ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Bermuda Hospitals Board

Hamilton, Bermuda

On-site survey dates: November 6, 2023 - November 10, 2023

Report issued: March 7, 2024

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 November 2023. 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 will be treated in confidence by Accreditation Canada in accordance with the terms and conditions as agreed between your organization and Accreditation Canada for the Assessment Program.

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 (Report)

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

About the On-site Survey

- **On-site survey dates: November 6, 2023 to November 10, 2023**

- **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

  Population-specific Standards

  4. Population Health and Wellness

  Service Excellence Standards

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

17. Long-Term Care Services - Service Excellence Standards
18. Medication Management (For Surveys in 2021) - 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)	74	18	0	92
Accessibility (Give me timely and equitable services)	154	4	2	160
Safety (Keep me safe)	919	14	26	959
Worklife (Take care of those who take care of me)	207	5	1	213
Client-centred Services (Partner with me and my family in our care)	686	13	4	703
Continuity (Coordinate my care across the continuum)	148	1	4	153
Appropriateness (Do the right thing to achieve the best results)	1344	118	12	1474
Efficiency (Make the best use of resources)	89	2	0	91
Total	**3621**	**175**	**49**	**3845**

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	49 (98.0%)	1 (2.0%)	0	36 (100.0%)	0 (0.0%)	0	85 (98.8%)	1 (1.2%)	0
Leadership	50 (100.0%)	0 (0.0%)	0	93 (96.9%)	3 (3.1%)	0	143 (97.9%)	3 (2.1%)	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
Population Health and Wellness	3 (75.0%)	1 (25.0%)	0	32 (91.4%)	3 (8.6%)	0	35 (89.7%)	4 (10.3%)	0
Medication Management (For Surveys in 2021)	99 (99.0%)	1 (1.0%)	0	50 (100.0%)	0 (0.0%)	0	149 (99.3%)	1 (0.7%)	0
Ambulatory Care Services	42 (93.3%)	3 (6.7%)	2	71 (91.0%)	7 (9.0%)	0	113 (91.9%)	10 (8.1%)	2
Biomedical Laboratory Services	68 (95.8%)	3 (4.2%)	1	100 (95.2%)	5 (4.8%)	0	168 (95.5%)	8 (4.5%)	1
Cancer Care	75 (96.2%)	3 (3.8%)	3	107 (94.7%)	6 (5.3%)	1	182 (95.3%)	9 (4.7%)	4

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	42 (93.3%)	3 (6.7%)	0	89 (95.7%)	4 (4.3%)	1	131 (94.9%)	7 (5.1%)	1
Critical Care Services	58 (96.7%)	2 (3.3%)	0	102 (97.1%)	3 (2.9%)	0	160 (97.0%)	5 (3.0%)	0
Diagnostic Imaging Services	63 (92.6%)	5 (7.4%)	0	67 (97.1%)	2 (2.9%)	0	130 (94.9%)	7 (5.1%)	0
Emergency Department	67 (93.1%)	5 (6.9%)	0	101 (95.3%)	5 (4.7%)	1	168 (94.4%)	10 (5.6%)	1
EMS and Interfacility Transport	105 (94.6%)	6 (5.4%)	3	108 (93.1%)	8 (6.9%)	4	213 (93.8%)	14 (6.2%)	7
Home Care Services	42 (89.4%)	5 (10.6%)	1	69 (93.2%)	5 (6.8%)	1	111 (91.7%)	10 (8.3%)	2
Hospice, Palliative, End-of-Life Services	40 (88.9%)	5 (11.1%)	0	102 (95.3%)	5 (4.7%)	1	142 (93.4%)	10 (6.6%)	1
Inpatient Services	57 (95.0%)	3 (5.0%)	0	80 (94.1%)	5 (5.9%)	0	137 (94.5%)	8 (5.5%)	0
Intellectual and Developmental Disabilities	54 (100.0%)	0 (0.0%)	0	93 (100.0%)	0 (0.0%)	0	147 (100.0%)	0 (0.0%)	0
Long-Term Care Services	56 (100.0%)	0 (0.0%)	0	94 (95.9%)	4 (4.1%)	1	150 (97.4%)	4 (2.6%)	1
Mental Health Services	47 (94.0%)	3 (6.0%)	0	80 (87.0%)	12 (13.0%)	0	127 (89.4%)	15 (10.6%)	0
Obstetrics Services	66 (93.0%)	5 (7.0%)	2	82 (93.2%)	6 (6.8%)	0	148 (93.1%)	11 (6.9%)	2
Perioperative Services and Invasive Procedures	114 (99.1%)	1 (0.9%)	0	103 (94.5%)	6 (5.5%)	0	217 (96.9%)	7 (3.1%)	0
Point-of-Care Testing	37 (97.4%)	1 (2.6%)	0	47 (97.9%)	1 (2.1%)	0	84 (97.7%)	2 (2.3%)	0
Rehabilitation Services	42 (93.3%)	3 (6.7%)	0	67 (93.1%)	5 (6.9%)	8	109 (93.2%)	8 (6.8%)	8

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 (97.7%)	2 (2.3%)	0	40 (100.0%)	0 (0.0%)	0	126 (98.4%)	2 (1.6%)	0
Substance Abuse and Problem Gambling	43 (93.5%)	3 (6.5%)	0	77 (93.9%)	5 (6.1%)	0	120 (93.8%)	8 (6.3%)	0
Transfusion Services	83 (95.4%)	4 (4.6%)	9	69 (93.2%)	5 (6.8%)	2	152 (94.4%)	9 (5.6%)	11
Total	**1528 (95.7%)**	68 (4.3%)	21	1990 (95.0%)	105 (5.0%)	20	3518 (95.3%)	173 (4.7%)	41

* 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 (For Surveys in 2021))	Met	4 of 4	3 of 3
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Unmet	3 of 4	0 of 1
Concentrated Electrolytes (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Heparin Safety (Medication Management (For Surveys in 2021))	Met	4 of 4	0 of 0
High-Alert Medications (Medication Management (For Surveys in 2021))	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Mental Health Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Obstetrics Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Perioperative Services and Invasive Procedures)	Met	4 of 4	2 of 2
Narcotics Safety (Medication Management (For Surveys in 2021))	Met	3 of 3	0 of 0
Patient Safety Goal Area: Worklife/Workforce			
Client Flow (Leadership)	Unmet	5 of 7	0 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Hand-Hygiene Education and Training (EMS and Interfacility Transport)	Met	1 of 1	0 of 0
Hand-Hygiene Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Reprocessing (EMS and Interfacility Transport)	Met	1 of 1	1 of 1
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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
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.

Bermuda Hospitals Board (BHB) is a Quasi Autonomous Non-Governmental Organization mandated through legislation to provide quality mental health and acute medical care for the people of Bermuda. The organization comprises King Edward VII Memorial Hospital (KEMH), the Mid-Atlantic Wellness Institute (MWI) and the Lamb Foggo Urgent Care Centre.

BHB is governed by a dynamic and engaged government-appointed Board. The current members bring a diversity of background, experience and expertise, and consider themselves quite representative of the Bermudian population. The Board ensures oversight of key BHB performance and activities and provides guidance and strategic direction to the organization.

In addition to the Board, BHB also has a competent and engaged leadership team and workforce. Employees express appreciation for their colleagues and the support received from managers.

The organization maintains a close relationship with the community it services. It also makes an effort to coordinate with other partners in an attempt to clarify roles and responsibilities in order to ensure continuity of services. An additional complexity stems from the disparate insurance coverage status of the population and the different remuneration models for healthcare providers in the private and public sectors.

Since the last Accreditation Canada survey in 2019, and despite the passage of a global pandemic, BHB has completed a new strategic planning process, resulting in a 2021-2026 strategic plan. Other plans derived from this strategic plan include a BHB Digital Health Strategy, a BHB Enterprise Risk Management Plan, a BHB People Plan, a Quality Improvement and Patient Safety Plan, etc.

BHB also was awarded the Certificate of Distinction for primary stroke care and successfully implemented an organization-wide electronic medical record (EMR).

The organization has recently launched a new quality improvement initiative they named “Wards of Excellence”. This has been rolled out to certain units including the Acute Care Wing, as well as Long Term Care. The objective of this is to encourage creativity and initiative for quality improvement at the unit level.

BHB continues to face challenges in patient flow, causing overcrowding at the Emergency Department. The organization is encouraged to intensively pursue coordination efforts, especially with partner organizations to identify strategies to offer patients therapeutic settings and intensities appropriate for their needs.

In addition, BHB is encouraged to review its bed management and administration, as well as resource allocation to ensure optimal use of all its beds as well as brick-and-mortar resources such as operating rooms, and buildings.

In order to optimize the use of limited resources, BHB is encouraged to define, in collaboration with other stakeholders, its role and responsibilities and limitations to the scope of service it provides so that it can focus on a well-circumscribed range of services, thereby decreasing the possibility of patients “orphaned” without services.

To maximize the investment and minimize the waste of material resources, a more rigorous inventory control process is recommended in order to reduce over-stocking of materials, leading to waste due to expiration.

Health human resources, recruitment and retention remain a significant challenge for BHB. The organization is encouraged to pursue the deployment of its People Plan in order to ensure it has the resources and expertise required to serve the needs of the population.

Detailed Required Organizational Practices

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

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

Unmet Required Organizational Practice	Standards Set
Patient Safety Goal Area: Medication Use	
Antimicrobial Stewardship There is an antimicrobial stewardship program to optimize antimicrobial use.Note: This ROP applies only to organizations that provide acute inpatient care, cancer treatment services or inpatient rehabilitation services.	· Medication Management (For Surveys in 2021) 2.3
Patient Safety Goal Area: Worklife/Workforce	
Client Flow Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors.NOTE: This ROP only applies to organizations with an emergency department that can admit clients.	· Leadership 13.4

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

Unmet Criteria	High Priority Criteria
Standards Set: Governance	
2.1 The mix of background, experience, and competencies needed in the governing body's membership is identified.	!
Surveyor comments on the priority process(es)	

The Board at BHB is a very dynamic, diverse group appointed by the Minister of Health. With the various professional backgrounds, the Board considers itself representative of the community of Bermuda. However, at this time, there is no pre-defined skills matrix for Board member composition. BHB is encouraged to develop a document identifying the desired complement of skillsets for the Board in order to ensure recommendations made to the Minister for the appointment of candidates will meet the Board's needs.

The activities of the Board are well structured, with terms of reference as well as a description of responsibilities for Board members and the various subcommittees. A thorough orientation document is provided to Board members detailing their roles.

The Board has created several subcommittees to assist in the fulfillment of its responsibilities. These committees receive documentation as well as reports on key performance indicators and other quality and risk management data to inform their decisions.

Board members are active in promoting BHB’s mission as well as its position within the continuum of Bermudian healthcare. They also actively engage collaborators/stakeholders in order to facilitate greater system-wide planning and organization.

Board members also perform self and peer skill assessment on alternate years to ensure good functioning and a productive dynamic.

Priority Process: Planning and Service Design

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
1.6 Input is sought from clients and families during the organization's key decision-making processes.	

Surveyor comments on the priority process(es)

The elaboration of the 2021-2026 strategic plan involved extensive community and staff consultation in order to ascertain community needs.

BHB also utilizes demographic data and tools such as “zip code analysis” to identify the specific needs of populations in various parts of Bermuda. An example of the use of this data is the addition of the asthma program to the Lamb Foggo site following an analysis of the prevalence of this condition in the population.

Many other plans such as operational plans and annual plans for each department flow from the overall strategic plan. These plans are still in the rollout phase, and BHB is encouraged to monitor the implementation of these strategies and pursue the roll-out to all areas.

BHB has implemented the initiative to transition from patient-centred care to a people-centred care approach. This organization plans to proceed with this implementation in a very intentional and deliberate manner to ensure an adequate culture shift to accompany this change. As such, the deployment of patient advisors is in a very early stage.

Although BHB makes use of community and patient survey data to drive many of its decisions, the organization is encouraged to pursue the development of patient advisors to integrate patient experience and expertise into its decision-making processes.

BHB has adopted the ADKAR model of change management and has applied these principles successfully to major implementations such as the PEARL EMR. The organization is encouraged to continue the promotion of this practice, such that it becomes a standard part of new projects.

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)

BHB has an annual budget cycle which starts in December of each year, with distribution of historic budget data to each manager responsible for budget centers, followed by discussion and meetings with the budget team and culminating in a final budget adopted by the Board for the beginning of the new fiscal year on April 1. This budget team provides education and support to ensure that managers have the knowledge necessary to validate as well as monitor their budget spendings as the year progresses.

The senior leadership team meets monthly to monitor budget progress and collaborate to find solutions and move resources as necessary to ensure organizational financial health.

As for capital and equipment purchase budgets, BHB is in the process of compiling an inventory of its equipment, with manufacturer's recommended life cycle. The team is encouraged to finalize this exercise in order to proactively plan equipment and infrastructure budgets.

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)

BHB endeavours to coach managers to be accountable for the workplace culture of their department and encourages its managers to maintain close relationships with their employees and have frequent "checkpoints" for timely assessments of staff morale and fatigue. Most staff expressed appreciation for the flexibility and "reminders" offered by their employer to maintain a work-life balance. However, despite efforts by BHB, the general economic conditions of Bermuda are such that most employees need to take on extra shifts or even other employment in order to afford their daily living.

Options to help manage stress and maintain health offered by the employer include an on-site gym at reduced rates, birthday celebrations for staff, etc.

A Dignity at Work program is in place as part of the prevention of workplace violence strategy. Staff seem knowledgeable of these policies and procedures. Most staff indicate that they feel prepared and able to deal with situations where they may be at risk. BHB is encouraged to continue to promote workplace civility and to pursue their communication in collaboration with other partners to remind patients and the general population of their responsibility to treat staff with respect. Given the high rate of foreign workers at BHB, leadership is also encouraged to continue to work with the authorities to facilitate the integration and acceptance of newcomers into Bermudian society.

BHB has a general onboarding for all employees. Departments have developed additional department-specific orientation. The organization is encouraged to pursue this development to ensure that all departments have, in addition to the general orientation, an onboarding program adapted to their realities.

A considerable percentage of BHB staff are recruited internationally. The organization indicates that this recruitment process has been more complex over the past few months because of new government regulations, creating delays and sometimes even limiting the effectiveness of recruitment efforts. Given the challenge of health human resources, the organization is encouraged to pursue discussions with government authorities to find solutions which will facilitate the arrival of new staff.

There exists currently a succession planning and leadership development program for senior leadership. Given the aging workforce as well as the turnover rate, the organization is encouraged to continue the development of leadership for all levels of management, including the development of medical leadership.

The team recognizes that they have difficulty tracking the completion of performance appraisals for staff. BHB is encouraged to complete the roll-out of their new IT system for HR in order to update their HR file-keeping and management systems.

Although a risk assessment was done several years ago, given their priority to address workplace violence, BHB is encouraged to move ahead with its planned gap analysis for workplace violence risk in 2024 and to subsequently develop risk mitigation plans.

To help identify strategies for staff retention, BHB started structured exit questionnaires about 6 months ago. The organization should now be in a position to examine the collected data and begin to adjust its retention action plans accordingly.

Priority Process: Integrated Quality Management

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

Unmet Criteria	High Priority Criteria
Standards Set: Leadership	
12.5 The effectiveness of the integrated risk management approach is regularly evaluated and improvements are made as necessary.	

Surveyor comments on the priority process(es)

A multidisciplinary Quality Council oversees the integrated quality management and improvement activities of BHB.

The organization has recently implemented a “Wards of Excellence” initiative to promote frontline participation and contribution to quality improvement. In addition, quality managers are “integrated” into clinical teams in order to more closely support local initiatives.

To date, the Wards of Excellence programme is rolled out in certain clinical units including the Acute Care Wing inpatient units and Long Term Care. Unit managers and staff interviewed were engaged and demonstrated great enthusiasm toward their involvement in the unit-based quality teams.

