is kept clean and well organized. However, the floor plan does not allow for easy workflow or wayfinding for patients and visitors. Staff reported environmental challenges including flooding and plumbing issues. Mothers have 24 hour rooming in services. The unit is clean and well equipped throughout.

Priority Process: Competency

Continuous learning and professional development are supported and evident. Training requirements for all nursing staff is extensive and includes requirements on hiring and comprehensive mandatory annual and two yearly training, which is reviewed regularly and signed off with the nurse educator. Infusion pump training and K2 Fetal Monitoring is completed every two years. Annual performance evaluation is completed.

The team participates in nurse educator-led “PROMPT” drills for the emergency situational learning experience.

Priority Process: Episode of Care

Patients are registered from the physicians’ office. The prenatal forms are sent to the unit at 20 and 36 weeks gestation. Elective Caesarian Sections are pre-booked. There are established criteria for admission to the service. Patients who can not be accommodated are transferred out to one of the affiliated centers.

One to one nursing is provided throughout the labour. Care is well documented and supported by evidence-based policies, procedures and care pathways. Medication reconciliation is performed by the physician. The patient receives a discharge medication list on the Patient Discharge Instruction Sheet at the end of the service. Standardized tools are used for information transfer at transitions.

Patients and families have access to social work services and assisted to other community services as required.

Priority Process: Decision Support

The patient record is in paper format. Patients have access to their record upon request through the records department. Staff reported they are kept informed about the organizational information technologies privacy and cybersecurity and use of emails policies security policies and procedures.

Priority Process: Impact on Outcomes

Policies and procedures are based on current evidence. There are a number of care pathways medical directives applicable to maternal and newborn care.

Safety incident is reported in Quantros. Trends are analyzed and discussed at the Maternity & SCUB Team meetings. Staff are familiar with the disclosure policy.

The team follows a number of performance evaluation processed to identify areas for improvement. The Maternity Nursery Ward Statistical report includes a broad range of clinical indicators. Surgical site infection reports are provided by infection control. Patient satisfaction reports are provided by Quality and Risk. Corporate KPIs are posted monthly on the main corridor within the unit. Physician-led morbidity and mortality rounds are held monthly. Reducing Surgical Site Infections is a current area for improvement.

Parents spoke highly of the professionalism and knowledge of the nursing staff. In particular, assistance with breastfeeding and baby care was identified as an area of excellence. A noteworthy area for improvement is to move to a more progressive birth plan to support a more natural birthing experience in keeping with international trends. The age of the physical facility and difficulty finding a way through the two buildings was also identified as an area for improvement.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	
Priority Process: Medication Management	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Perioperative and Invasive Procedure team is comprised of a group of highly skilled professionals. This group works well together for the safety of the patients they serve.

Each area of this program area is dependent on the integrity of the whole team. The journey from the pre-operative assessment unit, the intraoperative care suites, the postoperative recovery unit and finally to the transfer of the patient to inpatient services or to preparing the patient for discharge is a high-risk one requiring skilled staff and clearly defined and enforced protocols.

The Perioperative and Invasive Procedure program is housed in the new Acute Care Wing (ACW) of the King Edward VII Memorial Hospital (KEMH). The area is spacious and well designed. Equipment and supplies were identified as appropriate and adequate to meet program needs.

Priority Process: Competency

Staff in this area is made up of nurses, surgeons, anesthesiologists etc. Credentialing is in accordance with professional regulations and hospital requirements.

Education and training are accessible by all staff and training on new equipment are provided.

Attention to safety is paramount and many checks and balances were noted in minimizing risks to patients.

Patients and families are kept informed of procedures and outcomes and, in the case of a child, the mom was permitted to stay with the child until she was sedated in the operating room.

Priority Process: Episode of Care

Good processes are in place to ensure that the environment is clean, free from clutter, and accessible.

Emergency crash carts are readily available and stocked with current medication and equipment. Both the crash carts and the anesthesiology carts are checked at the beginning and of each shift and after each use.

The pre-operative assessment process is comprehensive. Patients are kept informed of any changes to the timing of their procedures and/or reasons for further follow up prior to proceeding with the procedure.

