ACCREDITATION
AGRÉMENT
CANADA
Qmentum

Accreditation Report

Health PEI

Charlottetown, PE

On-site survey dates: June 12, 2022 - June 17, 2022

Report issued: August 24, 2022

About the Accreditation Report

Health PEI (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 June 2022. 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

Health PEI (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

Health PEI'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: June 12, 2022 to June 17, 2022**

- **Locations**

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

1. Addiction Services Provincial Addictions Treatment Facility
2. Addiction Services Talbot House
3. Cancer Treatment Centre
4. Community Hospital O'Leary
5. Cornwall Medical Centre
6. Douses Road
7. Garfield Street (Health PEI Headquarters)
8. Harbourside Family Health Centre
9. Hillsborough Hospital
10. Home Care - Queens County
11. Home Care - Souris Hospital
12. Home Care - Summerside
13. INSIGHT Program
14. Kings County Memorial Hospital
15. McGill Centre
16. Montague Health Centre
17. O'Leary Family Health Centre
18. Palliative Care Centre
19. Prince County Hospital
20. Prince Edward Home
21. Public Health - Sherwood Business Centre
22. Public Health - Summerside
23. Queen Elizabeth Hospital
24. Riverview Manor

25. Souris Hospital
26. Stewart Memorial
27. Summerset Manor
28. Wedgewood Manor
29. Western Hospital
30. Youth Recovery Centre, Summerside - Strength Program

- **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

Service Excellence Standards

4. Ambulatory Care Services - Service Excellence Standards
5. Biomedical Laboratory Services - Service Excellence Standards
6. Cancer Care - Service Excellence Standards
7. Community-Based Mental Health Services and Supports - Service Excellence Standards
8. Critical Care Services - Service Excellence Standards
9. Diagnostic Imaging Services - Service Excellence Standards
10. Emergency Department - Service Excellence Standards
11. Home Care Services - Service Excellence Standards
12. Hospice, Palliative, End-of-Life Services - Service Excellence Standards
13. Inpatient Services - Service Excellence Standards
14. Long-Term Care Services - Service Excellence Standards
15. Medication Management (For Surveys in 2021) - Service Excellence Standards
16. Mental Health Services - Service Excellence Standards
17. Obstetrics Services - Service Excellence Standards
18. Perioperative Services and Invasive Procedures - Service Excellence Standards
19. Point-of-Care Testing - Service Excellence Standards
20. Primary Care Services - Service Excellence Standards
21. Public Health Services - Service Excellence Standards
22. Rehabilitation Services - Service Excellence Standards

23. Reprocessing of Reusable Medical Devices - Service Excellence Standards
24. Substance Abuse and Problem Gambling - Service Excellence Standards
25. Transfusion Services - Service Excellence Standards

- **Instruments**

The organization administered:

1. Worklife Pulse
2. Canadian Patient Safety Culture Survey Tool
3. Governance Functioning Tool (2016)
4. 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)	89	3	10	102
 Accessibility (Give me timely and equitable services)	152	9	1	162
 Safety (Keep me safe)	846	33	25	904
 Worklife (Take care of those who take care of me)	194	7	1	202
 Client-centred Services (Partner with me and my family in our care)	650	14	0	664
 Continuity (Coordinate my care across the continuum)	139	4	2	145
 Appropriateness (Do the right thing to achieve the best results)	1360	54	17	1431
 Efficiency (Make the best use of resources)	77	3	3	83
Total	**3507**	**127**	**59**	**3693**

Overview by Standards

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

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

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

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

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Governance	50 (100.0%)	0 (0.0%)	0	36 (100.0%)	0 (0.0%)	0	86 (100.0%)	0 (0.0%)	0
Leadership	49 (98.0%)	1 (2.0%)	0	94 (97.9%)	2 (2.1%)	0	143 (97.9%)	3 (2.1%)	0
Infection Prevention and Control Standards	38 (97.4%)	1 (2.6%)	1	27 (87.1%)	4 (12.9%)	0	65 (92.9%)	5 (7.1%)	1
Medication Management (For Surveys in 2021)	93 (93.0%)	7 (7.0%)	0	48 (96.0%)	2 (4.0%)	0	141 (94.0%)	9 (6.0%)	0
Ambulatory Care Services	45 (100.0%)	0 (0.0%)	2	77 (98.7%)	1 (1.3%)	0	122 (99.2%)	1 (0.8%)	2
Biomedical Laboratory Services	70 (98.6%)	1 (1.4%)	1	99 (94.3%)	6 (5.7%)	0	169 (96.0%)	7 (4.0%)	1
Cancer Care	92 (92.0%)	8 (8.0%)	1	112 (87.5%)	16 (12.5%)	0	204 (89.5%)	24 (10.5%)	1
Community-Based Mental Health Services and Supports	45 (100.0%)	0 (0.0%)	0	93 (98.9%)	1 (1.1%)	0	138 (99.3%)	1 (0.7%)	0