A multitude of key performance indicators have been identified and tracked at all levels by BHB. These are presented quarterly to the Board, and more frequently if needed.

Key Performance Indicators are also displayed in patient-care units, and improvement initiatives are also creatively displayed in different formats for staff, patients, and their families. Staff are proud to share the results of their quality improvement efforts, and the recognition they receive from the leadership of the organization in the form of Gold Stars.

With roll out in more and more departments, BHB is encouraged to continue to promote the spread and sustainability of some of the innovative practices that emerge from these local initiatives. Valuable lessons learned can be shared with other units to maximize efficiency and minimize redundancy of effort, and to ensure standardization throughout the organization. In addition, BHB is encouraged to follow its plan to ensure the rollout of the “Wards of Excellence” in other services such as at MWI and non-clinical areas.

While the teams appear to be doing a commendable job of reducing reported adverse events, the leadership of BHB is encouraged to remind teams also the importance of reporting and to find strategies to celebrate reporting of “near misses” as well.

BHB is also transitioning to an integrated risk management structure. The organization is encouraged to continue to build on this momentum and continue this implementation and to evaluate the effectiveness of this approach.

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)

There is a dynamic, engaged, multidisciplinary committee that coordinates ethics support at BHB. This committee is very active and responds to requests for consultation not only from BHB teams but also for clinical and research ethics questions from all of Bermuda.

BHB has adopted the IDEA framework to guide deliberations during ethical dilemmas. This framework seems well known by staff and is used in official consultations as well as some team discussions when necessary.

The Ethics committee expresses appreciation for the structure this framework provides and allows discussions and deliberations to be done in a more objective and comprehensive manner.

One of these consultations resulted in a bed and critical resource prioritization process and procedure for patients during the COVID-19 pandemic.

Although there are community representatives, the committee is encouraged to explore the possibility of formalizing patient involvement to represent the perspective of the organization's patients.

In addition, the team is encouraged to promote organizational learning by seeking strategies to share the results of their deliberations while maintaining confidentiality.

Priority Process: Communication

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

A major rollout at BHB over the past year has been the PEARL electronic medical record. This is the result of careful planning and change management and appears to be a success as most staff appreciate the new tool. The organization is encouraged now to proceed with the next phase of the rollout, including the fine-tuning of report generators in order to extract data for quality improvement and performance analysis, validation of the quality of the data, as well as the creation of a patient portal whereby patients can access their own information.

The leadership of BHB promotes transparency in their communication and posts key performance indicators and other data such as wait times on their external website. There is also an independent Omnibus telephone survey whereby patients from various demographic groupings are contacted to validate their comprehension of key messages transmitted by BHB.

BHB is encouraged also to continue their coordination with the national strategy of promoting health literacy amongst Bermudians, with the objective of promoting the use of the right healthcare resources at the right time across the country.

A multi-prong strategy is used for internal communication with staff to accommodate various degrees of technical and informational savviness. The organization is encouraged to continue the development of their “employee Thinktank” as an additional venue whereby staff can exchange freely with leadership on various topics.

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)

Fleet vehicles including ambulances and those used for adult day programs and home care all receive preventative maintenance and drivers are authorized and provide up-to-date licences. Incidents are to be recorded through RLDatix, following the organizational guidelines.

The Mid-Atlantic Wellness Institute (MWI) has installed a panic alarm system, and all entrances open to the public are staffed with security, who rotate entrances and are connected by radio. Additionally, there is swipe card access to patient areas and video surveillance of the pharmacy and multiple entrances.

A new pharmacy area has been built at MWI, and equipment, physical layout and lighting support a safe and healthy work environment for staff working in the area.

The primary hospital site is divided into an older building and a newer building, the latter being maintained through a subcontract by Black & McDonald. There are procedures for safe work posted especially through newer areas of the building. Generator testing is regularly performed, and the process for providing notice of testing to all staff is included as a process reminder near generators and communicated to all team managers.

Reverse osmosis water supply for medical device reprocessing as well as two areas of water supply for dialysis are well maintained and checked daily. Oxygen condensers and gas lines are also maintained.

Due in part to aging infrastructure, there are some teams who experience constraints in layout and reported a desire to enhance the environment to be more appealing. Infection prevention and control representatives assist the organization in following CSA standards for the planning and execution of construction projects.

The organization completed an update of laundry services with a layout that allows for the separation of soiled and clean linens and more efficient workflows. There were opportunities to ensure the placement of bins to collect soiled linens below laundry chutes. Additional attention to workflows and having both PPE and cleaning supplies more accessible so that workers can perform tasks to prevent infection more easily may be helpful for the organization's staff.

Teams are encouraged to evaluate physical layout with attention to workflow and having required supplies for activities (including hand hygiene) in accessible places and quantities. Attention to regular supply needs to help reduce waste and provide tidy and spacious work environments may be an area where rapid improvement cycles have some effect.

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)

Bermuda is susceptible to a variety of disasters and mass casualty events including hurricanes, airplane accidents, as well as disease outbreaks.

There is evidence that policies addressing pandemic outbreaks including influenza, COVID and other respiratory viruses are updated on a regular basis and based on best available evidence from credible sources. These updates are done in collaboration with the Ministry of Health.

BHB has a disaster management plan, and a new version is in draft form for consultation. The organization is encouraged to rapidly finalize this new plan and proceed with education and training for all staff so they can act with the most recent procedures. BHB participates regularly with other agencies such as the police and fire department as well as the military in drills and exercises of different scenarios.

For local emergency codes, BHB executes drills and exercises regularly, and feedback is provided post-drill to teams for improvement.

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.

Unmet Criteria		High Priority Criteria
Standards Set: Ambulatory Care Services		
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Critical Care Services		
3.13	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
17.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Emergency Department		
4.15	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: EMS and Interfacility Transport		
27.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from patients and families.	!
Standards Set: Home Care Services		
15.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Obstetrics Services		

18.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!
Standards Set: Perioperative Services and Invasive Procedures		
6.12	Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.	
25.3	Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.	!

Surveyor comments on the priority process(es)

BHB had an active patient and family advisory council. The activities of this council have been greatly reduced in the past few years for various reasons including the COVID pandemic. Unfortunately, since the end of the pandemic, the committee has not been able to resume its activities.

With the transition from a patient-centred care approach to one of people-centred care, the organization is encouraged to pursue its revision of the terms of reference of this council, define the roles and expectations of patients and family, and support the activation and continued good functioning of the various instances.

BHB considers itself the “safety net” for patients seeking healthcare and positions itself as the “last resort” for patients. BHB also is coordinating with government authorities and other partners in an attempt to define roles and responsibilities and care pathways. Initiatives such as integrated care for various illnesses as well as the Patient-Centred Medical Home are examples of attempts to lower barriers to service. To consolidate the transition to a People-Centred Care approach, BHB is encouraged to formalize engagement strategies with these stakeholders including patients and their families to ensure that efforts are well-targeted and will respond to the needs of the population.

Service provision and treatment objectives at BHB are generally done in collaboration with patients and their families. Patient-centred care appears to be well established at the clinical treatment level, personifying the phrase “nothing about me without me”. BHB is encouraged to formalize their patient and family engagement strategies whereby patients and their families are prepared and empowered to participate in processes such as the definition of their roles and responsibilities, clinical and administrative processes, etc.

Quality improvement activities occur in a structured manner in areas where the Wards of Excellence initiative has been implemented and in a more organic manner in others. Indicators related to program-specific quality improvement activities were not clearly identified in the latter units during this survey. These services are starting to develop reporting after recently implementing the new electronic medical record. From these indicators, teams are encouraged to formalize quality improvement initiatives with measurable objectives and timeframes for completion and to define and formalize patient and family engagement in these activities.

Priority Process: Patient Flow

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

Unmet Criteria			High Priority Criteria
Standards Set: Emergency Department			
3.1	Client flow throughout the organization is addressed and managed in collaboration with organizational leaders, and with input from clients and families.		!
3.2	A proactive approach is taken to prevent and manage overcrowding in the emergency department, in collaboration with organizational leaders, and with input from clients and families.		!
3.12	Protocols are followed to manage clients when access to inpatient beds is blocked.		
Standards Set: Leadership			
13.3	The organization's leaders collaborate with other service providers and partners to improve and optimize client flow.		
13.4	Client flow is improved throughout the organization and emergency department overcrowding is mitigated by working proactively with internal teams and teams from other sectors. NOTE: This ROP only applies to organizations with an emergency department that can admit clients.		ROP
	13.4.1	The organization's leaders, including physicians, are held accountable for working proactively to improve client flow and mitigate emergency department overcrowding.	**MAJOR**
	13.4.2	Client flow data (e.g., length of stay, turnaround times for labs or imaging, community placement times, consultant response times) is used to identify variations in demand and barriers to delivering timely emergency department services.	**MAJOR**
	13.4.8	Client flow data is used to measure whether the interventions prevent or reduce overcrowding in the emergency department, and improvements are made when needed.	**MINOR**

Standards Set: Perioperative Services and Invasive Procedures	
9.5 Scheduling strategies, such as block times, are used to achieve an optimal flow of clients.	

Surveyor comments on the priority process(es)

Patient flow pressures on the healthcare system are recognized issues for Bermuda Hospitals Board (BHB). The challenges include an aging demographic, limitations in long-term care and assisted living availability and gaps in community resources to support patients and families in the community. BHB is engaged with the Bermuda government and community partners in efforts to address and mitigate these recognized healthcare gaps.

Staff, physicians, patients and families across the organization identified elements of patient flow as the primary concern adversely impacting care delivery and patient experience. It is recommended that the leadership of BHB support staff and physicians in identifying organizational medical priorities in conjunction with the Government of Bermuda, build high-level relationships to support partnerships and defend hospital policy to the media and political representatives.

BHB, in consultation with the community, physicians and staff need to define their clinical priorities and align hospital resources. The scheduled operating room closures to facilitate upgrades are an opportunity to review utilization practices and ensure that the philosophy of the right patient in the right bed at the right time includes operating room beds. Diagnostic imaging and biomedical laboratory services require review to ensure that outpatient services do not adversely impact inpatient access. Ambulatory clinics require oversight to ensure they support program priorities and are not more suitably provided in the clinician's office.

BHB is recognized for its efforts to develop community programs and clinical supports to decentralize healthcare, provide support in the community and prevent patients from requiring emergency services or admissions for their chronic health needs. There is a significant opportunity to build relationships with community partners to expand patient and family support and to break down the many silos that exist between programs.

There are many elements contributing to the patient flow issues experienced within BHB and multiple opportunities recognized by the organization that are planned for review and action as part of the 100-Day Challenge. This multidisciplinary approach to tackling patient flow will require leadership support and resources in order to break down silos and optimize the movement of patients through, and most importantly out, of the hospital. To ensure length of stay (LOS) data is meaningful, long-term care patients need to be identified and excluded from acute care data to provide appropriate metrics for tracking.

Bed boarding (inpatient admissions) in the emergency department is a significant issue and should be the admission location of last resort except in exceptional cases (e.g., imminent air evacuation). The overcapacity plan includes the utilization of surge beds in three inpatient areas. Admission criteria to these areas should be reviewed to ensure that the intent of the overcapacity plan is met and barriers to inpatient admission are addressed. The emergency department should be the admission location of last resort. If the emergency department is utilized as an inpatient unit, then patients in that location require beds and access to allied health professionals so they receive appropriate care without delay.

The porter and environmental services are critical components of patient flow. With the introduction of PEARL, the communication and assignment platform has changed, creating response delays and inefficiencies. The organization is encouraged to prioritize review and trial alternative means of communication. It is recommended that response time be quantified to confirm that changes are having the intended consequence.

Discharge planning is a multidisciplinary approach that needs to begin at the moment of admission. As part of the 100-Day Challenge, barriers to discharge need to be identified on admission with early consultation with community resources. The hospitalist and specialist groups are encouraged to identify all potential discharges for the next day to the patient, other physicians, nurse managers and the bed-flow coordinator. This allows the night shift to prepare discharge paperwork, communicate discharge plans to the patient and identify last-minute barriers, and for the physician to prioritize early morning review.

Diagnostic imaging and laboratory services play a key role in patient flow. Prioritization of inpatient services over outpatient is one element to review to maintain patient flow. Active engagement from these departments to identify opportunities to prioritize services, avoid delays and provide advanced access for early discharged patients are all required to minimize admission time.

EMS services provide patient transfer which is problematic when emergency calls prevent the timely movement of patients. This is particularly problematic when staffing at the receiving residence requires arrival prior to 4 pm. The organization is encouraged to utilize data to determine if there is a business case to support a patient transfer service.

BHB does not have a transfusion unit, forcing staff to provide care in the emergency department, block an inpatient bed or devise unit-specific solutions (e.g., iron transfusions in the blood donor clinic). The organization is encouraged to review utilization data to determine if a transfusion clinic is supportable to improve patient flow, and more importantly, improve patient care and experience.

Patient flow is an ongoing issue and requires frequent review and evaluation to identify areas of strength and opportunity.

Priority Process: Medical Devices and Equipment

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

Unmet Criteria		High Priority Criteria
Standards Set: Reprocessing of Reusable Medical Devices		
8.6	Eating and drinking, storing food, applying cosmetics, and handling contact lenses are all prohibited in the reprocessing area.	!
8.9	Workplace assessments of the MDR department are regularly conducted for ergonomics and occupational health and safety.	!
Surveyor comments on the priority process(es)		

Overall coordination of reprocessing and sterilization activities are reviewed and documented within the organization and practiced with careful attention. Necessary equipment and expertise for cleaning, sterilizing and maintaining equipment is available onsite, and the organization is connected to suppliers and networks of expertise for advice when needed. Contingency plans for sterilizer equipment downtime have been created.

Areas, where equipment is cleaned, are separated into clean and soiled zones, space is at a premium and risk for contamination may be further reduced if the organization were to consider more robust barriers or visual cues to differentiate between clean and dirty areas.

There are educational programs developed and delivered in-house to train technicians, and support for training and review of procedures is supported by infection prevention and control. Diagnostic equipment appears to be clean and well-maintained. The organization may consider alternate storage for clean portable diagnostic equipment that is not accessible or posing any risk to patients (e.g.: portable x-ray in the hallway – though it is recognized that theoretical risk is low in an area of hospital largely accessed by in-patients and medical personnel).

All existing equipment is part of a maintenance program where equipment is tagged and tracked electronically, with items nearing the end of their expected lifespan flagged for replacement as needed. Of note, there are some pieces of equipment which are owned by practicing physicians, but tagged, maintained, and managed by the hospital. Equipment for laundry and within food services areas are not maintained by the same team for medical devices.

Staff who were interviewed over the course of the survey identified that they had received additional support for training and certification through the organization, including education and a growing awareness of training available to them on workplace respect, civility and anti-violence. Areas, where equipment and instruments were maintained and reprocessed, were mostly well-lit, though space for all activities may be somewhat challenging, especially related to endoscopy cleaning/reprocessing and medical device repair and maintenance. Areas which provide sufficient ventilation, lighting and temperature control may be more difficult to achieve in older areas of the building (for example, basement level).

The introduction of an electronic system and dashboard showing OR and PACU needs in real-time within areas where sterile processing occurs was reported by staff to have led to major improvements in planning and supporting in-time availability of all necessary sterile equipment to reduce waste and delays in care.

The department is staffed 24 hours per day, and though the staff is often not required overnight, the availability of reprocessing and assistance to obtain necessary supplies is identified as a need for providing safe tertiary care.

At the unit level, some clean equipment storage areas also had staff lunch. Individual pieces of equipment were observed to have identifier tags and barcodes, as well as stickers showing the last service, however, cleaning of equipment often makes the last service date illegible. The organization may wish to clarify available training and assessments to support ergonomic health for all staff, including those working primarily with devices and medical equipment.