The post-operative recovery procedures are well established and one-to-one staffing is provided until the patient is awake and stable.

Transfer and/or discharge processes are clearly defined.

Priority Process: Decision Support

An electronic health record system which provides access to real-time blood work reports, x-rays, etc. allows staff to document actions at the point of care (e.g. drugs required during surgery).

Surgical and anesthesiology checklists are checked as per policy and procedures.

Patient identity and accuracy of the procedure is checked multiple times.

Priority Process: Impact on Outcomes

Indicator measures are in place for this program area. There is evidence of follow through on areas of safety and risk that require immediate attention.

The cleaning schedule for the operating rooms is posted and there are checklists requiring sign off on completion of each cleaning. This was an area requiring to follow up from the last survey visit.

Priority Process: Medication Management

All standards related to medication management for this program area were met at the time of the survey.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
9.5	When the health care professional verbally reports POCT results to clinicians, the results and methods used to obtain those results must later be documented in a written format and identified as POCT results.	!
9.8	When completing the POCT report and filing it in the client record, the health care professional delivering POCT clearly labels the results as "POCT".	
Surveyor comments on the priority process(es)		
Priority Process: Point-of-care Testing Services		

Point of Care Tests (POCT) fall under the authority of the laboratory who is responsible for overseeing the POCT program. Staff are appropriately trained on the use of POCT equipment and the equipment itself is appropriately maintained, calibrated and monitored.

The majority of POCT consist of glucometer testing which is barcoded to provide automated controls on authorized users and maintains a memory of provider, patient and result for future review. Urinalysis is also available in the KEMH emergency department and the strips are held for reference by the laboratory for the required minimum time. Single-use test strips are used for pregnancy testing at both KEMH and at LFUCC and urine test strips are used at LFUCC.

The organization may consider modifying the procedure for frontline staff in documenting POCT results to include the annotation confirming that it is a POCT result rather than a laboratory provided number. Currently, results in the medical files are not consistently annotated as being POCT results.

Standards Set: Rehabilitation Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The rehabilitative services team is highly motivated and committed to patient-focused care and service delivery. Members of this team shared the respect they feel for the allied health disciplines which make up their cohesive group.

There is evidence of indicator identification, tracking and analysis. Information obtained from the analysis is used for quality improvement. One example of this is evident in the implementation of a quality improvement initiative identified to resolve a problem identified by the number of patients who expressed frustration regarding not being called in advance of the Home Care Nurse visits. Through a Plan-Do-Study-Act (PDSA) cycle the team implemented a 2-hour pre-visit notification call which resulted in increased patient satisfaction.

Space for treatment was identified by staff as a needed area of improvement. Rehabilitation services were moved from its original located at the King Edward VII Memorial Hospital (KEMH)in September of 2017 due to an air quality control concern. The service continues to operate from this temporary site. Staff note that space is limited making it difficult to see as many patients as they previously could. They also noted that privacy and confidentiality are also of concern when discussing treatment plans with patients.

Difficulty with access to specialized equipment in a timely manner is sometimes a concern as it may have to be imported.

Casual staff availability was identified as a concern as all employees hired from outside Bermuda are hired as full-time employees. This limits the ability to employ casuals to backfill full-time shifts. To address this concern consideration is being given to implementing a six (6) day a week rota.

Priority Process: Competency

The organization is applauded for its commitment to professional growth and development for its staff. Staff spoke highly of the opportunities available to them through KEMH.

Credentialing for the allied health services team requires a bi-annual re-registering for each discipline. Social Workers are the current exception however, it is anticipated that re-registering will soon become a requirement for them as well. Currently, social workers are required to have a masters degree to practice with the Bermuda Hospital Board (BHB).

Annual mandatory education and training are extensive.

Lunch and learning opportunities are also offered on site.

Priority Process: Episode of Care

Rehabilitation services operate Monday through Friday. Consideration is being given to developing a six-day work rota which will include a Saturday shift. The team hopes that this will enable them to see more patients. They are wished success in this undertaking.

There is a comprehensive individualized plan of care for each patient which is developed with input from the patient and family members as appropriate. Goals are measurable and realistic.

It is evident that the rehabilitative team are clearly patient focused. The feedback received from patients interviewed strongly supports this.