Standards Set	High Priority Criteria *			Other Criteria			Total Criteria (High Priority + Other)		
	Met	Unmet	N/A	Met	Unmet	N/A	Met	Unmet	N/A
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Critical Care Services	60 (100.0%)	0 (0.0%)	0	103 (98.1%)	2 (1.9%)	0	163 (98.8%)	2 (1.2%)	0
Diagnostic Imaging Services	66 (97.1%)	2 (2.9%)	0	67 (98.5%)	1 (1.5%)	1	133 (97.8%)	3 (2.2%)	1
Emergency Department	67 (93.1%)	5 (6.9%)	0	96 (89.7%)	11 (10.3%)	0	163 (91.1%)	16 (8.9%)	0
Home Care Services	48 (100.0%)	0 (0.0%)	1	74 (100.0%)	0 (0.0%)	2	122 (100.0%)	0 (0.0%)	3
Hospice, Palliative, End-of-Life Services	45 (100.0%)	0 (0.0%)	0	108 (100.0%)	0 (0.0%)	0	153 (100.0%)	0 (0.0%)	0
Inpatient Services	47 (78.3%)	13 (21.7%)	0	77 (90.6%)	8 (9.4%)	0	124 (85.5%)	21 (14.5%)	0
Long-Term Care Services	56 (100.0%)	0 (0.0%)	0	99 (100.0%)	0 (0.0%)	0	155 (100.0%)	0 (0.0%)	0
Mental Health Services	48 (96.0%)	2 (4.0%)	0	92 (100.0%)	0 (0.0%)	0	140 (98.6%)	2 (1.4%)	0
Obstetrics Services	69 (97.2%)	2 (2.8%)	2	88 (100.0%)	0 (0.0%)	0	157 (98.7%)	2 (1.3%)	2
Perioperative Services and Invasive Procedures	112 (98.2%)	2 (1.8%)	1	106 (98.1%)	2 (1.9%)	1	218 (98.2%)	4 (1.8%)	2
Point-of-Care Testing	37 (100.0%)	0 (0.0%)	1	46 (100.0%)	0 (0.0%)	2	83 (100.0%)	0 (0.0%)	3
Primary Care Services	55 (93.2%)	4 (6.8%)	0	86 (94.5%)	5 (5.5%)	0	141 (94.0%)	9 (6.0%)	0
Public Health Services	31 (100.0%)	0 (0.0%)	16	54 (100.0%)	0 (0.0%)	15	85 (100.0%)	0 (0.0%)	31
Rehabilitation Services	45 (100.0%)	0 (0.0%)	0	79 (98.8%)	1 (1.3%)	0	124 (99.2%)	1 (0.8%)	0
Reprocessing of Reusable Medical Devices	82 (97.6%)	2 (2.4%)	4	37 (92.5%)	3 (7.5%)	0	119 (96.0%)	5 (4.0%)	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
	# (%)	# (%)	#	# (%)	# (%)	#	# (%)	# (%)	#
Substance Abuse and Problem Gambling	46 (100.0%)	0 (0.0%)	0	81 (98.8%)	1 (1.2%)	0	127 (99.2%)	1 (0.8%)	0
Transfusion Services	68 (95.8%)	3 (4.2%)	5	63 (95.5%)	3 (4.5%)	3	131 (95.6%)	6 (4.4%)	8
Total	**1464 (96.5%)**	53 (3.5%)	35	1942 (96.6%)	69 (3.4%)	24	3406 (96.5%)	122 (3.5%)	59