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		
6.4	The organization works with primary care providers, partners, and other organizations to integrate information systems.	
6.5	The organization uses the information system to generate regular reports about performance and adherence to guidelines, and to improve services and processes.	
7.1	The organization identifies and monitors performance measures for its services for its priority population(s).	!
7.6	The organization shares information about its successes and opportunities for improvement, improvements made, and what it is planning for the future with staff, service providers, clients and families.	
Surveyor comments on the priority process(es)		
Priority Process: Population Health and Wellness		

The organization does monitor statistics for the volume of visits in departments and information about the demographic makeup of the population served. Target populations are somewhat defined by the program. Clients and families are invited to participate in providing feedback on service in a number of ways, ranging from formal invitations to participate in advising the organization, to informal feedback shared with individual staff.

Leaders and many staff who were interviewed throughout the survey commented on the desire to ensure preventative services and support for after-care to prevent the need for acute service is a priority, and this involves programs which strategically target outreach for clients who may experience socioeconomic barriers to care, as well as outreach to provide a rapid response to at-home support required for successful discharge from hospital.

While the organization does dedicate resources to services and programs for priority populations, it is acknowledged that ongoing work to leverage all available community resources and partnerships is needed since providing community care without resourcing leads to significant compromises to the quality of care provided, thus negating the intended impact of reducing the need for more expensive acute services.

The organization has started to develop its capacity for reporting and managing reporting through the new electronic medical records system, and as this capacity grows, writing to audit adherence to guidelines and performance across all units will improve. The survey did not identify evidence of regular reporting and subsequent improvements to services and processes done consistently across the organization.

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		
2.6	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
	The organization has met all criteria for this priority process.	
Priority Process: Episode of Care		
6.2	When scheduling services, set criteria are followed and input is gathered to ensure clients with the most urgent needs are seen first.	
Priority Process: Decision Support		
	The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes		
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Services visited during this survey included the Patient-Centred Medical Home, Dialysis Unit, Out-patient clinic, Orthapaedic (Fracture) Clinic and wound Care Clinic, and Hyperbaric Services at BHB, as well as the diabetes clinic and integrated care team mental health clinic at Lamb Foggo.

Initiatives such as integrated care for various illnesses as well as the Patient-Centred Medical Home are examples of attempts to lower barriers to service. To consolidate the transition to a People-Centred Care approach, BHB is encouraged to formalize engagement strategies with these stakeholders including patients and their families to ensure that efforts are well-targeted and will respond to the needs of the population.

Although patient feedback is informally gathered, the organization is encouraged to formalize structures by which input can be channelled in order to evaluate the effectiveness of resource deployment. In addition, in some sectors such as the diabetes clinic, the team is encouraged to resume patient experience surveys to ensure that the services provided meet the needs of its patients.

In some areas, the service is provided by one key person. BHB is encouraged to explore possibilities for backup solutions to avoid service interruptions in case of absence (eg the nurse practitioner at the Patient-Centred Medical Home and the orthopedic clinic manager who is the only staff person qualified to apply casts).

Priority Process: Competency

The teams offering ambulatory services are encouraged to explore strategies to include patient and family input in identifying priorities for education and training for its staff. This could be done by means of areas of improvement identified through patient feedback, etc.

Teams employ a collaborative approach to provide care. Whenever possible, teams facilitate the patient's presence by attempting to group appointments with multiple team members on the same day.

Staff in administration/reception roles express experiencing frequent verbal aggression from patients. Although most staff observed during the survey demonstrate compassion and appear to be able to de-escalate these situations. BHB is encouraged to continue to promote the importance of civility and its zero-tolerance policy to all stakeholders.

Priority Process: Episode of Care

Requests for most ambulatory services are done on standardized paper forms. Some services report that required information is not always complete, thereby causing delays in initiating service. BHB is encouraged to continue to inform and educate its referring partners on the importance of a complete referral, and to seek electronic strategies to ensure rapid and complete transmission of this information.

In all ambulatory services programs visited during the survey, there were respectful professional relationships with their patients. All clinics demonstrated respect for the 2-person identifier policy.

Patients interviewed all expressed satisfaction with their experience. Most are grateful for the services. Patients who received services at the Lamb Foggo Urgent Care Centre also appreciate the proximity and convenience of services close to where they live. Integrated mental health team patients also mention the convenience of having appointments with multiple healthcare professionals on the same day at the same place. However, to this point, the team indicates that the "integrated" portion of integrated care teams is yet to be developed to its full potential. The organization is encouraged to pursue this development in order to maximize the anticipated value-added of these services.

The implementation of PEARL has allowed ambulatory service clinics to standardize their clinical documentation and information communicated during transfers of care.

Priority Process: Decision Support

Although teams appear to embrace the PEARL electronic medical record system, some teams continue to complete certain documentation and processes manually. BHB is encouraged to continue support for these teams to optimize the data collection and reporting capabilities of PEARL to facilitate data mining for staff, thereby minimizing the risk of errors by transcription.

Priority Process: Impact on Outcomes

Most ambulatory clinics provide services according to guidelines and protocols. These are reviewed and revised periodically considering patient feedback as well as best available practice information.

Although some services have undertaken quality improvement activities, not all clinics have been able to demonstrate QI initiatives. With the indicator information that the teams collect on their own services, as well as incident data and patient feedback, teams are encouraged to replicate the Wards of Excellent approach, identify quality improvement opportunities, and build projects to improve their activities.

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		
7.2	The laboratory has sufficient space to carry out laboratory services.	
7.7	The laboratory's space for record keeping and other administrative activities is separate from pre-analytical and analytical testing areas.	
29.4	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
29.6	The team regularly monitors the use of its services and uses the results to learn about the appropriate use of laboratory services.	
29.8	The team designs and tests quality improvement activities to meet its objectives.	!
29.11	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
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.	
29.17	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Universal fall precautions are applied throughout the departments in which biomedical laboratory services are provided.

Priority Process: Diagnostic Services: Laboratory

The Biomedical laboratory team is commended on being accredited by the Joint Commission International in 2021.

The BHB laboratory provides outpatient phlebotomy services. The phlebotomy team provides excellent service with sound processes for booked patient appointments.

The Biomedical laboratory team has outgrown its space. The team has done a remarkable job in dividing spaces to support the wide variety of specialized tests and functions completed within the laboratory service despite the spatial limitations. The technologists collaborate well within and between teams and understand their role in providing excellent service and supporting patient care. The team is encouraged to review opportunities to maximize space and function as equipment is replaced and/or space becomes available.

The transition to PEARL and electronic documentation is in the optimization phase and the team is encouraged to identify opportunities to further transition from paper-based process to electronic through existing mechanisms and the potential introduction of tablet technology to complete worksheets and forms. There is an opportunity to decrease the amount of paper throughout the department.

The Biomedical laboratory team does not have a phlebotomy team and laboratory resources are located throughout hospital departments. Large quantities of laboratory tubes and other equipment were found throughout the facility. Expired laboratory equipment was found in multiple locations, mixed in with unexpired tubes. This increases the risk of error in accidentally using expired equipment. Reducing quantities of laboratory (and other equipment) throughout the hospital will reduce waste and improve patient safety. BHB may consider adjusting its procurement and redistribution processes to improve accountability in resource management.

The Biomedical laboratory team does an exceptional job in quality assurance and is beginning the process of identifying quality improvement opportunities. The team measures indicators for quality improvement initiatives but objectives have not been identified. The staffing pressures in the laboratory are significant and the department is encouraged to prioritize quality improvement initiatives and limit efforts to specific concerns with definable targets. Limiting the focus will assist the staff in identifying and targeting a pertinent area without fatiguing limited staff resources.

The team monitors the use of services but does not use the results to review whether laboratory use is appropriate. As the team moves forward in its quality journey and becomes familiar with PEARL capability, the team may consider utilization data to review and trend lab test utilization to identify targets of educational opportunity.

The Biomedical laboratory team is part of the organizational patient flow strategy. Reviewing test prioritization to ensure processes support admission criteria and discharge planning should be prioritized.

The morgue is clean and well-situated for its purpose. The infrastructure is dated and, should the opportunity arise, upgrades to the ventilation system should be considered to limit the spread of infectious particles and mitigate the impact of fumes.

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		
27.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
27.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
27.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
27.5	Quality improvement activities are designed and tested to meet objectives.	!
27.6	New or existing indicator data are used to establish a baseline for each indicator.	
27.14	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
27.15	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
27.16	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
27.17	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Priority Process: Medication Management

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The cancer care unit is spacious and designed with patient comfort and safety in mind. There are highly engaged clinical and leadership teams. Although there has been some staff, physician, and leadership turnover the clinic has well-established protocols and practices that have resulted in minimal disruption to patient flow and established routines. The introduction of the electronic health record and partnerships with well-established international leaders in the field with whom the service collaborates supports the service to meet standards that ensure equivalent care to clients who travel abroad for similar programs. Proactive partnerships with organizations such as PALS and the Bermuda Cancer and Health Centre support efforts to ensure a coordinated continuum of care.

The unit currently consists of three physicians, five nurses, a pharmacy, and admin support. The team is highly collaborative on a day-to-day basis and has mechanisms such as tumour boards in place to be proactive about planning but identifies pressures related to physician turnover and workload that represent an opportunity for improvement. They express a desire to formalize the navigation role to support people who come to the clinic with a cancer diagnosis. These items point to the value that a more organized and proactive approach to continuous improvement might bring.

To address program and leadership continuity and succession planning issues it would be helpful to identify and support leaders and emerging leaders to develop their competencies to lead and take a more structured and standardized approach to ongoing improvement at the unit level.

Priority Process: Competency

There is a team of three physicians and five infusion nurses. There is an in-house pharmacy and administrative support. The clinic works closely with community partners to optimize continuity of care. There are established relationships to coordinate care with tertiary services that are accessed overseas including secure access to information systems to ensure information transfer. The team works closely together to ensure timely access to services at transition points across the continuum of care and has taken the initiative to address quality improvements around things like time from referral to assessment and treatment, sufficient notice for the pharmacy to prepare infusion meds in a safe and methodical way, tumour boards, and regular care conferences and progress updates to clients.

The unit accesses allied health and other professional supports from the hospital's inpatient resources and via partnerships with other community services to address navigation challenges that clients may experience beyond episodes of care at the clinic. Additional administrative support and an in-house navigator have been identified as potential quality improvement initiatives.

Infusion pumps are standardized across the hospital and regular training and instruction can be accessed through the online learning management system.

Staff and leadership in the clinic are highly engaged and passionate about building on the work of the people who initiated the service but do identify that a more proactive approach to quality improvement would support more focused efforts to achieve key performance indicators and advance strategic priorities.

Priority Process: Episode of Care

The oncology unit at BHB is a modern, well-equipped facility that operates out of the acute care hospital five days per week. The clinic is staffed by three physicians, five RNs, an in-house pharmacy, and administrative support. Allied health and other corporate services can be accessed from the hospital as required. Over the past decade, the clinic has established a well-utilized service that was previously referred exclusively to international locations, thereby allowing residents of Bermuda access to cancer care close to home.

There are several key partnerships that come together to provide services with the common goal of developing and strengthening the continuum of cancer care services. These include PALS, Bermuda Cancer Care, and Healt Centre. Although the team has mechanisms in place to collaborate and to support clients to navigate the system and to mitigate risks of miscommunication at care transition points it has been identified that having a navigator dedicated to the unit would improve patient-centred care and facilitate input from clients that could inform quality improvement initiatives.

There are relationships with tertiary centres abroad to support clinical practice and to facilitate care for patients who choose to go abroad or who must go abroad for care while also attached to the clinic. This includes approved and secure access to IT systems in some cases so that information transfer can occur seamlessly.

There is a focus on staff and patient safety. Medication reconciliation, suicide risk assessment, and fall assessment and prevention are covered in the admission processes and documented in the EMR, and PEARL. The EMR is not yet used to its full potential, but staff are finding it to be a useful tool for standardizing documentation, guiding staff and patients through care pathways, and scheduling services in a timely way. There is interest and engagement in discussions about selecting and developing customized reports that could inform practice and support evidence-based decision-making. For example, there is currently a manual data collection and input process to track and improve wait times from referral to assessment and treatment. This is the type of report that will eventually be accessed from the EMR.

The clinic uses NCCN guidelines and protocols from the British Columbia Cancer Agency to guide decision-making for treatment services provided at the clinic.

For standards related to patient and family-centred care and quality improvement staff generally refer to the conversations between physicians and their patients upon admission and throughout the treatment process. It is recommended that the clinic participate fully in the relatively new BHB improvement initiatives to take a more structured approach to both Patient Centred Care and Continuous Quality Improvement. There is interest and engagement in these discussions at the unit level, but the clinic identifies that with such a small staff focused on direct care delivery they could use the support of a Quality Improvement facilitator/educator that is more hands-on.

Priority Process: Decision Support

The clinic uses the Pearl EMR and other online resources available throughout the hospital to document care, search for information, schedule appointments, and support improvement and continuity of care. The EMR is relatively new as are the current selected key performance indicators. There is an opportunity to make better use of the data available in the EMR to support management decisions and quality improvement. It is also notable that the clinic has some data-sharing agreements that facilitate the transfer of information with tertiary centres overseas using unique identifiers to access those systems.

There is an online incident reporting and management system as well as access to education and professional development resources.

Priority Process: Impact on Outcomes

The unit references NCCN Clinical Practice Guidelines and the British Columbia Cancer Agency's protocols to inform and guide best practices. The PEARL EMR provides the mechanism to input data at the point of care and extract management reports to support quality improvement work.

There is a highly engaged team in the unit who identify the need and desire to learn more about proactive quality improvement. The team has selected key performance indicators and is focused on providing and continuing to develop a program that is equivalent to internationally recognized leading practices so that people in Bermuda can receive excellent care as close to home as possible.

It is recommended that consideration be given to the provision of more concentrated support to the unit for a more structured approach to Continuous Quality Improvement and building the capacity of leaders and emerging leaders to facilitate, implement, and sustain quality improvement initiatives.

Priority Process: Medication Management

There is an in-house pharmacy on the unit. The pharmacy uses established professional guidelines for the safe preparation and dispensing of systemic cancer therapy medications. There are processes in place for independent double checks prior to meds leaving the pharmacy and prior to administration.

Specific attention has been paid to the movement of systemic therapy medications from contaminated to clean areas in the pharmacy due to the design of the physical space. Staff are well versed in the safe handling, storage, and disposal of hazardous waste. Cleanup kits are readily available in any area where infusions take place.
The team develops power plans/care plans using standardized protocols. These are discussed and agreed to by clients prior to initiation and at regular intervals throughout the treatment process.

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		
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
17.5	Quality improvement activities are designed and tested to meet objectives.	!
17.7	There is a process to regularly collect indicator data and track progress.	
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There is a highly engaged community mental health team with leadership support in place. The service is made up of community mental health services delivered to clients in the community and at the MWI by a multidisciplinary team of physicians, nurses, and allied health workers. The programs are divided into acute services for people who may require brief, episodic, or medium-term interventions and rehabilitation services that deliver care to individuals with serious and persistent mental illness. The leadership team values community partnerships and recognizes that a coordinated and responsive continuum of care should be a strategic priority.

Recently the organization has participated in education and discussion about organizational efforts to adopt a recovery model and move away from the medical model of service delivery that has been historically associated with MWI as a psychiatric institution. The team is early in this journey, but leadership is committed to being at the table with its internal and external partners to explore current practices and future initiatives that lead in the direction of a strengths-based recovery model that is designed to optimize client-driven care in the future.

This is a relatively small team that has experienced significant staffing challenges so change management and continuous quality improvement initiatives are gradually being discussed and introduced while point-of-care leaders are often pulled into day-to-day service delivery to ensure continuity of care as a priority.

There is recognition that as much as possible the team needs to be represented at tables that include private, NGO, and government partners who will be key stakeholders in a national strategy for mental health that staff say has only been released in recent weeks.

Priority Process: Competency

There is a small multidisciplinary team that provides acute and rehabilitation services to the mental health population. Staff have current job descriptions and a process to receive feedback on performance on a regular basis. The biggest barrier to this is challenges with recruitment and retention.