The transfer and discharge process is thorough and monitored closely to follow up as necessary. Patients interviewed during this survey expressed great satisfaction with the team and with the services they receive. They stated that they feel included in decisions related to their care and go approach any of the team with questions and/or concerns.

Informed consent is obtained for all procedures. Substitute decision-makers or public trustees are established should the patient not have the capacity to consent.

There is evidence of good follow through on the falls risk assessment which can include going into the patient's home to assess potential safety concerns and to recommend changes as appropriate.

Priority Process: Decision Support

The organization's plan to move to an interdisciplinary electronic record is noted with approval. The current system of paper-based charting makes it difficult to achieve integrated charting. The flow of the patient record should be much improved once this is in place.

Policies and procedures are readily available to staff via the intranet.

There is good communication across the disciplines and services which ensures timely access to patient information.

Attention to privacy, security and confidentiality of patient records is noted.

Priority Process: Impact on Outcomes

Evidence-based guidelines for rehabilitation services are accessible through the individual disciplines respective colleges. It is strongly encouraged that the organization work with the service areas to standardize guidelines specific to each service area. It is suggested that this may be a quality improvement initiative for the Unit Based Quality Safety Teams (UBQST) and the Quality Council.

Education and training are provided to team members on an ongoing basis. Annual mandatory training includes focussing on safety and risk management.

Written materials are provided to patients and families related to their role in safety. Examples include teaching on hand hygiene and falls prevention. The 'Staying Steady' group is another example of the focus on safety.

Indicators such as falls, wait times, and readmissions have been identified however, to complete the quality improvement process further development is required across the organization. Establishment of baseline data, measurement tools, analysis of trends, evaluation of outcomes based actions taken etc., is required. It is recognized that the organization is focused in this direction and is commended for its progress to date.

Benchmarking activities with other healthcare organizations will prove beneficial once the quality improvement process is complete.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
1.7 Awareness campaigns are conducted with partners to raise awareness of substance abuse and problem gambling services available in the community.	
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	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

During this survey, the Turning Point Centre and the Inpatient Detox unit were visited.

The Substance Abuse and Gambling team was very engaged and demonstrated a commitment to the people they serve.

Gambling was not identified as a major concern during this survey.

A recent satisfaction survey indicated a lengthy wait period for services as an area for improvement.

Walk-in service is available five (5) days a week. During these visits, assessments can lead to pre-scheduled appointments. This service is relatively new and, so far, seems to be cutting down on the wait time for service users to enter the system. At present this type of access to the system is not being actively promoted as more data on the efficiency and effectiveness of this needs to be collected and analyzed.

The bulk of admissions to the service are through the regular intake process.

The assessment, admission and transfer/discharge processes are comprehensive.

Service user privacy is respected. Staff try to minimize the potential for traffic around the entry to the program areas as much as possible.

Priority Process: Competency

Availability of full-time nursing staff has been identified as a challenge at the time of this survey. At present, temporary staff have been covering. It is expected that the program will be at its full complement by the end of the year. One recruit is expected to arrive soon.

Education and training are readily accessible to all staff. Annual mandatory education requirements have been identified for all staff.

Safety measures are in place to ensure a safe workplace. These include, but are not limited to, video surveillance, security guards, workplace violence training, panic buttons etc.

A collaborative approach to the Recovery Model is noted.

Priority Process: Episode of Care

There are very good processes established for the methadone clinic. Strict screening and security checks for service users are in place. This includes body wane scan by a guard, screening walk-through detector and limitation on the number of service users who can access the clinic at the same time.

In the detox centre, staff safety needs are well addressed.

Training and education are provided which includes annual mandatory requirements.

There is a Day Program Support Group for families which seen as beneficial but, at times can be an emotional time for both family and service user.

While many service users complete the detox program, some do discharge themselves against medical advice.

Priority Process: Decision Support

The service user records reviewed were current and stored appropriately.

There was evidence of a good flow of service user information across.

The team noted that they are extremely proud of the multidisciplinary team meetings and the template that they use to inform that meeting.

Policies and procedures are current and readily accessible.