* 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 (Home Care Services)	Met	1 of 1	0 of 0
Client Identification (Hospice, Palliative, End-of-Life Services)	Unmet	0 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
Information transfer at care transitions (Ambulatory Care 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 (Cancer Care)	Unmet	4 of 4	0 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)	Unmet	4 of 4	0 of 1
Information transfer at care transitions (Emergency Department)	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 (Long-Term Care Services)	Met	4 of 4	1 of 1
Information transfer at care transitions (Mental Health Services)	Unmet	2 of 4	1 of 1
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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)	Unmet	4 of 5	0 of 0
Medication reconciliation at care transitions (Cancer Care)	Met	9 of 9	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
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

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Communication			
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 (Rehabilitation Services)	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
The “Do Not Use” list of abbreviations (Medication Management (For Surveys in 2021))	Met	4 of 4	3 of 3

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Antimicrobial Stewardship (Medication Management (For Surveys in 2021))	Met	4 of 4	1 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 (Home Care Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Hospice, Palliative, End-of-Life Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Inpatient Services)	Met	4 of 4	2 of 2
Infusion Pumps Training (Long-Term Care Services)	Met	4 of 4	2 of 2

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Medication Use			
Infusion Pumps Training (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
Infusion Pumps Training (Rehabilitation Services)	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)	Met	7 of 7	1 of 1
Patient safety plan (Leadership)	Met	2 of 2	2 of 2
Patient safety: education and training (Leadership)	Met	1 of 1	0 of 0
Preventive Maintenance Program (Leadership)	Met	3 of 3	1 of 1
Workplace Violence Prevention (Leadership)	Met	5 of 5	3 of 3
Patient Safety Goal Area: Infection Control			
Hand-Hygiene Compliance (Infection Prevention and Control Standards)	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 Education and Training (Infection Prevention and Control Standards)	Met	1 of 1	0 of 0
Infection Rates (Infection Prevention and Control Standards)	Met	1 of 1	2 of 2
Patient Safety Goal Area: Risk Assessment			
Falls Prevention Strategy (Cancer Care)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Critical Care Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Hospice, Palliative, End-of-Life Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Inpatient Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Long-Term Care Services)	Met	5 of 5	1 of 1
Falls Prevention Strategy (Mental Health Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Obstetrics Services)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Perioperative Services and Invasive Procedures)	Met	2 of 2	1 of 1
Falls Prevention Strategy (Rehabilitation Services)	Met	2 of 2	1 of 1

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
Home Safety Risk Assessment (Home Care Services)	Met	3 of 3	2 of 2
Pressure Ulcer Prevention (Cancer Care)	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
Pressure Ulcer Prevention (Rehabilitation Services)	Met	3 of 3	2 of 2
Skin and Wound Care (Home Care Services)	Met	7 of 7	1 of 1
Suicide Prevention (Community-Based Mental Health Services and Supports)	Met	5 of 5	0 of 0
Suicide Prevention (Emergency Department)	Met	5 of 5	0 of 0
Suicide Prevention (Long-Term Care Services)	Met	5 of 5	0 of 0

Required Organizational Practice	Overall rating	Test for Compliance Rating	
		Major Met	Minor Met
Patient Safety Goal Area: Risk Assessment			
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 (Cancer Care)	Met	3 of 3	2 of 2
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.

Health PEI is a Crown Corporation with a Board of Directors appointed by the Minister of Health. There is a dedicated and engaged Board of Directors in place with a desire to have the right mix of skills and membership that reflects the diversity of the community served. The current iteration of the Board is relatively new and is getting its feet under it along with a relatively new leadership team.

During the survey, the team met a variety of community partners who spoke highly of their relationships with Health PEI. The feedback is that relationships are purposeful and essential to the kinds of upstream partnerships that contribute to the health of the population, keep people from falling through the cracks, and prevent unnecessary admissions to hospital.

There is a highly engaged leadership team with a strong CEO who is present, supportive of the team, pro-active and visible.

Health Human Resource recruitment and retention is identified as one of the greatest challenges that the authority is facing. There are efforts underway to create a healthcare environment that healthcare workers and physicians will be attracted to. A review of scopes of practice in various settings would be beneficial to ensure that people are able to use all their skills to support system capacity. The organization is encouraged to continue to revamp the primary care system.

The changing face of the population on PEI is forcing discussions about whether the workforce and the programs being offered are reflective of today's population, with a population health needs assessment.