Staff state that they feel supported in their work and that there are policies and mechanisms in place to promote a culture of safety and to prevent violence in the workplace. It is recommended that effort be put into raising the profile of workplace violence prevention and promoting a culture of safety.

Currently, staff and leaders involved in these tracers describe workplace violence prevention as if it is primarily an issue of client-on-staff violence, which tends to lead to a discussion about how to minimize risk with the use of chemical and even physical restraints. Staff responded to discussions about “culture of safety” and “patient safety and staff safety must both be priorities” in a more engaged and collaborative way.

Staff do state that they feel supported with professional development opportunities.

Priority Process: Episode of Care

The EMR does support a rigorous process in terms of intake, assessment, care planning, discharge, and referral for clients of this program. Staff were observed to be engaged, compassionate, and compliant with standards when delivering care. Community-based care was delivered safely and respectfully in community and home settings with evidence that clients are listened to and responded to based on their rights and responsibilities for their well-being, what the legislation says, and how to work with the system to have their concerns and expectations addressed.

The service delivery model is defined as a case management model, meaning that clients have a say in their care, but that care may require significant navigation through a variety of services and programs provided by various stakeholders.

Leaders and staff facilitate and participate in interagency forums and care conferences to advocate for their clients and do see the value in pursuing a model of service delivery that is better coordinated and more easily directed by clients who have the capacity to make decisions for themselves, and for their substitute decision makers when applicable. To this end, there is interest in continuing to explore the recovery model with the understanding that there should be an acknowledgement of how far some services have already come. Staff identified a need for some assurance that this is an improvement journey as opposed to a budget-cutting exercise. Deliberate attention should be paid to good practices for leading a change of this magnitude in a small organization with longstanding adherence to an institution-based medical model of service delivery.

Priority Process: Decision Support

The unit uses the PEARL EMR and some paper chart backups to ensure continuity between old and new patient records. In some cases, pertinent documents are scanned into the EMR. The EMR does provide the software to follow a logical process in terms of the patient journey from referral through to discharge, but it is evident that staff are still adapting to the technology. For example, nurses talked about creating care plans in the format that was used pre-EMR and scanning them in. There was discussion about the EMR not being as logical for community-based care as it is for inpatient acute services. It is recommended that the opportunity to address concerns such as this and explore opportunities to customize the software and address identified opportunities for improvement so that staff remain engaged.

Priority Process: Impact on Outcomes

The team is highly collaborative and does invite feedback from clients in its efforts to evaluate performance and make decisions about service design but there is plenty of opportunity to do this in a more deliberate way.

The organization is encouraged to continue its efforts to approach quality improvement in a more deliberate, interactive, and visible way.

The EMR is relatively new but has the potential to produce reports by sourcing data entered in real-time at the point of care to help with the selection, monitoring, and achievement of outcomes anticipated from an increased focus on key performance indicators.

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		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
17.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
17.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
17.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

BHB Intensive Care Unit (ICU) is a nine-bed unit which includes one room equipped with pediatric equipment. The unit includes two negative pressure rooms.

The ICU is spacious, well designed and appropriate for the care provided. The unit is led by the Anesthesia team who work closely with the hospitalist group which admits and manages "step-down" patients who don't meet ICU criteria but require closer observation and acute nursing skills.

The ICU team is energetic and passionate about acute care medicine. Patients and families interviewed speak highly of their compassion and skill. The multidisciplinary team meets daily to identify opportunities for clinical progression and barriers to discharge to a lower level of care. The entire team impresses as being professional and respectful of the range of occupational expertise.

Due to the significant patient flow issues impacting the organization, it is not uncommon for ICU patients to be discharged directly to the community. The critical care team needs to adjust and address community discharge requirements earlier in the admission process as many patients skip admission to the medicine ward.

Priority Process: Competency

The critical care team maintains the required competencies and training through organization-led training, educator-facilitated competencies and peer training within the department. Continuing education opportunities are supported by the leadership.

Acute care training is encouraged and increasingly taken by nursing staff in less acute areas, improving comfort with managing acuity on the floors, especially in areas where telemetry is utilized. This trend should be encouraged and facilitated.

With the implementation of PEARL, there is an increased capacity to flag concerning vital signs and deteriorating patients. Early management by the critical care nursing team to support inpatient nurses to stabilize patients and prevent ICU admission may be beneficial for competency development as well as the clinical benefits to the patient.

Priority Process: Episode of Care

The intensive care unit at BHB manages acutely ill patients who require a higher level of care. BHB does not have a step-down unit, so the intensive care unit manages two populations - intensive care patients and medically ill patients who require a higher level of nursing care and monitoring. The unit may consider formalizing this distinction to support decisions on assignment between anesthesia-managed and hospitalist-managed patients.

Patient flow is a significant issue for the department and bed blocking through the inpatient departments limits the capability to discharge patients to an appropriate bed. Patient flow needs to be addressed throughout the organization so that patients can receive care appropriate to their condition.

Mobilization has always been a priority for intensive care staff, and they are formalizing their processes through an Activity Mobility Programme to standardize expectations for patients to mobilize. Staff are currently being trained on program components and are excited to formally begin following the protocols.

With increased mobilization and longer stays the team needs more equipment to support their efforts. Support and lift devices, particularly for bariatric patients, are required for the team to safely mobilize patients. A review of available equipment and gaps in capability should be undertaken with patient and family involvement.

Patient and family input should also be obtained to determine other areas in which their stay can be improved. Entertainment for step-down patients and mitigation measures for noise and light to improve patient sleep and experience are areas of opportunity on which patient and family feedback could be collected.

Multidisciplinary rounds take place daily to discuss plans and identify barriers in patient care. They demonstrate a respectful and collegial working relationship. Where possible, the team is encouraged to include the patient and family members in discussions to improve understanding and participation in care.

Priority Process: Decision Support

The introduction of PEARL has streamlined communication within the intensive care environment and with other units. The team spoke positively regarding the impact of the electronic health record on practice.

The intensive team remotely provides secondary monitoring of the telemetry patients located throughout the inpatient departments. When upgrades are considered, the department may consider improving the functionality by improving the alert system to notify the nursing team when there is a telemetry anomaly requiring review.

Priority Process: Impact on Outcomes

The quality improvement activities at BHB were significantly set back by the COVID pandemic, limited due to PEARL implementation prioritization and continue to be hindered by staffing shortfalls. The organization has partnered with Johns Hopkins for support in re-energizing the quality improvement journey.

The critical care team is excited about the training received on the Activity Mobility Promotion programme and looks forward to formally implementing it in the department.

The team is encouraged to regularly collect objective data as well as patient opinions about the program to assess the strengths and opportunities of the initiative. Sharing the program and successes with patients, families and the wider community is also encouraged.

Priority Process: Organ and Tissue Donation

Bermuda Hospitals Board partners with the New England Organ Bank (NEOB) to provide organ donation services to the supported population. The policies and procedures supporting this program are developed with the NEOB and the Organ Procurement & Transplantation Network (OPTN).

It was noted that outdated printed information was available in the department. These should be removed so teams utilize the updated online documents.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
17.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
17.5	The team collects, analyzes, and interprets data on the appropriateness of examinations, the accuracy of the interpretations, and the incidence of complications and patient safety incidents.	!
17.9	The team designs and tests quality improvement activities to meet its objectives.	!
17.12	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
17.13	The team implements effective quality improvement activities broadly.	!
17.14	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
17.15	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

The Diagnostic Imaging Department at BHB provides digital radiography (x-ray), ultrasound, CT, MRI, bone density, nuclear medicine, mammography and cardiac diagnostics. The departments are in multiple locations due to legacy and specialized building requirements. The department is encouraged to facilitate creative ways to build and maintain connections between and within departments to bridge the physical separation.

The Lamb Foggo Urgent Care Centre includes x-ray capability on some days, currently only on Sundays. A review of utilization and positive yield may assist the organization in determining appropriate hours for this service.

The technologists report feeling well supported by the radiology team and can access radiologists promptly when required. The technologists can access career education opportunities and development and several spoke positively of their experience and the support received by the organization.

The team tracks wait times for different modalities and there is an opportunity to review and identify bottlenecks to improve the patient experience. Diagnostic imaging plays a significant role in patient flow, and identifying barriers to timely examinations is critical. Quantifying gaps in support will help to identify quality improvement opportunities.

The main ultrasound area is co-located with mammography and most interventional radiology procedures are performed in this area. The nuclear medicine department has multiple rooms suitable for the preparation, injection and scanning of patients. Cardiac diagnostics performs a variety of high-demand services.

The single MRI and two CT machines are well set up to support the processes and patients. It was noted that CT technologists are frequently called in and do not have access to a call room. Consideration of a call room for technologist's use may be considered to improve safety and reduce technologist fatigue.

Outpatient imaging services are a significant proportion of the workload for every modality. As there are community resources available for many modalities, the team is encouraged to review and optimize processes to ensure that inpatient services are prioritized to support patient flow through the emergency department through admission and timely discharge.

One area that is a source of frustration for the patient, physicians, referring department and imaging is absent or incomplete requisitions resulting in delayed or cancelled imaging. The teams are encouraged to work together to develop processes to mitigate this risk and with IT to include questionnaires and consent as mandatory fields within the requisition.

The Bone Density room opens directly onto a busy corridor. It is suggested that the door include signage that explicitly deters interruptions and directs all questions to the ultrasound reception to prevent imaging interruption and maintain patient privacy.

Unnecessary secondary imaging is a concern, predominantly in digital radiography and CT. This issue could be reduced with educational engagement between the radiologists and emergency physician staff.

No-shows are an issue at variable rates throughout the department. The teams indicate that a proportion of these situations are due to the patient being unaware of the appointment due to confusion between the referring physician's office and the DI department. This needs to be clarified as ultimately, it is the patient who suffers.

Each team is interested in Quality Improvement initiatives and encouraged to identify specific areas with objective measurements to improve performance throughout the department.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
12.3	Client privacy is respected during registration.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
18.11	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
18.13	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	
Priority Process: Organ and Tissue Donation		
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 King Edward VII Memorial Hospital (KEMH) is well-signed, clean and bright. Patient care rooms are spacious and include appropriate equipment for patient care activities. The department has been designated into zones to prioritize patients and facilitate clinical care.

The Lamb Foggo Urgent Care Centre provides non-emergency care within well-equipped clinic spaces. The BHB team is trialling variations of opening hours to determine a model that continues to provide medical services at the site in the context of low volumes. The organization is encouraged to continue monitoring for opportunities to maximize the clinical spaces available to decrease volume from the KEMH site and optimize ambulatory clinic opportunities. The move to incorporate community care clinics for a range of chronic disease care is an exciting opportunity to more fully utilize this space and disperse access to care from the primary King Edward site.

A review of resources stocked in the rooms at KEMH and at the Lamb Foggo site is recommended to ensure that they are appropriate to the services and volume of services offered. A program of review and re-distribution from the low-volume to the high-volume site to minimize expiration may provide an opportunity to prevent stock loss. It was noted that expired supplies were stored at Lamb Foggo in multiple locations and should be moved for destruction. At KEMH, recommended stocking levels in each patient care room were exceeded and included medical supplies not intended for storage in patient care areas. Expired medical supplies were also found in multiple rooms. It is recommended that the leadership ensure that supply requirements are validated with maximum and minimum levels, medical supplies are routinely rotated for use to prevent expiration and that sites are regularly audited to ensure that supplies are not stored inappropriately.

Questionnaires and website support for feedback from patients and families are utilized. The introduction of QR codes in addition to website access and paper questionnaires is excellent. It is noted that the QR code posters are busy and unclear as to their purpose. Simplifying and placing them in immediate patient and family proximity in waiting and patient care areas may increase utilization.

Community partnerships continue to develop to support patient care. The organization is encouraged to continue to develop these partnerships to improve the continuity of medical care and expand access.

Priority Process: Competency

The Emergency Department provides education and training specific to their department as well as facilitating organization-wide training. Physicians and staff are supported by Educators and a robust online educational platform.

Mentorship for new staff in the department is facilitated, including adaptation of modules to define training requirements for nursing staff to transition into the acute care environment. The nurse leadership is mindful of the need to balance the development and mentorship of new staff with the workload and capacity of the current staff.

Priority Process: Episode of Care

The emergency department team is energetic and enthusiastic about emergency medicine. Although frustrated with patient flow issues, they contribute practical ideas to improve the system and move patients out of the department. The physicians and staff work together to maintain focus on the patient.

The addition of geriatrician consultation has been beneficial in managing patients and the rapid consult service successfully prevents admission in some cases. Further efforts to prevent admission using community services are supported.

The triage room is utilized as designated until the FastTrack opens late morning, at which time the triage function moves forward and adjacent to the waiting room. The emergency team is congratulated on their flexibility in utilizing available spaces to maximize flow through their department. The forward triage area has great sightlines across the emergency waiting room which allows the triage nurse to visually monitor those waiting to be seen. The organization should consider the installation of a plexiglass enclosure to improve privacy for patients being triaged and permanently utilize this as the primary triage space.

Patients noted that due to the microphone system used at registration, they were able to hear the patient information in the adjacent cubicle and be heard by other patients and families. The department may consider utilizing a headset to facilitate communication at a lower volume to improve confidentiality and privacy.

The KEMH Emergency Department and the Lamb Foggo Urgent Care Centre would both benefit from a review of the quantities and types of medical supplies held in the respective departments and in patient rooms. The Medication Management team should also be engaged at the Lamb Foggo site to ensure the types and quantities of medications held are appropriate.

The crash carts at KEMH are standardized. The crash cart at Lamb Foggo Urgent Care Centre is not standardized with KEMH and should be reviewed to ensure that the components are required in the context of urgent and ambulatory care clinics. BHB may determine that an emergency room crash cart is not required and could be replaced by an AED, minimizing the medication, medical equipment and nursing checks required. It was noted that the Lamb Foggo crash cart did contain expired medication and equipment.

Patient flow significantly impacts the emergency department and its ability to assess and treat emergency patients. Patient flow has been identified as a priority and the 100 Day Challenge should help to improve communication and break down the silos that impact flow.

Priority Process: Decision Support

BHB has done a commendable job in introducing and implementing PEARL - the electronic medical record. The physicians and staff report feeling well-supported through the transition.

There are concerns that some functionalities and efficiencies have not been addressed. From a patient safety perspective, the high frequency of low-level medication alerts increases the risk of an important alert being ignored. BHB leadership is encouraged to engage IT, the Medication Management team and the Emergency Department physicians and staff to define and address areas to improve platform functionality.

Priority Process: Impact on Outcomes

The Emergency Department has identified Quality Improvement initiatives to address the concerns identified. The team is encouraged to continue with these efforts and to ensure that these initiatives are shared within the department, with patients and families and throughout the organization.

The switch to telephone from in-person handover from the Emergency Department to inpatient units demonstrates early promising results. The team is encouraged to continue to identify opportunities and develop initiatives to improve patient flow.

Patient safety is a priority for the department and all staff are aware of how to report incidents. The department is reminded to encourage staff to report all incidents as well as "good catches" and to ensure that reports are followed up so that staff know that their reporting is being reviewed.

Priority Process: Organ and Tissue Donation

Bermuda Hospitals Board partners with the New England Organ Bank (NEOB) to provide organ donation services to the supported population. The policies and procedures supporting this program are developed with the NEOB and the Organ Procurement and Transplantation Network (OPTN).

Standards Set: EMS and Interfacility Transport - 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		
5.17	Remedial or supplementary training and education is provided to team members to improve their skills and performance.	
5.23	Ongoing professional development, education, and training opportunities are available to each team member.	
Priority Process: Episode of Care		
16.1	A protocol is followed to determine if a mission will be accepted.	!
Priority Process: Decision Support		
23.7	Policies and procedures for securely storing, retaining, and destroying patient records are followed.	!
Priority Process: Impact on Outcomes		
27.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, 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.	
27.6	Quality improvement activities are designed and tested to meet objectives.	!
27.7	New or existing indicator data are used to establish a baseline for each indicator.	
27.9	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
27.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
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

9.8	There is a process to follow when team members are not immunized.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Emergency Medical Service includes Basic and Advanced Emergency Medical Technicians. Wherever possible, the ambulance team includes both to provide service to the community and mentorship within the team.