Priority Process: Impact on Outcomes

The process for reporting safety incidents is followed and any resultant correctly actions are implemented.

There are guidelines identified for this program however, it is recommended that the organization establish a standardized process for selecting guidelines and integrating them into the program areas.

Indicator data is collected for this program area however, it is noted that the organization-wide process for quality improvement needs to be further developed.

Standards Set: Transfusion Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Transfusion Services	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

The hospital has an extensive falls prevention program that is followed by the transfusion services team.

Priority Process: Transfusion Services

The Transfusion Services team is split into two locations, one part is co-located with the laboratory and while the other part is co-located with the donor clinic on the same floor. While the team makes the location work with attention to process, it is not ideal and if there is an opportunity during future infrastructure changes, the transfusion services should be co-located to improve flow.

The blood donor area is clean, comfortable and well lit and the team is fortunate to have a large number of dedicated blood donors who respond promptly when a donation is required. All blood donors are volunteers and directed donations are not accepted. A policy defining the requirement for only accepting voluntary, non-directed and non-designated donations may be considered.

The transfusion services team is in the enviable position of having a sufficient blood donor pool available to meet their needs. This speaks to the success of the program and the hard work and dedication of the team who maintain relationships with these life-saving community volunteer donators. The team recognizes donors with milestone pins, t-shirts and super donors with named recognition on wall plaques.

The team is currently in the process of opening a second donor location outside of the hospital to increase the potential donor pool. With the implementation of these changes, the team may want to conduct surveys to determine successes and opportunities to further direct this initiative and inform future change.

The team collects empirical data on many aspects of the transfusion process from donation to delivery. Incorporating further client focused surveys may assist to build the program into the future.

The transfusion team does not currently support home or external transfusion services. Defining this in a policy, or conversely, defining what would need to be in place in order to consider providing this service, could be considered.

Instrument Results

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

Governance Functioning Tool (2016)

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

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

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

- **Data collection period: November 19, 2018 to December 8, 2018**
- **Number of responses: 12**

Governance Functioning Tool Results

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	8	0	92	N/A
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	8	0	92	N/A
3. Subcommittees need better defined roles and responsibilities.	75	17	8	N/A
4. As a governing body, we do not become directly involved in management issues.	17	8	75	N/A
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	8	0	92	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	0	8	92	N/A
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	8	0	92	N/A
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	8	8	83	N/A
9. Our governance processes need to better ensure that everyone participates in decision making.	42	17	42	N/A
10. The composition of our governing body contributes to strong governance and leadership performance.	0	8	92	N/A
11. Individual members ask for and listen to one another's ideas and input.	0	8	92	N/A
12. Our ongoing education and professional development is encouraged.	0	17	83	N/A
13. Working relationships among individual members are positive.	0	0	100	N/A
14. We have a process to set bylaws and corporate policies.	8	25	67	N/A
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	N/A
16. We benchmark our performance against other similar organizations and/or national standards.	8	33	58	N/A
17. Contributions of individual members are reviewed regularly.	17	50	33	N/A
18. As a team, we regularly review how we function together and how our governance processes could be improved.	17	25	58	N/A
19. There is a process for improving individual effectiveness when non-performance is an issue.	33	50	17	N/A
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	17	25	58	N/A

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
21. As individual members, we need better feedback about our contribution to the governing body.	17	8	75	N/A
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	8	25	67	N/A
23. As a governing body, we oversee the development of the organization's strategic plan.	0	0	100	N/A
24. As a governing body, we hear stories about clients who experienced harm during care.	8	0	92	N/A
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	8	92	N/A
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	8	17	75	N/A
27. We lack explicit criteria to recruit and select new members.	67	17	17	N/A
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	0	8	92	N/A
29. The composition of our governing body allows us to meet stakeholder and community needs.	0	25	75	N/A
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	8	0	92	N/A
31. We review our own structure, including size and subcommittee structure.	8	8	83	N/A
32. We have a process to elect or appoint our chair.	8	50	42	N/A

Overall, what is your assessment of the governing body's impact over the past 12 months, in terms of driving improvements to:	% Poor / Fair	% Good	% Very Good / Excellent	%Agree * Canadian Average
	Organization	Organization	Organization	
33. Patient safety	25	17	58	N/A
34. Quality of care	25	25	50	N/A