The organization is making efforts to evaluate the level of engagement of the workforce and the degree of satisfaction that the public has with the services provided. This work has been impacted by the pandemic response and by significant restructuring and leadership turnover in recent years.

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: Communication	
Information transfer at care transitions Information relevant to the care of the client is communicated effectively during care transitions.	· Cancer Care 22.9 · Mental Health Services 9.18 · Critical Care Services 9.23
Client Identification Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	· Hospice, Palliative, End-of-Life Services 9.2
Medication reconciliation at care transitions Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.	· Ambulatory Care Services 8.5

Detailed On-site Survey Results

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

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

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

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

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

See Appendix B for a list of priority processes.

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

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

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

Priority Process Results for System-wide Standards

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

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

Priority Process: Governance

Meeting the demands for excellence in governance practice.

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

The Board is in the first couple of years of its mandate. This Board, appointed by the Minister of Health, was created at a time when a reorganization of the Health Authorities was taking place. There was a push to have an integrated provincial health authority (Crown Corporation) that would be fully aligned with the Ministry of Health.

The Chair of the Board is appointed by the Minister and the Vice-Chair is selected by the Board. Previously the Board operated with guidance from medical staff bylaws; new governance bylaws have been formulated in the past year. The bylaws provide guidance to the organization around recruitment and retention of the CEO, including performance review and planning. The Board states that a skills matrix has been developed but it does not necessarily influence ministerial appointments.

Senior Board memebers support the orientation of new Board members and provide a mentor from the more experienced Board members for support. It is recommended that the Board formalize orientation and education to promote consistency and the development of new skills around good governance. This should include education about concepts such as conflict of interest; being on a small island conflicts will arise and the Board needs to have a clear process to deal with them. The Board is encouraged to strengthen the governance practices by establishing a clear role for oversight and planning. Although the Board has focused on the organizational structure in its initial mandate, it also should consider mechanisms that encourage generative thinking for continuous improvement.

There are three standing committees that Board members participate in: Quality and Safety; Audit Risk and Planning; and Human Resources.

The Board is supported by the senior leadership team to obtain data to support decision-making. Senior leaders participate in committees and preparation of Board packages. The objective is to have Board packages to Board members a minimum of one week prior to meetings.

The Board is proud to own and promote the in-place, strategic plan for 2021 – 2024 which includes a comprehensive mission, vision, and values statement. The Board acknowledges and celebrates the competencies and engagement that the leadership team has demonstrated throughout the response to the COVID-19 pandemic and the CEO's style for engagement with the public. The Board is fully committed to an integrated provincial health system and to strategic partnerships both in PEI and across the maritime provinces that will provide affordable and reasonable access to primary, secondary, and tertiary care. Like most provincial health authorities across the country, there is a commitment to alignment with the Minister's mandate through the Ministry of Health. The Board is interested in efficiencies that can be gained by strategically determining what functions can be directly operationalized by government and what should be the specific mandate of the Health Authority, particularly clinical service design.

The Board is proud of the work that has been done to embed patient advisors in decision-making structures throughout the organization.

There have been some challenges with defining and adhering to good governance principles around governance and operations because the Board has had to make many decisions, including a new leadership executive team in a short period of time. There is a desire to get to a place where the clinical operations team can operate independently within their pre-approved authority levels. The Board's stated intention is to be "nose in; hands out". The new bylaws are a significant step in that direction.

There is an interest in beefing up the approach to enterprise risk management so that risks are identified and approached in a more defined and deliberate way from the Board's perspective.

Priority Process: Planning and Service Design

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Health PEI is a Crown Corporation. Their mandate is to operationalize the priorities of government for the health of the population. In practice, there is not a clear distinction between governance and operations. The Health Authority is expected to operate in lock step with the Ministry of Health and decision-making is expected to be joint and collaborative.

The organization has a new strategic plan for Fiscal Year (FY) 2021 - 2024. The strategic plan is a user-friendly document that describes the accountabilities, explains the structure of the organization, and provides a current environmental scan which includes some population health information to set the stage for the strategic priorities that have been adopted.