The team has made significant progress in standardizing ambulance setups and streamlining available equipment. The six ambulances include three different vehicle generations with minor variations in configuration. The ambulances are well set up to support the teams and their ability to provide pre-hospital care.

EMS teams are dispatched by the Fire Department. There is an opportunity for dispatch to note potential logistical challenges for the ambulance and for the EMS team including laneway limitations and stairs. This information can support the early utilization of fire department staff to assist with patient movement when required. Dispatch also collects notes on potential safety concerns. This collection and passage of information is critical for the safety of EMS crews and for identifying support requirements early to minimize response time and transport to the hospital.

BHB does not have a patient transfer service and relies on EMS to move patients who are unable to sit, from the hospital to their residences. This is a discharge barrier as EMS must prioritize emergency response which frequently delays transport. Further, most transportation to staffed residences must be completed prior to 4 p.m. or the receiving staff are unable to accept the patient. This combination of factors requires that scheduled patient transfers must be planned for the early morning and must be considered in discharge planning.

Tracking the number of patient transfers, appropriateness of the request and measuring delays in service and the impact on patient flow may be considered to identify opportunities to improve this element of the discharge process.

The Emergency Department staff in conjunction with EMS clinically assess and triage ambulance patients, which includes placing patients in the waiting room when appropriate. The Bermuda public may benefit from further education on appropriate EMS utilization.

Priority Process: Competency

The team receives required training, but several frontline staff noted an absence of ongoing competency reinforcement. When the annual testing takes place, they are concerned that those who fail are not provided with adequate supplemental training. Ongoing and regular opportunities to practice skills and review competencies were requested by several staff.

The EMS team receives the mandatory training required by BHB and for licensure but feels excluded from other educational opportunities. They are not prioritized for clinical courses offered by BHB and EMS-specific hands-on training is limited. They appreciate the monthly lectures and case reviews provided by the Medical Director.

Due to the nature of their work outside of the hospital facility, it can be challenging for educators to find opportunities to provide education and skills for the EMS team. The Educator is encouraged to work with the EMS manager to overcome this barrier and provide these opportunities.

Priority Process: Episode of Care

The EMS team at BHB is a dynamic group that enjoys the challenge of pre-hospital medical care. They are keen to improve and expand their skills and competencies and provide quality patient care.

When ambulances are dispatched, trackers can pinpoint locations and monitor response times and times on scene. This is critical information to support EMS teams at the moment and also provides an opportunity to utilize the available data to determine areas for targeted improvements.

The team has standardized treatment protocols to support the medical care provided. The team is encouraged to utilize downtime to practice and review protocols and associated skills.

Patient transfers are a significant component of the EMS workload, and the team needs to work with the patient flow team to identify the best opportunities to make transfers a success The 100-Day Challenge to address patient flow is an opportunity to ensure that patient transport availability and alternatives are evaluated and discussed.

The EMS team is professional and ensures that all relevant patient information is passed during the transition. The team has a solid working relationship with the Emergency Department and provides advance notice to allow the emergency to prepare for incoming patients when required.

With the implementation of the stroke program and the BE FAST education, the EMS team has played an important role in the success of the program in the pre-hospital environment. The EMS team is proud of their role in supporting patient care and safety and getting the potential stroke patient identified and into care as quickly as possible.

Priority Process: Decision Support

EMS medical records continue to be held in the EMS storage room. While access to this room is limited, medical records should be held in a secure area. Once these files are scanned into the patient record, they should be moved to a secure area for storage or destruction.

The EMS department was not included in the PEARL electronic health record implementation due to technological limitations with “dead zones” in multiple parts of the islands. BHB is encouraged to continue to work with industry and other partners to identify problematic areas. Once this logistical issue has been mitigated, providing the EMS team with electronic charting capability will help consolidate the patient record and support pre-hospital care.

Priority Process: Impact on Outcomes

The EMS department collects quantitative data to track its functions and targets but has not embarked on formal initiatives to target specific areas for improvement. With the support of the quality team, the EMS department may decide to utilize available metrics (emergency room, car tracking data) to identify areas of opportunity for improvement.

With the 100-Day Challenge on patient flow, opportunities for initiatives within pre-hospital care or patient transfer may be identified for a quality improvement initiative.

Priority Process: Medication Management

The EMS service does not stock narcotics, other controlled medications or high-alert medications in the ambulances. The Advanced and Basic Emergency Medical Technicians do not have these medications in their scope of practice. When these medications are required on a patient transfer, the nurse or physician is responsible for these medications.

Priority Process: Infection Prevention and Control

The Emergency Medical Service has support from designated infection prevention and control nurses.

Hand hygiene is monitored, and improvements have been made through education and monitoring.

EMS personnel are often excluded from facility education and program opportunities as their pre-hospital role physically removes them from the hospital environment. Ensuring that an effort is made to include EMS staff in IPC training and audits despite the logistical challenges is recommended.

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		
7.12	Ethics-related issues are proactively identified, managed, and addressed.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Home care services are designed with the intent to support clients to be discharged home safely with support to reduce the need for re-admission and to prevent the need for patients in outpatient clinics to be admitted. Services are provided by a team of four full-time and two casual staff. Absences and vacancies are managed to the best of the ability of existing staff. Client experience surveys have been used to collect information on experience, and new forms are being harmonized for use across all allied health services.

Priority Process: Competency

The organization supports education and training for all staff in-house through an online learning management system which provides a record of completed and required modules. The nursing education office also provides support for addressing emerging clinical questions with the team, and organizational support for conferences and support is provided to the clinical team.

An organizational policy on ethical frameworks exists, and the team regularly meets to discuss client cases and concerns. Examples of situations where staff have used the ethical framework to address issues of real or potential moral distress were not identified in the survey, and the organization may consider exploring how ethical issues are identified and addressed across the organization.

Priority Process: Episode of Care

The team ensures that patients and families are involved in the design of their care plan, including planning to mitigate the risk of cancelled visits. Caregivers and patients are supported in learning self-management skills. The daily schedule is designed to accommodate for needs and preferences of individual clients, and the team works to ensure timely access to service.

There was no evidence of a waitlist on the survey. Staff who were interviewed described different ways in which they were able to adjust care delivery to support the safety and well-being of clients and themselves.

Currently, clients who have failed to provide a safe environment are ineligible for service, and there may be opportunities to assess readiness to resume service for clients who have not been able to provide a safe environment for home care in the past.

The team works to ensure that services offered are non-duplicative and works with partners who provide palliative and publicly funded community home care to ensure service is not duplicated. This can sometimes result in a client receiving health services in the home from more than one team, with each providing a different aspect of care.

Priority Process: Decision Support

The Home Care service uses PEARL electronic records for documentation and communication with inpatient and outpatient units. Standardized intake forms, including risk assessment tools, are used. Home visits are documented in real-time using laptops. Policies for secondary use of information apply organization-wide and the team is supported with in-house IT support to develop reporting relevant to program evaluation.

Priority Process: Impact on Outcomes

Home Care services use standardized templates and workflow documents within the PEARL electronic medical record, which also includes alerts and a shared medical record which is updated in real-time. The scope of services offered by the home care team is restricted to match the intent and purpose of the team. Errors, omissions and near-misses are reported in RLDatix and analyzed for improvement. During the survey, however, there were no recent reports identified. At the present time, the team is learning to optimize the use of the new medical record and working with IT to develop tools and reports that will help monitor quality improvement activities in the future. Program-specific KPIs and program-specific quality improvement activities were not identified in the survey.

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		
5.10	Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.	!
5.11	The organization's policy on reporting workplace violence is followed by team members.	!
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.6	New or existing indicator data are used to establish a baseline for each indicator.	
16.7	There is a process to regularly collect indicator data and track progress.	
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

This is a small, well-established team of nursing staff looking after up to six patients in a home-like setting directly across the parking lot from the hospital. The service is supported by three physicians specializing in geriatric care. Friends of Hospice is a charity that supports Agape House and hospice care in Bermuda. In addition to the regular BHB staff who work in Agape House 24/7, there is access to allied health services from BHB and complimentary services such as music therapy and foot care on a designated day of the week by Friends of Hospice.

The clinical program is managed by the same RN leader who manages long-term care in the hospital. Although the program's central area of focus at the present time is palliative care, the service also occasionally supports clients who require stabilization after an acute episode of care, geriatric assessment, consultation around pain management, etc. However, these services depend on bed capacity and individualized assessment of need on an ad hoc basis. There is some strategic thinking about how the services of Agape House would evolve to address gaps in the continuum of health care for clients with complex needs if there is an opportunity to replace the current building with a modern facility.

Although this is an older facility that is not ideally suited to the services being provided it is well maintained with attention to the provision of safe care in a homelike environment for clients who require total care.

Priority Process: Competency

The team at Agape House is provided with the same access to ongoing professional development and mandatory training as all staff at BHB. This is monitored and supported by an assigned Clinical Nurse Educator. The volunteer program has been less active since the COVID-19 pandemic, but it is expected to return to full capacity as time and resource availability permit.

Priority Process: Episode of Care

This is a small program that facilitates hospice care for clients who can be discharged from active acute care but may not have resources or the desire to receive end-of-life care at home. The objective of the program is to provide a peaceful and comfortable space to be cared for with dignity and respect with a focus on pain management and self-directed care.

Care plans are documented and monitored in the EMR. Care is provided by a team of physicians, registered nurses, health care aides, and a variety of allied health services that can be accessed through BHB or the Friends of Hospice charity.

The services meet the standards for all Required Organizational Practices for Hospice, Palliative, and End of Life Care.

Priority Process: Decision Support

The program at Agape House is supported by the PEARL Electronic Medical Record. Staff use the electronic record to record information at referral, intake, care planning, follow-up, and discharge. Assessment and planning tools are standardized within the EMR.

Medication reconciliation, fall assessment, and suicide risk assessment tools are present and complete. Policies on privacy and use of the EMR are in place although in one case during the site visit a staff person was observed to access patient records under another person's login credentials.

Priority Process: Impact on Outcomes

This is a very small facility with a specialized mandate. However, there are opportunities to play a vital role in improvement initiatives such as better utilization of beds when some units are at full capacity and others are operating under capacity. During the site survey, there was also discussion about the current and future role of the unit when there is bed capacity, and the demand doesn't exactly fit the criteria for hospice or palliative care.

Although there are similar accountability mechanisms in place to ensure structured high-quality care to patients who participate in the Agape House's programs as there are throughout BHB and plenty of evidence that care is provided in an organized way with full attention to the quality of care and patient input, there is no structured quality improvement activity in evidence.

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

There are two dedicated infection control practitioners and one manager who support infection prevention and control (IPC) activities and promotion for the hospital and all of its sites. Funding for these beyond the regular salary of personnel comes from a global budget for quality, and requests for funding are made following the regular request and approval process of all departments within the hospital.

The team has consulted with expertise from Johns Hopkins, noting that hand hygiene measurements have been validated and there were recommendations for further improving the hand hygiene program. Hand hygiene is monitored monthly using a combination of unit self-reports, observation by medical students, patient surveys, and observation by the IPC practitioners. Rates are recorded and reported widely through the units, with most units maintaining between 75% to 90% compliance rates.

The onsite survey revealed there may be more opportunities to support non-clinical teams such as environmental services staff, laundry, and food services to review workflow and layouts which better support the use of required PPE and hand hygiene.

IPC practitioners have regular meetings with local public health and regular contact with the Hospital's infectious disease medical specialist. The team is consulted in purchasing and construction decisions and help ensure that CSA standards are followed for any planned construction, and the organization is encouraged to find ways to enhance the ongoing and continued involvement of IPC in planning and monitoring new spaces and activities within all areas of the organization.

Both actual and suspected nosocomial infections are investigated, tracked and reported regularly. As the organization continues to develop its capacity for using EMR and more advanced functions, IPC may also consider new opportunities to reduce any administrative or reporting burden for both clinicians and IPC practitioners.

IPC practitioners have familiarized themselves with several sets of best practice standards, to be able to work effectively with multi-national and multi-disciplinary teams. Audit tools are used to monitor the effectiveness of policies, as well as RLDatix data to monitor areas where more attention is needed, use of RLDatix may be enhanced with more work to normalize reporting across the organization.

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		
16.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
16.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
16.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
16.5	Quality improvement activities are designed and tested to meet objectives.	!
16.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
16.10	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
16.11	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
16.12	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

There are three inpatient medical units within BHB. One of these is primarily a pediatric unit with the capacity to take medical and surgical patients when there is limited or no capacity in other units. One of the units is focused on stroke care. One of the units is a general medical unit.

Programs are designed to optimize the experience of acute care in such a way that clients receive the services that they need with a view to discharge as soon as possible when acute care services are no longer required. There is a bed flow process in place that consists of acute care managers huddling with a bed flow coordinator to review existing bed capacity and associated pressures throughout the hospital so that effort can be concentrated on interventions that free up available bed space by solving specific problems preventing discharge of patients who no longer require acute care. In addition, there are bullet rounds and other mechanisms designed to bring multidisciplinary services to clients as efficiently as possible to prevent extended lengths of stay beyond what is required.

Unit leaders referenced the work done in the recent past to implement the Wards of Excellence program which has been shown to have some benefits for CQI in Great Britain. There was visual evidence of the efforts that staff and managers have taken to realize the benefits of this approach to CQI.

Priority Process: Competency

There is a highly engaged and competent workforce in the inpatient medical units. There is evidence of strong leadership and multidisciplinary collaboration designed to incorporate leading practices in patient care. Staff report that they feel supported with ongoing education and professional development to support their practice and career aspirations.

There have been a variety of practices adopted from world-class organizations overseas to support quality improvement in Bermuda.

There is an opportunity to promote and increase awareness around workplace violence prevention policy and to take steps to ensure that improvements brought from other places become Bermuda's best practices to support their sustainability.

Priority Process: Episode of Care

During tracer activities to assess compliance with standards of care a number of clients and staff were interviewed and chart reviews were conducted.

Feedback from patients was consistently positive in terms of interaction between patients and care providers, the physical environment, and opportunities for patients to provide input on their experience and goals.

Care planning and delivery was witnessed to be highly collaborative including huddles, rounds and other opportunities to exchange information about clients and to discuss what needs to be done to have clients ready to meet their expected date of discharge.

Priority Process: Decision Support

The introduction of the Electronic Medical Record is reported to have made a significant positive difference in the way that work is done, and information is shared.

While there are opportunities for improvement and people have different ideas about how the program could be tweaked to make it work better for them, for the most part feedback indicates that people are excited about how the platform makes it possible to document the patient journey in a logical sequence with prompts to address and complete required organizational practices along the way. The EMR also supports the exchange of information at points of transition. There is also the potential to use the EMR as a tool for data collection and extraction to support quality improvement initiatives.

Priority Process: Impact on Outcomes

The organization has undertaken significant work to support quality improvement and accreditation in inpatient services during the last year. The Wards of Excellence Program has demonstrated significant progress in engaging unit-level staff in understanding and initiating improvements around hand hygiene, pressure ulcers and falls, team building, and quality of care in the inpatient units. This work is very good in the sense that it demonstrates a model that is truly embedded in the day-to-day activities of staff in the units. The organization is encouraged to continue with this work and other efforts to align unit-level quality improvement with the strategic and operational priorities of the organization.

The units have begun to select key performance indicators and associated measures to monitor and facilitate discussion around targeted quality improvement. The work is at the initiation stage.

There is excellent nursing leadership evident in the units and a relatively high level of engagement in activities designed to meet and maintain standards of care in a challenging and changing environment.