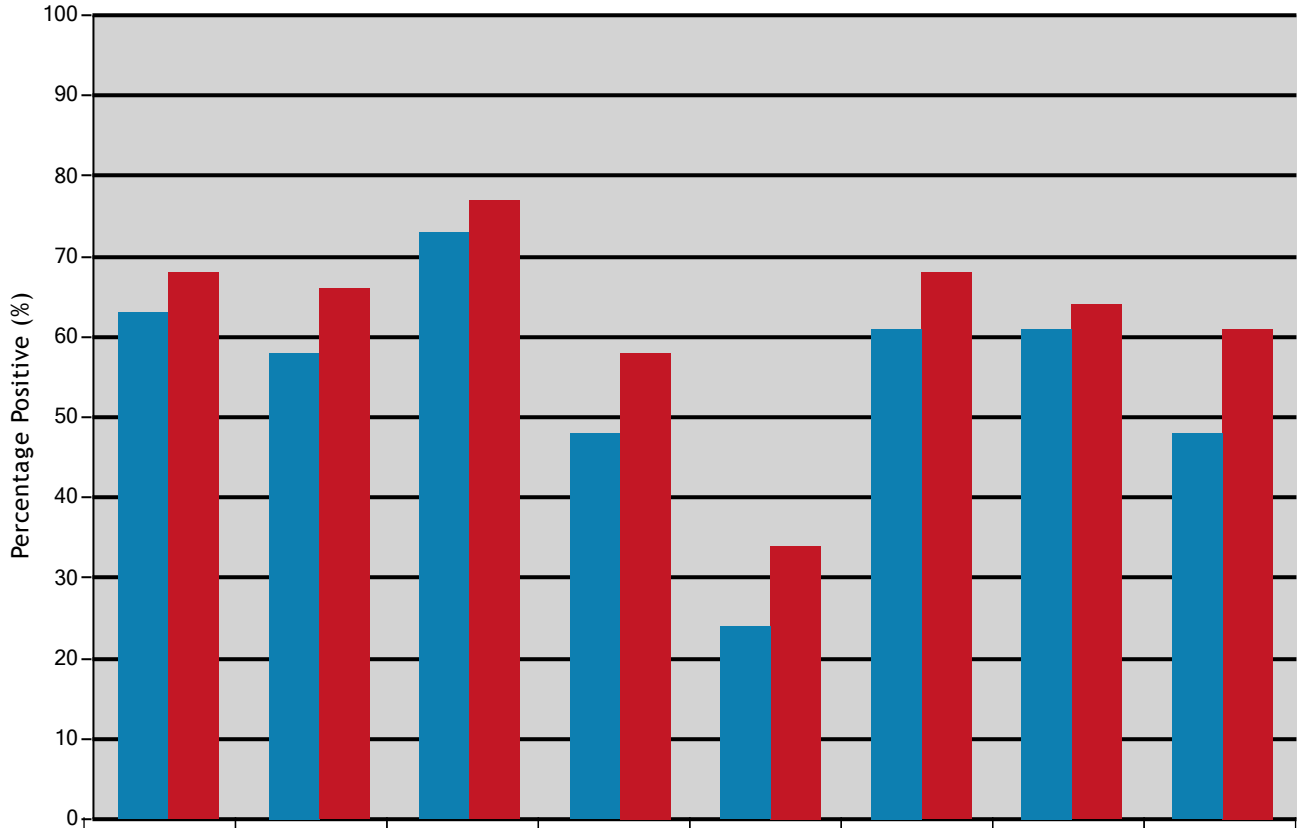
Canadian Patient Safety Culture Survey Tool

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

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

- **Data collection period: September 11, 2017 to September 24, 2017**
- **Minimum responses rate (based on the number of eligible employees): 271**
- **Number of responses: 593**

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



	Organizational (senior) leadership support for safety	Supervisory leadership for safety	Unit learning culture	Enabling Open Communication I: judgment-free environment	Enabling Open Communication II: job repercussions of error	Incident follow up	Stand-alone items	Overall Perceptions of Client Safety
	63%	58%	73%	48%	24%	61%	61%	48%
	68%	66%	77%	58%	34%	68%	64%	61%

Legend

Bermuda Hospitals Board

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2018 and agreed with the instrument items.