The strategic and operational priorities are well understood and owned by the leadership team. One of the challenges is that with many of the significant organizational changes that have occurred in the past several years, there is some skepticism about whether the team has the mandate to proceed in bold new directions based on what the evidence says about organizational design and best practice. For example, HHR recruitment and retention is a huge priority for Health PEI. To compete in this HHR environment, organizations must be proactive and ready to make decisions quickly when opportunities present themselves. In the current arrangement, some of the Human Resource components for physicians and staff sit with Health PEI and some sit with the Public Service Commission and the Department of Health and Wellness, which calls into question the ability, for the system, to be as flexible and timely as required to be competitive with other health jurisdictions.

There is a process and structure to solicit and organize client and family partner input into all aspects of the organization's decision-making processes. Client and family representatives were present and engaged in many of the tracers, especially at the leadership level. It is noted that with the COVID-19 pandemic response, and the fact that this is a relatively new leadership team, there is still a lot of work to ensure that strategic and operational priorities, such as this, make their way to the front line.

Community partners were present and engaged in a session designed to seek their input into what is going well and opportunities for improvement from their perspective. The input was generally positive about opportunities to collaborate and responsiveness from the Health Authority on work that is done together to create system improvements. Examples of strong and collaborative working relationships were provided by partners from the University, the Hospice Society, and others. It is worth exploring whether the organization in all its facets is representative of the communities it serves. The Health Authority is working to strengthen its relationships with the Indigenous and Francophone communities.

Although, there is representation from Immigrant Services at the community partner table and at the Board level. The concept of the "changing face of the population" of PEI was consistently repeated over the course of the onsite survey and should be a strong theme as the strategic plan is operationalized.

Having a framework for managing change was described as something for which there are toolkits but not a robust change management plan. Frameworks such as the ADKAR model was mentioned as informative. Leaders stated that with all the challenges that the organization has faced in recent years it would be prudent to put some work into fleshing out what a more organized approach to change would look like.

Generally, great work has been done on the formulation of the strategic plan and on demonstrating the dedication of leadership to advocate for and to steer the organization in the directions to which they have committed.

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)

Health PEI is a Crown Corporation. Strictly speaking, it has an arm's length relationship with government but practically, like many healthcare organizations, the relationship between this publicly funded agency and government requires a very high level of accountability for the significant investments that go into the healthcare system.

The fiscal year is aligned with government: April 1 to March 31. Following the Financial Services Act and the Health Services Act, the organization prepares and provides financial forecasts to the Treasury Board each quarter of the fiscal year. These forecasts and the work that is done in between provide the opportunity to address and adjust to variances that are anticipated and substantiated. There is full transparency and accountability demonstrated for public funds that are allocated to health system operations.

The Authority is subject to the expected accountabilities laid out by public government.

To facilitate the steps in the annual financial cycle there are business analysts assigned to support the work of cost centre managers throughout the organization. These business partnerships help the operations managers to understand their budgets and to analyze variances so that adjustments can be made depending on the cost drivers that have ben identified.

As a Crown Corporation, Health PEI is subject to audit by the Auditor General's office. The Board of Directors has an active Audit, Risk and Finance Committee that provides input and feedback on accountability measures and exercises. There are specific criteria that are used to vet proposed expenditures, such as: Does it support the strategic plan? Is it critical to operations? Is it a Board priority? Is it in the Minister's mandate? Is it a government priority?

There is a robust accountability structure in place to secure and account for funding that has been allocated to categories of expenditure that have been pre-approved by government. There is some concern about the ability to respond quickly to situations where the Board and CEO might want to pursue an opportunity that would be an advantage to PEI even though it does not fit perfectly with a pre-approved category of expenditure. An example of this is the opportunity to recruit a physician or healthcare professional who is also being courted by other provinces at the same time without going through a complicated bureaucratic process.

Priority Process: Human Capital

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

Unmet Criteria		High Priority Criteria
Standards Set: Leadership		
2.8	Continuing professional development and learning is supported.	
10.10	Reporting relationships and leaders' span of control is regularly evaluated.	
10.11	Policies and procedures for monitoring team member performance align with the organization's mission, vision, and values.	!

Surveyor comments on the priority process(es)

Health PEI identifies recruitment and retention of staff and physicians as one of its major challenges. This is a topic that is routinely discussed with the government and the Board of Directors.