The newly implemented EMR is being well received by most staff eager to adopt new technologies to facilitate their work. There is interest from many staff to use more of the EMR's functionality to produce management reports that are meaningful in terms of the improvements they would like to see in their everyday work. As the potential of the EMR to produce reports in support of evidence-based decision-making evolves staff should see management reports as more accurate and current than they have when selected data had to be collected and organized manually with paper-based systems.

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	

This is a very strong and engaged team providing a range of services to adult persons with intellectual and developmental disabilities. These currently include fifteen group home settings, a day program, and a recently established community-based outreach team. The team is embracing and implementing programs and services consistent with the concept of a recovery model and strength-based care and planning. Key performance indicators have been identified and work is ongoing to select and collect data to inform quality improvement initiatives.

The MWI Directorate Plan includes 19 recommendations arising from an assessment of the national health strategy for Bermuda conducted in 2019. Work is underway to bring stakeholders from BHB, the Ministries of Health and Social Development and Seniors, and other partners together around initiatives to support the recovery model of care in alignment with BHB's vision "to pursue excellence through improvement, to make Bermuda proud" and its mission "to continuously deliver the highest quality and safest care to our patients, every day". This along with the National Plan for Adults with Intellectual Disabilities and Their Families (2023-28) provide the impetus for the Leadership Team in this service area to advance their vision for a stronger, more inclusive continuum of care for this population.

The team is taking concrete steps to improve patient and family-centred care with the establishment of a Client Empowerment Council with leadership elected by the participants. Improved opportunities for families to join in care conferences have been instituted with access through WebEx. The program area is somewhat of a champion for patient and family-centred care with its vision for optimizing independence to improve the quality of life for clients and residents. This gives it a head start in terms of transition to a community-based recovery model. Clinical tracers validate that the vision is embraced at the point of care through to senior leadership. Person Centred Care plans are formulated and maintained with input from clients, families, and caregivers.

Priority Process: Competency

The program optimizes its human resources by employing community support workers at the point of care with registered nursing and physician and allied health support as needed to direct and update individualized assessments and care plans. Staff have access to support for mandatory training and professional development. The management team is made up of leaders who cover multiple sites, working collaboratively to ensure consistent application of protocols, policies, and procedures across the sites.

The team comes together routinely to report progress, monitor, and plan for improvements. The leadership team has selected key performance indicators that align with strategic and operational priorities and there are regular efforts to share and discuss progress using available metrics. The work around structured quality improvement is relatively new following some work with IHI to explore concepts and learn about tools and processes such as PDSA to structure and guide CQI initiatives.

This is a high-functioning team with a high level of engagement amongst staff and leaders who have an eye on optimizing independent living for clients now and with an eye to making improvements by strengthening partnerships and leading progress on the implementation of a recovery model. The aim is to strengthen the continuum of care through collaborative practice informed wherever possible by input from clients and families.

Priority Process: Episode of Care

There was evidence throughout the episode of care tracers in the group homes and the time spent with clinical and administrative leadership that the service is an early adopter of BHB's strategic work to move the organization away from the hospital-based medical model of care to a community-based recovery model that supports and promotes independent living and optimization of clients' participation in any decisions about their care and living situation. This strengths-based approach was witnessed and described through the tracer activities.

There is a deliberate effort to link community living with structured in-house day programming and access to community living beyond the scope of BHB's current mandate. It is acknowledged that to truly support optimized independence with support the work that the health system goes beyond the boundaries of any one organization. To this end, there are a number of initiatives underway to make the care pathways

seamless for individuals and in terms of partnerships to strengthen the continuum of care. The organization does have capacity issues but is working to balance advocacy for change and improvement systemically while addressing opportunities for improvement internally to ensure things like appropriate co-hosting of clients with compatible needs and staff with compatible skill sets and interests.

The EMR facilitates organized and logical care planning and documentation on the commitments to clients and families and on routine protocols to ensure accountability and a structured approach to multidisciplinary care with input from clients and families. There is documented evidence of efforts to ensure that information is communicated to clients in ways that give them the best opportunity to understand decisions that are being made about their journey with the organization. The environments are homelike and well maintained with attention to safety in terms of minimizing fall risk, having safe space and necessary equipment when lifts and transfers are required, and incorporating equipment, technology, and administrative space in ways that do not disrupt the commitment to a homelike environment. Clients who age in place are accommodated to the extent possible in their initial placement and there is a collaborative process that includes families when a move is required for safety or other reasons.

The process of creating and updating an Individual Person Centred Care Plan supports efforts to ensure continuity of care at internal and external points of transition in care, augmenting the information currently documented in the EMR with an eye to longer-term planning for individuals who are generally not expected to have short lengths of stay or a focus on any one single issue in the plan of care, although there are designated respite beds that are used to support clients and caregivers who require time for self-care or stabilization and assessment.

The New Dimensions Day Program and the Client Empowerment Council demonstrate proactive programs and initiatives to ensure people-centred care and connection to the community within BHB's programs and beyond. There is a process referred to as "best interest meetings" that is designed to bring people together to work through decision-making around issues that have a strong ethical component that is not resolved in the usual course of day-to-day care delivery and decision-making. Ethics issues that cannot be resolved within the program can be escalated to the BHB system-wide ethics committee.

Priority Process: Decision Support

The PEARL Electronic Medical Record has been introduced across these programs. The EMR facilitates ease of documentation in an organized way. It is early in the implementation process, leaving the opportunity to optimize the functionality of the EMR in support of evidence-based decision-making and quality improvement. Health Care Workers document their work and observations as the main care providers in the homes 24/7.

There is a highly collaborative process to ensure that registered staff are available and responsive when HCWs require support for decisions and procedures that are beyond their scope of practice. Individual Person-Centred Plans (IPP) are in place for all residents. These provide an at-a-glance description of who the client is and what their preferences and care needs are. These are updated by the RN via an interdisciplinary conference held at least annually.

Priority Process: Impact on Outcomes

The introduction of the Electronic Medical Record has opened up a whole new opportunity for the organization to input data at the point of care and create management reports with that data in support of quality improvement. However, there is an opportunity to do more work around ensuring that the selected key performance indicators are supported with metrics and regular reports that inform discussions and planning around progress, needs for corrective action, and next steps in the journey toward realization of strategic plans. In the case of this program, this work seems to be critically important to ensure readiness and accountability when using public funds to grow and move in the direction of leader and community partner in a network of services built to support a responsive and coordinated continuum of care consistent with the Government of Bermuda's National Plan for Adults with Disabilities and Their Families.

There is evidence that BHB's leaders are already leaders and major players among the stakeholders in this strategic plan.

Standards around the use of data to inform quality improvement, engagement of people in identifying and facilitating quality improvement initiatives and having well-defined strategies and operational undertakings in support of those strategies are met. However, there is an opportunity to continue the work of formalizing BHB's approach to Continuous Quality Improvement and to support current and emerging leaders in their efforts to lead and facilitate this work. As with any organizational transition, there are early adopters and individuals who need additional support to work in this way.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
2.4	The physical space is designed with input from residents and families and is safe, comfortable, and reflects a home-like environment.	
2.6	The effectiveness of resources, space, and staffing is evaluated with input from residents and families, the team, and stakeholders.	
5.2	Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from residents and families where appropriate.	
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		
17.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from residents and families.	
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

The Long Term Care Team at the BHB is a very engaged and enthusiastic team.

Located in a hospital setting, the physical layout of this unit is one of an institutional setting. Given the long length of stay of the residents on this unit, the organization is encouraged to seek feasible options to render the environment more “home-like” for its residents.

Although this service has a resident family council, the team indicates that they have some difficulty creating active engagement from residents and their families. They report that residents and families will attend information sessions, but few will participate in initiatives or consultations, making it difficult to obtain direct input in order to ensure space and resource allocation meet the needs of the residents. To compensate in part, the team utilizes informal input such as direct discussions with some residents and/or families, as well as information from satisfaction surveys. The team is encouraged to continue to stimulate interest by offering support to residents and families so that they can be prepared to participate and contribute to quality improvement activities.

The team actively collaborates with other services in order to ensure continuity of care for patient with a geriatric profile, namely by offering consultations and follow-up by their geriatricians on other clinical units such as the Acute Care Wing.

Priority Process: Competency

The team receives training and continuing education on many topics, including patient safety as well as concepts of quality improvement.

Team members who attend training share with colleagues their findings, and discussions are held as to their application in the context of their unit.

With the roll-out of the electronic medical record (PEARL), communication between team members as well as between the team and other units have been standardized and structured, thereby enabling a collaborative approach to care.

Priority Process: Episode of Care

Residents are evaluated by geriatricians and decisions to admit to the unit are made according to a set of written admission criteria. Because of difficulty coordinating places in private care homes, there is very little "turnover" of the long-term care beds at BHB. As a result, the delay for admission could be very long. The organization is encouraged to pursue discussions with partner organizations to seek strategies to facilitate patient flow so that the appropriate resources and intensity of services are offered to the right patients at the right time.

The team, in addition to applying its own falls prevention strategies, also invests in the education of family as well as members of the public on falls prevention. For example, the team recently presented a Falls prevention expo and radio interview to much satisfaction and appreciation of participants.

The team also has initiated an improvement project to minimizing the use of restraints. Although restraints continue to be used on some residents on the 4 long-term care units, there has been major reduction since implementation of this initiative. The team is encouraged to continue follow-up of this initiative, and to find strategies to spread this knowledge to other teams in the organization.

Another quality improvement initiative is the pressure injury prevention project. This project makes use of the PDSA continuous improvement cycle, and is recognized internationally as the team was invited to present at major international nursing conferences.

Some residents indicate that weekend meals are not always of the same quality and variety as meals served during the week. The organization is encouraged to investigate and ensure a consistent quality of meal services.

Priority Process: Decision Support

With the roll-out of the electronic medical record (PEARL), clinical documentation has been standardized. Resident records are up to date and can be consulted in a timely manner by all within the circle of care.

At shift changes, rounds are held with the portable computer at the bedside, thereby offering residents the opportunity to participate in the transfer of information.

Potential ethics-related issues are proactively identified. It is noteworthy that all 3 geriatricians on this unit sit on the organizational ethics committee, providing the team with expertise and guidance when facing ethics dilemmas.

Priority Process: Impact on Outcomes

The teams in Long Term Care are very motivated and enthusiastic about their Wards of Excellence participation and achievements. For the unit-based quality teams, each nurse on the unit is assigned to lead one of the quality initiatives, including monitoring of the indicators as well as quality improvement initiatives.

Initiatives are structured, and evidence-based. For example, to support fall prevention initiatives, a special event named “Falls Expo” was presented to all staff, residents and their families, and participation was even open to the general public. Another commendable project is pressure injury reduction. This evidence-based initiative has produced measurable positive results, and the team has been invited to present the project at major conferences both in the U.S. and the U.K.

For these initiatives, we invite the team to continue their efforts to formalize a resident and family engagement and to define resident and family contribution and participation in these activities.

Standards Set: Medication Management (For Surveys in 2021) - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Medication Management			
2.3	There is an antimicrobial stewardship program to optimize antimicrobial use. Note: This ROP applies only to organizations that provide acute inpatient care, cancer treatment services or inpatient rehabilitation services.		ROP
	2.3.1	An antimicrobial stewardship program has been implemented.	**MAJOR**
	2.3.5	The program is evaluated on an ongoing basis and results are shared with stakeholders in the organization.	**MINOR**
14.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.		!
Surveyor comments on the priority process(es)			
Priority Process: Medication Management			

The organization has an active and engaged Pharmacy and Therapeutics Committee with subcommittees who manage recommendations for formulary, best practice guidelines, and regular policy review and recommendations. A variety of teams are represented on the committee, and a sub-committee for antimicrobial stewardship has restarted and is moving toward completing activities that will allow for a more complete approach to supporting safer and reduced use of antibiotics across the organization.

Pharmacy services are organized across two sites, additionally, methadone supports are available through the onsite pharmacy at MWI.

Electronic systems to track the ordering and use of medications are in place, and the pharmacy is working on developing integrated reports with the new electronic medical record system to monitor performance and efficiency.

The pharmacy works collaboratively with all departments to help and advice on medications for all patients. Subscriptions to Lexicomp and UptoDate, which is also available to all staff in the organization, help inform best practice and consultation with pharmacists when clinical questions arise. Most pharmacists rotate through different areas of responsibility, and leads are assigned to different clinical areas.

The CPOE system is reported to be effective and user-friendly by staff in the pharmacy and on units who were interviewed through tracers. The pharmacy manager actively addresses any new questions or concerns about alerts, and the pharmacy is sensitive to the downstream effect of workflow or technology changes in the ordering system.

Medications are stored in clean, dry areas at sites. The ISMP Tallman lettering and Do Not Use Abbreviation Lists are used, along with alert stickers and drug spacing on shelves to prevent errors in medication administration. Pyxis machines are used in all areas, and crash carts on units are partially maintained by the pharmacy, with some areas maintaining unique crash-cart medications specific to their specialty areas.

Infusion pump education is provided in clinical areas where they are used. There are syringe and cartridge-style patient-controlled analgesia pumps in use, the latter being much more common.

Medication administration areas are clean and organized through the widespread use of Pyxis. Some medication areas are in closed rooms with poor airflow and elevated room temperatures (e.g.: MWI) these were noted on the survey. Other space challenges in chemotherapy areas are under review, noting too that the volume of chemotherapy drugs prepared was felt by staff to have increased significantly, while challenges to both space and staffing to safely prepare the drugs have not increased, creating challenges for technicians working in more physically demanding roles for extended periods of time, with less space. The assessed risk in this area may be re-evaluated by the organization, with consideration for the risk of occupational injury to staff and patients at current space and staffing levels.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	A strengths-based, and client-directed approach to services and supports is taken.	
1.3	Clinical services and supports are recovery-oriented and focused on well-being.	
Priority Process: Competency		
3.10	Education and training on how to prevent and manage violent or aggressive behaviour using de-escalation techniques are regularly provided to the team.	
3.11	Education and training on the organization's process to respond to incidents of violent or aggressive behaviour are provided to the team.	
Priority Process: Episode of Care		
2.7	The physical environment is safe, comfortable, and promotes client recovery.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	

15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The organization is currently embarking on a process to fully introduce the recovery model of care for mental health and other programs at BHB's MWI site. Historically the inpatient mental health program has been housed in a hospital ward setting in a large psychiatric institution. There is a government-wide plan to move in the direction of a more community-integrated continuum of care for clients experiencing mental health conditions. This work is in the early stages.

Under the current circumstances, the program is housed in an older facility that does present certain limitations in terms of the physical environment and location. There is a highly engaged staff who are interested in what the new directions would provide in terms of better care for their patients. However limited work has been done to initiate quality improvement activities that will move the service delivery model in that direction. There is some skepticism that the model can be implemented without significant capital investment.

Site Leadership has embraced the EMR and the identification of key performance indicators but otherwise, there has not been a high degree of interest in change to the way work is being done. Leadership at the site says that their voices are not being heard regarding how changes that have happened and are proposed could compromise staff safety. For example, the idea of least restraint, including chemical restraints is considered tone-deaf to the situations that staff are currently having to deal with in the inpatient units. This represents an opportunity for improvement around balancing safety culture, patient-centred care, and security.

There was some discussion about teaching around de-escalation of potentially violent situations during which it was noted that staff understood the priority to avoid physical engagement. The line of discussion from the surveyor was around de-escalating violent situations and restraint procedures with physical engagement only as a last resort.

Priority Process: Competency

There is an engaged group of staff working in the inpatient units. Staff have job descriptions and they do receive feedback on their performance. They are collaborative and rigorous in terms of how patient assessment and monitoring are done. They are embracing the EMR as a useful and efficient tool for care planning and documentation. People report satisfaction with their work and the support they receive for education and professional development.