Worklife Pulse

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

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

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.

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

Organization's Commentary

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

Bermuda Hospitals Board (BHB) extends our heartfelt appreciation to Accreditation Canada and the surveyors for being an integral part of our quality journey. The survey process plays a key role in the validation process of our quality journey as we pursue our vision of “Exceptional Care. Strong Partnerships. Healthy Community.” We are delighted that BHB achieved the highest status of Accredited with Exemplary Standing. This is a testament to our staff, who have worked diligently over the past four years to meet the care requirements of our community. The surveyors highlighted significant strengths of BHB as well as some opportunities for improvement. We agree with the surveyors’ observations and will work to improve, based on implementing the detailed recommendations.

There are a few areas noted in the report that are worthy of mention and comment.
We appreciate the recognition of our efforts in 2016 to ensure that BHB has a five-year strategic plan that includes input from our staff, community partners and the Bermuda Government. Over 350 individuals were involved in the process of ensuring we adopt a vision and mission that everybody understands to ensure there is alignment and focus. The adoption of the Triple Aim was also recognised by the surveyors as a strength for BHB. All of this was achieved despite a change in Government, a new Board and a restructured Executive Team since our last survey. Rather than view these changes negatively, we used the BHB Strategic Plan 2016-2021 to develop our Clinical Services Plan as well as the Financial Recovery Plan in 2018.

One of the highlights the surveyors remarked on was our engagement with the Institute for Healthcare Improvement (IHI). In 2015 it was recognised that “frontline staff, managers and physicians were not aware of the quality framework and had no knowledge of basic processes such as PDSA cycles”. We believed it was critical for BHB to develop a quality improvement and patient safety plan to ensure the organisation is aligned with and focused on improvement. The further development of our quality framework and quality tools gave us the ability to train our staff on the basics of quality and using Plan Do Study Act (PDSA). The investment in our staff using the collaborative process with IHI is already yielding some early successes as we continue our improvement focus on falls, pressure injuries and CLABSI.

We agree the Executive Team must continue to develop and engage the Board, physicians and our external partners as we make changes to our current model of care. We recognise that we must take a leadership role in establishing formal partnerships in the area of primary care and population health, bringing us closer to achieving our objective of improving the health of the Bermuda community. We agree that work has already commenced in this area.

We are very proud of the work that has started with the Patient and Family Advisory Council (PFAC). The surveyors believe this team will continue to grow in stature and prominence within BHB. Our ultimate goal is to see members of the PFAC and the community sitting on BHB’s committees and having a stronger voice on the Board.

The surveyors mentioned “there is an imperative to upgrade ageing technological/information systems to establish a great electronic health record so that each Bermudian has his/her health information available whenever they receive services…”. We are pleased to report that the RFP process for choosing a vendor has already commenced. After live demo sessions involving frontline staff, physicians and managers with the prospective vendors, a decision will be made shortly to invest in an electronic medical record (EMR) for BHB.

We also recognise the surveyors’ comments that BHB’s infrastructure challenges, particularly within the General Wing and the Mid-Atlantic Wellness Institute, need to be addressed urgently. The development of the Estates Master Plan will be the first step in rectifying this issue. It will also address the challenges of caring for the elderly in conditions that are not suitable in a modern world, as well as the challenges of addressing air quality concerns of staff due to mould, which is very prevalent in the Bermuda environment.

We greatly appreciate the surveyors’ commentary, as it provides BHB with an opportunity to recognise the significant achievements against the Strategic Plan 2016-2021 and the concerted efforts of our employees, and to celebrate our progress with our staff in a very tangible manner. We will continue our quality journey, working on process improvement opportunities as we strive to achieve our vision of *Exceptional Care. Strong Partnerships. Healthy Community.*

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.

Appendix B - Priority Processes

Priority processes associated with system-wide standards

Priority Process	Description
People-Centred Care	Working with clients and their families to plan and provide care that is respectful, compassionate, culturally safe, and competent, and to see that this care is continuously improved upon.