The organization has a somewhat unique relationship with government in the sense that some HR functions are with Health PEI, and some are with the public service. This can be challenging for a healthcare organization that is competing for specialized resources with healthcare organizations across the country. In this recruitment and retention environment, healthcare organizations must be nimble and responsive to the needs of hard to recruit clinicians and supports. Health PEI works closely with the human resource supports from the Public Service Commission and Department of Health and Wellness but sometimes finds it challenging to create a timely and smooth flow to recruit and onboard people with specific healthcare skill sets that are in very high demand.

There is a new talent management plan that is expected to be complete in the fall. The talent management plan outlines several initiatives to augment the recruitment and retention environment in support of the strategic priority related to "people". The plan outlines specific actions to be taken within specified timeframes to acknowledge the urgency of the HHR challenges. There is a strategy to consult with all stakeholders in order to take a comprehensive and consistent approach and to recognize the value of all clinicians, physicians, and allied healthcare workers.

The organization is currently attempting to achieve enough feedback on its employee engagement survey to consider the results significant. The engagement survey is seen as a major indicator that people have been invited to provide feedback and input into HHR strategies.

There is some significant work underway to discuss and address workplace violence.

Medical Affairs has a robust recruitment and retention strategy that is largely based on creating work

environments in which physicians can practice. The reforms to the primary health care delivery system are progressive and responsive to the needs of patients, communities, and physicians. These would promote work-life balance for physicians and provide variety of practice and guaranteed income.

Challenges were noted with a consistent approach to performance review and planning although there are plans underway to pivot to a less documentation-heavy approach. Access to and support for leadership professional development does not appear to be available. This is an item that is likely even more critical than it was prior to the COVID-19 pandemic response because many veteran leaders are making decisions to leave the system. Emerging leaders will need support to function and provide the leadership that is required for the dynamics associated with "pandemic recovery".

The organization will benefit from improving the technology in some areas to support and monitor staff education and training.

Priority Process: Integrated Quality Management

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

Health PEI's Strategic Plan, and other guiding documents, make bold statements about quality and safety being part of the fabric of the organizational culture. There are twenty-one quality improvement teams embedded in operations. These teams are intended to support every program and service throughout the organization by meeting monthly to identify strengths and opportunities for improvement.

Notably, the Quality Improvement Teams have performed at a high level and been present with its teams virtually and at the point of care, to the extent that COVID-19 pandemic precautions have allowed, throughout the pandemic response. Over the course of the survey, many examples were given of work that has been done to respond to issues, comply with audit requirements, and to improve existing services. Most notable is some of the work that has been done in long term care to engage residents, families, and the multi-disciplinary teams in how to maintain and improve conditions for seniors and others requiring ongoing residential care.

There is a lot of discussion about risk management as it relates to the quality improvement framework. Being a Crown Corporation presents some challenging dynamics for the organization when it is setting operational priorities. Strategic and operational plans must be in alignment with government priorities. Sometimes this can constrain the organization when it wishes to adjust priorities based on what population health data says about where resources should be allocated. Practically speaking, this means that the organization cannot be as nimble as it wishes to respond to demands at the front line because of the various levels of approval that are required at both organization and government levels to make decisions. In terms of quality and risk the organization has experienced this as a set of dynamics that forces it to focus its limited resources on responding to perceived crises and managing complaints instead of pro-actively identifying its greatest risks and methodically pursuing quality improvement initiatives to improve the system.

There is a structured way of gathering evidence and reporting on quality and risk, quarterly, to the Board of Directors. This includes the provision of raw data and a summary that will, for example present the top five incidents that have been responded to and the top five concerns that have been addressed. In this way, the Board and the operations team have the opportunity to discuss what quality and risk means at the point of care, how existing resources are being utilized, and what the pressures are to reallocate resources or invest in certain areas as priorities shift based on what is happening in the ever-changing healthcare environment.

The twenty-one quality teams are intended to have two client partners. The organization is committed to

the engagement of client and patient partners and has a structure in place to recruit, orientate, and support these vital partners.

During the survey, it was noted that the highest level of engagement in visible, structured, ways of integrating quality mechanisms in day-to-day operations is in long-term care. This is something the organization is proud of and is recognized as an example of how the concept of scale and spread could apply to the rest of the organization. For example, if the way in which a team uses quality boards is dynamic and effective, then the mechanism should be socialized with other units.