There is awareness and a sense that staff feel trained and competent to respond to violence in the workplace but there are challenges getting them to identify what the organization is doing to mitigate risks in this regard. It is recommended that workplace violence prevention policy be highlighted as an opportunity for improvement and reviewed with staff in an effort to raise the profile of workplace violence prevention and what we can all do to mitigate risk.

In terms of competency around the recovery model and any transition that needs to happen to take the organization from where it is now to where it wants to go strategically, it is recommended that a transition and communication plan be developed with a clear component that deals with staff consultation around how to make it work and education and awareness initiatives that build on what has already been offered.

Priority Process: Episode of Care

There are care plans in place for all clients. Client care is well documented in the EMR, and all risk assessments are done. ROPs are met. The limitations of the physical environment have to do with aging infrastructure and design. There is an opportunity to engage in quality improvement initiatives that would focus on what a recovery model could begin to look like in an environment like this. Beginning to do this work now would also lead to a discussion about what a new building or community residential design would look like if the opportunity does come for site redevelopment.

Generally, clients appear to be well cared for with a major emphasis on security and routine. While discussions are happening about how to strengthen the continuum of care and see this stage in the mental health continuum as the acute end, it would be worthwhile exploring improvements in program design that facilitate client independence and movement toward more independent living with safety as the highest priority.

Priority Process: Decision Support

The adoption of the EMR in the units has facilitated the standardization of care planning and documentation of progress at each stage of a client's journey from intake to discharge and transition points in between. Staff are positive and have embraced the technology. There is some feedback that the EMR could be better or that now that it has been in use for a year there are not working as well as it could be. So, support should continue to be provided about what the suggested improvements are, whether there is a strong case to make changes, and whether it is possible to customize the software to make any suggested improvements.

Priority Process: Impact on Outcomes

Tarheel House represents the most significant work that has been done to demonstrate an approach to a strengths-based recovery model for clients with chronic persistent mental illness. The model could be used as a Bermudian example of what one of the alternatives to institution-based medical model care looks like. The programs offered to persons with intellectual disabilities are similar in philosophy and design.

The inpatient mental health units are well-staffed and well-run within the limitations they have in the current physical environment. Efforts are undertaken to ensure staff and patient safety although there appears to be some debate about how staff and patient safety should be promoted.

Medication management practices including reconciliation are in place and meeting standards.

Like many other areas across the organization mental health services are early in the journey toward a proactive and structured approach to quality improvement, although there has been some work done to select key performance indicators and track progress.

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		
3.6	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
18.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
18.5	Quality improvement activities are designed and tested to meet objectives.	!
18.6	New or existing indicator data are used to establish a baseline for each indicator.	
18.7	There is a process to regularly collect indicator data and track progress.	
18.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
18.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
18.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
18.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Obstetrical services are in the process of updating the patient information sheets shared with community-based clinics to share with pregnant patients. Facility tours are made available, and the organization may wish to consider ways in which materials and support for pregnant patients, including wayfinding, orientation and tours may be done digitally.

Patient preferences and goals are reviewed and discussed with the team, and doulas and support partners are welcomed on units. Units are staffed with RNs, Midwives, and Nursing Assistants, and staffing schedules are created with consideration for covering OR and blending newer hires with more experienced nurses.

The building infrastructure does pose some challenges to universal accessibility, and staff are thoughtful in the rooming of different patients to allow for the most comfortable and accessible stays. Attention to the size and accessibility of washrooms and shower stalls for bariatric patients and/or those using mobility aids may be considered. The unit is encouraged to continue to consider the potential advantages of equipment and supplies storage with a more minimal footprint.

Priority Process: Competency

Standardized charting tools are used in the obstetrics service, and education and training are provided on the information systems and other technology used in all service areas. There are some elements of a chart that are paper-based and follow patients between units, which the organization may find suitable digital solutions for in the future. As staff notice potential improvements to the layout of charting tools, they discuss and review them with the manager, who also is supportive of reporting to IT for improvements and updates.

Staff receive training, orientation, and in-service education and are encouraged to pursue additional certifications and training.

While the organization has endorsed using an ethical framework, evidence of the use and which issues might be considered ethical dilemmas was not identified.

The team does huddles, debriefs on incidents, and relies on the skill and expertise of colleagues to help problem-solve issues as they arise. The organization may wish to explore ways to encourage awareness of moral distress, and ethical framework across the organization as it applies to real-time clinical scenarios.

Priority Process: Episode of Care

Planned c-sections are scheduled in the main OR, and an OR on the unit is available and stocked for emergency c-sections. Staffing is planned to ensure that nurses are available to assist in an emergency and c-section when needed.

Clients and families are encouraged to communicate any concerns or questions with staff. There is information on reporting patient complaints outlined in a policy, and information is shared by nurses and available online for connecting with a patient advocate. The organization may wish to assess the benefit and appropriateness of clear visual cues or written reminders for patients on how to file a complaint.

Standardized fall risk assessments are used, documented and communicated appropriately. Diagnostic and laboratory testing is available on the unit and technical support is available for assistance as required.

There are policies related to infant feeding, and the organization may consider the risks and benefits of a more global policy that covers additional measures or references procedures for assessing feeding, promoting breastfeeding, etc.

Priority Process: Decision Support

When interviewed on the survey, nurses and one patient commented on the importance of maintaining a sense of privacy and confidentiality on the unit. The staff are careful not to display client names in open areas. Privacy is also recognized as an important part of patient safety on the unit, especially to prevent restricted visitors.

Access to clear procedures and policies may be an area where the organization wishes to focus (for example, there are several policies that address different aspects of infant feeding, but not one overarching policy on the recommended frequency, volumes, instruction for patients, or safe use of breast pump identified during the survey).

Priority Process: Impact on Outcomes

The organization continues to improve on the expanded use of PEARL electronic medical records across multiple sites, including obstetrics. While the unit is interested and responsive to client feedback, there may be opportunities to involve recent patients more formally in the evaluation and planning for service improvement over time.

Incidents are noted and debriefed, however, no quality improvement plans and interventions specific to the team were identified in the survey. As the teams improve upon documentation in electronic records, there may also be opportunities to develop capacity for reporting and monitoring performance and impact on outcomes.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
2.5	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
9.3	Defined criteria are used to determine when to initiate services with clients.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
25.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
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 department enjoys modern facilities designed to support patient flow. The reception area is bright, spacious and welcoming and provides ample room for patients to check in for their procedure and for surgically discharged patients to await pick-up.

There is a clear demarcation between non-sterile, semi-sterile and sterile areas. There are four, brightly lit and spacious operating rooms, each with identical set-ups. Two rooms share an anteroom which holds surgical supplies and provides space for hand washing and preparation. A fifth operating room is utilized for endoscopy.

The utilization of the operating rooms requires review. With input from patients and families, the organization should review surgical priorities for Bermuda and prioritize surgical space in line with national volumes, clinical priorities and wait times. Wherever possible, non-surgical cases should be moved to alternative spaces outside the operating room. It may be determined appropriate for some procedures to be provided outside of BHB. An optimization review of surgical space and utilization should be conducted.

The obstetrical unit has an operating room currently used for emergency c-sections. Scheduled c-sections were moved to the perioperative department to facilitate upgrades which are complete. There are obstetrical and pediatric concerns regarding the physical distance for newborns to travel between the operating room and the Special Care Baby Unit (SCBU). From a surgical utilization perspective, the obstetrical surgical capability should be reviewed to optimize operating room utilization. The patient and family perspective should also be obtained and considered.

Priority Process: Competency

Team members report feeling well-supported by managers, educators and the organization to develop new skills and maintain competencies. The mentorship programs received positive reviews from both new team members and experienced staff conducting the mentorship.

BHB's educational program has successfully utilized technology to provide routine training, virtual seminars and discussions as well as track attendance and identify those who are due for educational updates.

Priority Process: Episode of Care

The team has done extensive work on streamlining the pre-operative assessment process. They have done a great job on efforts to consolidate services (lab, EKG, consults) in one location. This process change improves the patient experience, supports early identification of potential barriers to surgery and provides time to address the issue prior to surgery or to schedule another patient in that surgical spot.

Same-day surgery has significantly advanced processes. While initially motivated by COVID restrictions, the fortunate result is that the team has developed care pathways to support same-day discharges for an increasing range of surgeries including hip and knee replacements for patients who meet parameters. This has not only reduced the length of stay and mitigated the requirement for admission to an inpatient ward but has permitted the surgical team to continue providing the surgical service despite a lack of inpatient beds. Further, patient satisfaction has increased and positive feedback regarding the same-day program supports the continuation and furtherance of same-day care from a patient satisfaction perspective.

The utilization of the operating rooms requires review with defined criteria to support optimal utilization. Criteria consideration for operating room time could include the requirement to be a surgical procedure. Anesthesia requirements and appropriateness should also be considered.

The four main operating rooms are scheduled for upgrades of the technical equipment monitoring systems. This will decrease operating room availability by a quarter for the next 4-5 months. In order to maintain surgical availability, the perioperative team with support from BHB leadership, will need to evaluate the utilization of the operating room to ensure that availability is maximized to support the goals of the organization. This is an opportunity to implement change with patient, financial and staffing benefits.

Pre-surgery preparation, in particular procedures to reduce surgical site infection rates, is in place. The staff notes concerns with compliance in some cases. Public relations may play a role in educating the general population about the patient's role in reducing their own risk to socialize these concepts to the Bermuda population.

The surgical checklist and pause are routinely done in line with the department's policy. The surgical team's inclusion of the patient in the process with introductions and verifications is commendable and was noted to significantly improve the patient's comfort prior to procedure initiation.

The team is engaged with multiple quality improvement initiatives including a review of surgical site infections and pre-operative streamlining. Discharge follow-up interviews indicate improved patient satisfaction with both pre-operative clinic experience and same-day discharge.

Priority Process: Decision Support

The Perioperative team transitioned effectively to PEARL and is in the optimization phase of electronic health record utilization and functionality.

The hybrid chart is still utilized and poses a risk of missing information and delaying care in a couple of areas.

In the surgical scheduling department, a significant proportion of surgical offices continue to fax handwritten surgical booking forms, increasing the risk of missing information, illegible instructions and potential misplacement. The Perioperative team may consider providing some short-term virtual support to educate surgeons and their clerical staff on utilizing electronic booking sheets to streamline this process.

Surgical consent forms are also paper based for signature prior to scanning into the PEARL system. Working with IT, there is an opportunity to utilize tablet technology for consent signatures and immediate upload to the PEARL system to maintain one chart for each patient.

Priority Process: Impact on Outcomes

The perioperative team is involved in quality improvement initiatives and has implemented a pre-operative surgical preparation program and is monitoring surgical site infection rates.

In reviewing data, the team is encouraged to break down the data to highlight the incidence of significant infections. Further education targeted at patients and families may help improve compliance. Aiming education at the wider community through public media may also help to socialize concepts of pre-operative care and the important role patients and families play in their own health.

Priority Process: Medication Management

Medication management is controlled throughout the perioperative areas with automated medication dispensing and standardized anesthesia carts.

Narcotic control is excellent with a separate locked drawer within the anesthesia cart that requires nursing to key unlock, preventing individual access. Discrepancy rates for narcotics are very low.

Anesthesia has worked with medication management to optimize the medications available and to ensure that look-alike medications are adequately separated to mitigate the risk of confusion.

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

Unmet Criteria		High Priority Criteria
Priority Process: Point-of-care Testing Services		
8.12	In the event that samples are lost or damaged, the organization reports the incident to the appropriate person or people as specified in the SOP.	!
9.1	The organization has a standardized written or electronic policy or procedure on how to report and disclose all POCT results. CSA Reference: Z22870:07, 5.8.2.	
Surveyor comments on the priority process(es)		
Priority Process: Point-of-care Testing Services		

Point of care testing (POCT) reviewed on the survey included AccuCheck glucometers, hemoglobin measurement, urine-drug-screen collection kits, urinalysis strips, nitrizine, pH paper, pregnancy test, and small bedside analyzer used in the emergency department. Attestation on fecal occult blood tests used in emergency was shared, however not included on the survey.

Testing materials were stored in cool, dark, and dry places; however, it was noted that in some areas opened bottles were not dated with the date opened to know how long the pack had been open.

Quality assurance tests to compare results with reference ranges are performed regularly on machines, and logs are kept by the lab. In some clinical areas where quality assurance is done by staff and not monitored electronically, evidence of missed quality control checks was identified on the survey. The organization may consider ways to monitor electronically or introduce prompts or reminders to ensure checks are done on time.

Decisions about the risks and benefits of introducing new POCT machines and tests are made with input from the lab and consideration for the education, material cost, and administrative workload that comes with quality assurance for point-of-care testing. COVID-19 testing, for example, is now done by nasopharyngeal swabs sent to the lab.

While it may be extremely rare that samples are lost or damaged at the point of care without the possibility of recollection, evidence of direction for addressing the same in operating procedures was not identified on the survey, nor was evidence of incident reporting related to POCTs identified on the survey.

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		
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.6	New or existing indicator data are used to establish a baseline for each indicator.	
15.7	There is a process to regularly collect indicator data and track progress.	
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The rehabilitation service is a centralized service that allocates rehabilitation services to units across BHB based on demand. Occupational Therapists, Physiotherapists, Speech-Language Pathologists and Therapy Assistants along with other allied health services embed themselves in the care teams across the organization to participate in multidisciplinary care planning and provision of therapy services. There is high demand and some pressure on the team due to the challenges associated with the recruitment and retention of these professions.

Priority Process: Competency

Rehabilitation services are made up of Physiotherapists, Occupational Therapists, and Speech-Language Pathologists delivering service to inpatient units and clinics across BHB's facilities and services along with other Allied Health professionals such as Social Workers and Dieticians. These are currently hard to recruit positions so along with the pressures that come with big demand the services are stretched thin due to staff recruitment and retention limitations.

The current model is for services to be distributed across the organization and embedded in units and clinics but available to be deployed where they are most needed to prioritize the greatest need and to facilitate bed flow.

The services are highly regarded and in high demand. Staff in these occupations provide feedback that they feel supported in their roles and that opportunities for professional development and career laddering are adequate.

Priority Process: Episode of Care

The team participates in multidisciplinary rounds and responds to requests for service within available resources and is prioritized according to whether needs are routine, urgent, or emergent. In addition, there is an effort to prioritize patients who can be discharged from acute care following assessment or treatment in order to facilitate patient flow.

Priority Process: Decision Support

The rehabilitation staff utilizes the PEARL EMR to record clinical activity, assessment notes, and patient progress. As part of the multidisciplinary teams delivering service to patients on the units to which they are assigned the rehabilitation team participates in rounds, care conferences, and other communication vehicles to ensure appropriate information transfer at relevant points in the clients' care experience.

Priority Process: Impact on Outcomes

Rehabilitation staff deliver services according to their professional standards of care and within their scope of practice. If specialized competencies are required to work in certain units or to perform certain functions staff state that the organization provides the necessary support to ensure that service can be delivered safely and competently.

This team, like the rest of the organization, is beginning to identify key performance indicators for its services in an effort to move toward a more structured approach to quality improvement. It is early in this journey and the service is looking to the organization for additional support and direction to continue and develop the approach.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
The organization has met all criteria for this priority process.		
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
15.1	Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.	
15.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
15.4	Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.	
15.5	Quality improvement activities are designed and tested to meet objectives.	!
15.8	Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.	!
15.9	Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.	!
15.10	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	
15.11	Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The leadership team describes the current state of addiction services as episodic and focused on the crisis but with the opportunity to work with community partners to assist clients via referral to complimentary services based on individualized care plans that are developed while clients are in care with MWI-based programs.

There is access to harm reduction services but with a view to managing crises and preventing catastrophic outcomes more than navigating clients through a coordinated continuum of care.

Leaders are aware of national strategies and do see themselves as important stakeholders in government and BHB strategic plans for a more coordinated system in the future, both within addiction services and with internal and external partners providing other health and social programs.