There is an evaluation component to quality improvement initiatives, but it is recognized that this could be more structured and evident. It is a challenge for the Quality Team because they recognize the importance of understanding and sharing "what worked and what still needs to be done" but they are very constrained by precious resources. These resources are often pulled away to deal with issues that have been escalated to senior leadership or government. This takes resources away from improvement and into response to items that may or may not have substance. Examples were given of improvement efforts in point of care testing in emergency, the difference that specific nursing interventions make to patient outcomes, and the value of root cause analysis in LTC. The organization is encouraged to think about ways to make quality improvement initiatives highly visible and celebrated so lessons learned about both methodology and results, have a better chance of becoming socialized throughout the culture of the organization. The use of quality boards could be enhanced to become a useful and dynamic visibility tool with real time results to engage staff in things like quality huddles. The organization is encouraged to do further work on cascading quality improvement to the front-line staff and their day-to-day operations.

The organization uses the government procurement process to manage contracts. There is recognition that there should be a central repository of contracts and that the organization should be more proactive about contract management. The current process meets government requirements as to the format of contracts but does not push pro-active consideration of whether the organization is getting the best value for money. For example, there are site specific contracts that might be better managed as part of a multi-site/group purchase arrangement.

The Provincial Safety Incident Management System works well for the organization. There is confidence and evidence that there is a strong culture of reporting and a desire to be more pro-active in 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 long-standing and well-developed process in place to build, maintain, and lead operationalization of the ethics framework. There is a specific committee in place to vet research initiatives. The organization contracts the services of an ethicist from Dalhousie University.

Education and awareness of the ethics framework and the process for reviewing ethics issues is a major focus of the ethics committee. The committee has recognized that healthcare workers may have an academic understanding of what an ethical issue might be, but that they may need support and information to know when and how to access support when confronted by an issue with ethical implications. The organization makes itself available to provide training sessions of varying lengths and focus to groups throughout the organization. Members are recruited with the understanding that they must commit to participation in educational activities that build the organization's capacity.

The committee updated its ethics framework in 2021 and is in the process of updating the one-page colourful graphic of the framework to make it more user-friendly for people. The goal of this exercise is to arm people with information before they experience a situation that could lead to moral distress.

The committees described making presentations to the Board but neither the Board nor the committee could confidently say that there is a sense of ownership by the Board of Directors. This is an important factor to consider because strong ownership at the governance and leadership level is critical to creating what the team describes as a culture based on the organization's beliefs and approach about ethics.

There is patient representation on the committee and encouragement for the full involvement of all members in all aspects of this work. There is opportunity to consider membership that is representative of the communities served, including the Indigenous community.

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)

The organization has a small communications department that is very much focused on building some foundational platforms and tools to support the work with both internal and external stakeholders. The communications group has been impacted by organizational structure changes over the past few years. At some point, there was an intention to have Health Authority communications managed by the government of PEI, but this model proved to be challenging for the Authority because its priority is to deliver clinical operations whereas the government's focus is on broader communications about the design of the healthcare system and the priorities of the government of the day.
The Health Authority is encouraged to improve the communication system to ensure all staff are receiving the information and to reduce the current challenges related to spreading information across all employees.

Health PEI's communication team's areas of focus are issues management, engagement with community and partners, and building and sustaining the workforce (the people strategy). Currently the focus is to align with government on issues management and to tell the stories that inform and reassure the public about the priorities and sustainability of the health system.

Communication standards are met but with the acknowledgment that building a communications team with an updated communication plan is necessary to remain current and to demonstrate to the public that there is alignment on strategic priorities. Also, the strategic and operational priorities of Health PEI are built to serve Islanders but are generally aligned with the priorities of the Canadian healthcare system in other provinces. Examples of this would be Health Human Resource strategies, reform of the primary care system, and recovery from the COVID-19 pandemic. There are many lessons to be learned from organizations who have implemented high performing programs already. PEI can capitalize on what has worked well in other jurisdictions.