The world of addictions in Bermuda is described as highly stigmatized and somewhat hidden as families and communities attempt to manage crises as they arise without coming together to look at the problem more systemically. There is a tendency to fund and support "initiatives" than there is to identify problems and look at root causes and networks of resources and develop a service delivery model with primary, secondary, and tertiary components to it.

BHB leadership is aware of a very recently released government strategic document around the revitalization of addiction services and assumes there will be an opportunity to be a key player in plans to operationalize priorities that are adopted and funded by the public system.

Priority Process: Competency

There is an engaged and highly skilled team of people working in the withdrawal management and outpatient counselling programs at MWI. The withdrawal management program is staffed with a team of registered nurses, healthcare workers, and physicians who are focused on addictions and mental wellness and with access to allied health services from the broader BHB community of practice. The outpatient program is staffed with office-based therapists who offer individual counselling and group facilitation for individuals who are in recovery.

The inpatient detox unit is a short-stay unit that is very focused on stabilizing individuals seeking support to attain sobriety either episodically or with plans to remain abstinent upon discharge. As such there is a very medical focus with defined protocols that are driven by physician orders. Some principles of harm reduction are evident in the treatment process such as access to opioid replacement therapy while in the short-stay program and referral to community-based services upon discharge but planning that goes beyond this acute intervention is minimal and not viewed as within the scope of the program.

The outpatient addiction service is housed in the same building as the withdrawal management program and there are connections between the two units if clients of outpatient services are admitted for withdrawal management, but the outpatient program is clear that its mandate is to work with clients who are in recovery with longer-term plans; not to deal with crisis.

Priority Process: Episode of Care

There are standardized protocols for service delivery and documentation guiding the practice of the professionals who are delivering services in addiction recovery programs. Clients, staff and leadership all talk about the programs with an awareness that the scope of their individual programs is currently not consistent with a recovery approach in the sense that it is crisis-oriented and episodic.

There is a desire to move in the direction of a more coordinated model that links services delivered by BHB and its partners across a continuum and for the outpatient service to be attentive to working hours for people who can not attend during the workday. There is evidence that the programs have made minor adjustments to the current service delivery model to, for example, schedule groups in the early evening and to connect with community partners when clients are transitioning out of BHB programs or attempting to access other programs to support them in the next step in their recovery process.

Priority Process: Decision Support

BHB programs all use the PEARL EMR to guide care planning and to document the services offered to individual clients and the progress of clients receiving those services. Although this is a relatively new tool that staff are still getting comfortable with it is acknowledged that for the most part, people see the EMR as a tool that facilitates continuity of care, information transfer at points of transition, and an organized way of meeting standards and performing required organizational practices during an episode of care. For example, fall assessments, suicide assessments, and medication reconciliation processes are all standardized and documented in the EMR.

It is acknowledged that the EMR is only a tool and that its functionality has not been fully realized to support quality improvement at this time.

Priority Process: Impact on Outcomes

Programs are very well organized according to their current mandates. However, these programs are very episodic in nature and as such not connected in a deliberate way with other programs supporting clients in their recovery process in the community. This is not to say that staff do not connect with community partners and refer community partners to complimentary services and programs housed in the community, but the current model of service delivery across the system does not drive a recovery model. The current programs are well-managed and delivered within the scope of their current mandates.

The organization is early in its journey to build a more proactive and deliberate approach to quality improvement and client-centred care. Staff and unit-level leadership are just beginning to identify key performance indicators and work on ways to make them visible and to have focused conversations with staff about targets, progress, and corrective actions required to achieve the desired outcomes. Staff are not yet highly engaged in this effort although there is interest in discussing the added value of this type of work.

There is an opportunity to clearly demonstrate alignment between strategic priorities, operational plans, and quality improvement work to ensure the people at the point of care are in sync with strategic leaders and the larger addiction and mental health system. This could reinforce the notion that programs are designed to support recovery in partnership with clients and families in their recovery process. The ultimate objective should be a coordinated and responsive continuum of care with a high level of engagement and input from clients and families about the root causes of their addictions and the support needed to remain in recovery. In this respect, BHB is more of a partner in terms of the episodic care it provides than a driver for larger systemic changes in the addiction field in Bermuda. This underscores the value of movement toward a recovery model of care delivery that requires extensive and ongoing collaboration and partnership with government and community-based agencies.

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		
25.3	The team identifies measurable objectives for its quality improvement initiatives and specifies the timeframe in which they will be reached.	!
25.4	The team identifies the indicator(s) that will be used to monitor progress for each quality improvement objective.	
25.6	The team designs and tests quality improvement activities to meet its objectives.	!
25.7	The team collects new or uses existing data to establish a baseline for each indicator.	
25.8	The team follows a process to regularly collect indicator data to track its progress.	
25.9	The team regularly analyzes and evaluates its indicator data to determine the effectiveness of its quality improvement activities.	!
25.10	The team implements effective quality improvement activities broadly.	!
25.11	The team shares information about its quality improvement activities, results, and learnings with clients, families, staff, service providers, organization leaders, and other organizations, as appropriate.	
25.12	The team regularly reviews and evaluates its quality improvement initiatives for feasibility, relevance and usefulness.	
Surveyor comments on the priority process(es)		
Priority Process: Episode of Care		

BHB does not have a dedicated transfusion clinic so universal fall precautions apply as they do throughout the organization and wherever the transfusion is being offered.

Scheduled outpatient blood transfusions are frequently completed in the emergency department which is concerning from a falls perspective as nursing support is limited, bathrooms are seldom close to the transfusion area and emergency events may prevent staff from being attentive to a patient's needs.

Priority Process: Transfusion Services

The transfusion team has embraced the PEARL platform and is happy with many features, including its ability to interface with the Blood Donation E-DELPHYN system. There continues to be reliance on paper tracking and charting. Some of this is redundant and can be eliminated gradually as the team becomes more confident in the electronic system. Other elements would greatly benefit from tablet technology to directly enter data into a virtual document for inclusion in the electronic health record.

The Blood Donation team has positive relationships and a strong community of donors. The team provides a relaxing and friendly environment for donors and takes pride in the success of providing all blood products for Bermuda. While they function within a limited and challenging space, they succeed in maximizing donor comfort while maintaining safe blood-handling processes.

The Transfusion team is excited to formalize their quality improvement journey. The team is encouraged to work with partners in Emergency and Acute Care to quantify the number and types of transfusions that could be offered through an outpatient service to support the creation of a Transfusion Clinic. This is a significant quality improvement proposal to improve the patient experience, minimize delays in providing transfusions, mitigate risk and provide care in an outpatient setting rather than relying on the emergency department or inpatient beds for space and staff to provide this vital outpatient function. The team may consider collecting baseline data on patient satisfaction as well as PEARL-derived objective data on transfusion start and finish times to objectively measure current parameters to support proposals and later quantity successes and identify further opportunities.

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 23, 2022 to December 9, 2022**
- **Number of responses: 10**

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.	20	20	60	93
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	10	20	70	94
3. Subcommittees need better defined roles and responsibilities.	40	30	30	70
4. As a governing body, we do not become directly involved in management issues.	0	22	78	87
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	20	80	95

	% 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	0	100	95
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	10	90	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	30	20	50	92
9. Our governance processes need to better ensure that everyone participates in decision making.	30	20	50	61
10. The composition of our governing body contributes to strong governance and leadership performance.	10	30	60	92
11. Individual members ask for and listen to one another's ideas and input.	10	20	70	95
12. Our ongoing education and professional development is encouraged.	20	20	60	89
13. Working relationships among individual members are positive.	10	30	60	95
14. We have a process to set bylaws and corporate policies.	10	30	60	93
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	10	90	96
16. We benchmark our performance against other similar organizations and/or national standards.	50	10	40	77
17. Contributions of individual members are reviewed regularly.	40	20	40	71
18. As a team, we regularly review how we function together and how our governance processes could be improved.	50	30	20	77
19. There is a process for improving individual effectiveness when non-performance is an issue.	60	30	10	64

	% Strongly Disagree / Disagree	% Neutral	% Agree / Strongly Agree	%Agree * Canadian Average
	Organization	Organization	Organization	
20. As a governing body, we regularly identify areas for improvement and engage in our own quality improvement activities.	50	30	20	83
21. As individual members, we need better feedback about our contribution to the governing body.	30	0	70	44
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	50	20	30	78
23. As a governing body, we oversee the development of the organization's strategic plan.	20	10	70	94
24. As a governing body, we hear stories about clients who experienced harm during care.	10	0	90	82
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	10	90	91
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	40	30	30	88
27. We lack explicit criteria to recruit and select new members.	11	22	67	79
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	20	20	60	87
29. The composition of our governing body allows us to meet stakeholder and community needs.	50	0	50	87
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	20	0	80	92
31. We review our own structure, including size and subcommittee structure.	30	20	50	86
32. We have a process to elect or appoint our chair.	50	10	40	87

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	10	40	50	83
34. Quality of care	10	50	40	82

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2022 and agreed with the instrument items.

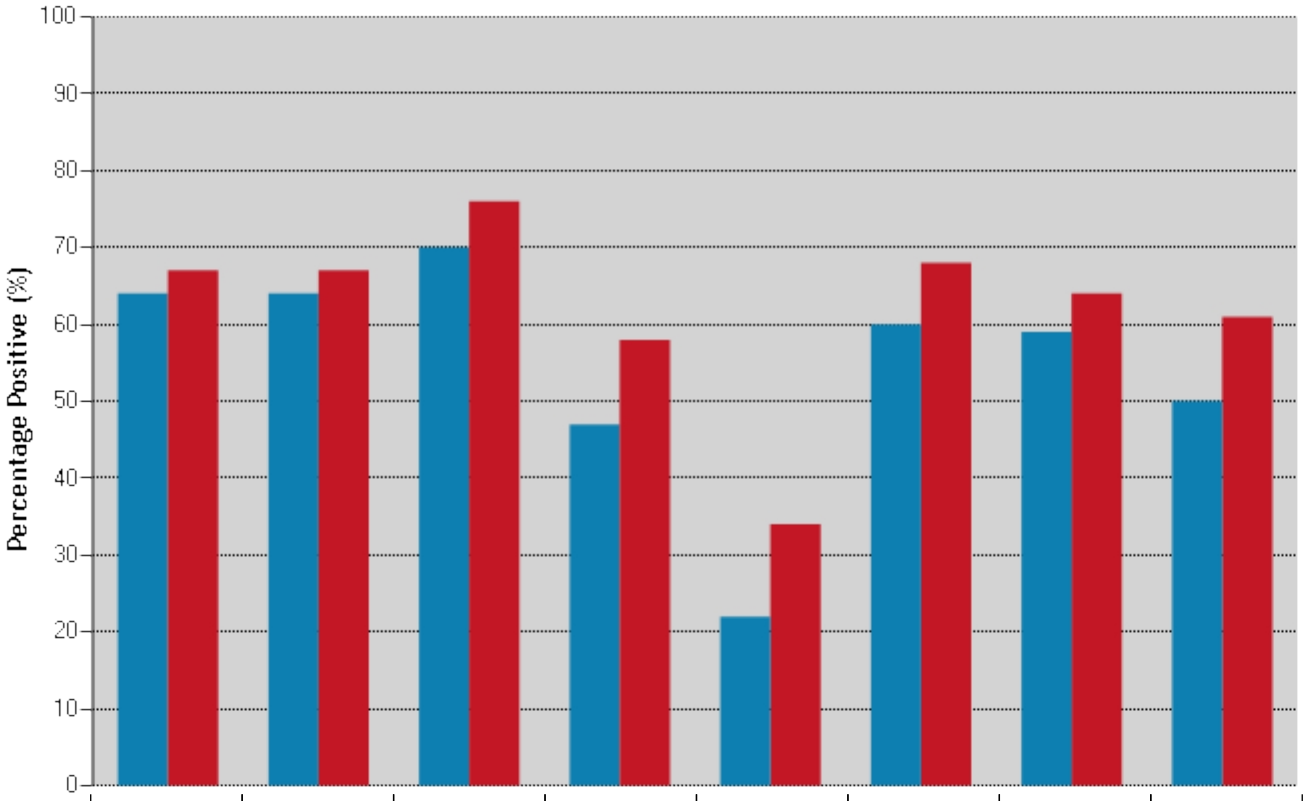
Canadian Patient Safety Culture Survey Tool

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 1, 2022 to September 30, 2022**
- **Minimum responses rate (based on the number of eligible employees): 271**
- **Number of responses: 525**

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
	64%	64%	70%	47%	22%	60%	59%	50%
	67%	67%	76%	58%	34%	68%	64%	61%

Legend

Bermuda Hospitals Board

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from January to June, 2023 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 validating our quality journey as we uphold our vision “To pursue excellence through improvement, to make Bermuda Proud.” We are immensely proud of the success achieved by our staff who have worked diligently over the past four years to meet our community's care requirements. Their accomplishments against a backdrop of first COVID-19 and then a major electronic medical record implementation have been phenomenal.

The surveyors highlighted significant BHB strengths and 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. Since the 2019 survey, BHB undertook a major project – the implementation of our electronic medical record, that we call PEARL (Patient Electronic and Administrative Records Log), a name suggested by and voted on by staff. This, in conjunction with other upgrades in our information systems, was a significant task that required the dedication of all staff. The implementation was the first step and with optimization as the next step, it will ensure that the data we can extract from PEARL will further assist BHB to improve services for the community.

Other quality initiatives include our ongoing collaboration with the Institute of Healthcare Improvement (IHI), the implementation of Wards of Excellence programme, and the partnership with Johns Hopkins, who supported us in achieving Stroke Distinction with Accreditation Canada. We started our transition to people-centred care by partnering with Accreditation Canada to educate our staff and community partners, drafting our patient-centred strategic plan, and involving patient advisors on two BHB committees. The organisation has embarked on various training workshops to reinforce the recovery model of care for mental health and other programs at BHB’s MWI site. Another improvement project is the development of integrated care pathways for breast cancer and mental health. These pathways aim to provide improved experiences and outcomes for those needing the services. All these projects, and more, are outlined in BHB’s 2021-2026 Strategic Plan.

While we are proud of the successes we have achieved, we acknowledge that there are areas that require continued development. Patient flow through the organisation is a challenge that we have identified. We have embarked on a 100-day challenge to identify issues and create solutions to address flow bottlenecks in the system. Human resources continue to be a global challenge in healthcare, and we are actively collaborating with external partners and the immigration department of Bermuda to ensure timely recruitment and retention of staff to provide the safest care to our community.

Accreditation Canada has been BHB’s partner in improving quality and patient safety for many decades, and we value the surveyors’ commentary. While it allows BHB to reflect on and celebrate with our staff the magnificent work achieved from the Strategic Plan 2021-2026, we recognise that the pursuit of excellence does not have an end point. We will incorporate the recommendations of the report to guide us on improving further. We will continue our quality journey, engaging our staff and community, to achieve our vision – the pursuit of excellence through improvement, to make Bermuda proud.

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 20 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
Communication	Communicating effectively at all levels of the organization and with external stakeholders.
Emergency Preparedness	Planning for and managing emergencies, disasters, or other aspects of public safety.
Governance	Meeting the demands for excellence in governance practice.
Human Capital	Developing the human resource capacity to deliver safe, high quality services.
Integrated Quality Management	Using a proactive, systematic, and ongoing process to manage and integrate quality and achieve organizational goals and objectives.
Medical Devices and Equipment	Obtaining and maintaining machinery and technologies used to diagnose and treat health problems.
Patient Flow	Assessing the smooth and timely movement of clients and families through service settings.
Physical Environment	Providing appropriate and safe structures and facilities to achieve the organization's mission, vision, and goals.
Planning and Service Design	Developing and implementing infrastructure, programs, and services to meet the needs of the populations and communities served.
Principle-based Care and Decision Making	Identifying and making decisions about ethical dilemmas and problems.
Resource Management	Monitoring, administering, and integrating activities related to the allocation and use of resources.

Priority processes associated with population-specific standards

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

Priority processes associated with service excellence standards

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

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