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)

Leaders from many of the Health PEI facilities participated in a general overview discussion related to physical environment as an introduction. There is oversight to ensure that legislative laws and codes are met effectively and efficiently. However, there must be attention placed on the safety of the buildings while many of the locations are awaiting redevelopment. Generators are tested weekly and additional testing occurs monthly. Hot water tanks are tested annually. There is a 48-hour supply of drinking water in the event of water loss. Portable toilets can be brought to the sites should they be required. Business continuity plans are in place so services can proceed as necessary to address whatever incidents might occur such as backup generators, steam/heat, and water.

A collaborative five-year capital planning process has been conducted to assess and address infrastructure needs Island-wide. Maintenance routines are standardized across the facilities. The maintenance teams perform regular preventative maintenance on the infrastructure systems.

Improving parking lot lighting for safety and risk reduction at Queen Elizabeth Hospital has been identified as a need and requires funding approvals. Western Hospital received funding for heating pumps.

The hospitals are challenged with staffing turnover and replacing engineering and other specialty roles.

Queen Elizabeth Hospital was originally built in 1981 and additions have been made to the original structure over subsequent years. The footprint of the entire building is approximately 350,000 square feet. The Cancer Treatment Centre includes a radiation bunker, and all relevant safety and risk processes are in place.

Members of the PCH maintenance team belong to the Construction Safety Association and have attended numerous education sessions to ensure their safety. PCH has a biomass burning plant that provides close to 80% of the facility's electrical needs. The community of Summerside has a wind farm from which the PCH accesses its electricity needs. The PCH will partner with the community of Summerside on an upcoming solar farm project; the organization is scheduled to install a solar farm on the PCH property to further supply energy to the site. These initiatives are to be commended.

Most sites are extremely clean, well lit, and free of clutter. Signage is very good inside most of the buildings. External signage, such as the location of H signs, should be evaluated. Hospitals that do not offer 24-hour emergency care may reconsider the H signage to mitigate the risk of patients presenting after hours to a closed department and delaying care.

Souris Hospital is 35 years old, and leaders indicate the building requires upgrades.

Kings County Memorial Hospital is an older hospital that has renovated the lab and phlebotomy area. They are in the process of completing renovations in the kitchen and cafeteria. A major roof repair is planned for this summer. Surveyors report that the roof is leaking in the newly renovated areas. The morgue is a closet with a folding door in an accessible area. This space must be reassessed for security and appropriateness. Storage space is minimal resulting in supplies being stored in the hallways and opportunities to recover alternate storage areas should be explored. The maintenance shed contents must be assessed for appropriateness of contents and much of what is stored there should be removed including garbage, such as food and beverage containers, medical records, and appliances.

Security at the KCMH should also be assessed including securing access doors and housekeeping closets. The emergency and inpatient care departments have poor sight lines for patient monitoring and supporting other staff. The ambulatory care unit should be re-evaluated for space, support, and patient volumes.

The staff smoking area at KCMH is adjacent to the oxygen storage facility and should be reviewed.

Community Hospital O'Leary has had additions and some renovations (former ED now the Ambulatory Care Unit), and the O'Leary Family Health Centre was built in the late 2000's and is attached to the hospital. It is a fabulous space with a good number of examination rooms, offices, procedure rooms, and a safe waiting area.

Hospitals have installed environmentally friendly and energy-saving fixtures (low flush toilets and LED lighting) when funding is available. Several hospitals have also focused on naturalized spaces and general greening with the involvement of community members.

The operating rooms meet standards for air quality, temperature, and humidity. Operating Room (OR) air exchanges meet the 20 exchange per minute requirement. Three-phase restrictions within the OR are in place.

The two hospitals in Charlottetown and Summerside host a helipad to facilitate patient transfers. Security is responsible for checking that the area around the helipad is safe and secure.

Access to patient and staff areas is restricted by key card access (QEH).

Health PEI is commended for installing electric car charging stations at several of the sites.

The Physical Environment teams are encouraged to conduct walkabouts throughout clinical areas to identify deficiencies that require repairs in areas such as Prince County Hospital, Kings County Memorial Hospital (KCMH) reprocessing area (flooring), and interior and exterior of KCMH and Queen Elizabeth Hospital central core area within the OR (flooring).

Priority Process: Emergency Preparedness

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

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)

The organization has a robust Emergency Preparedness Plan with designated resources assigned to it. The Incident Management System is the structure that is used for Emergency Response. The All Hazards approach to emergency planning is used. The organization has identified some of the most likely situations that Health PEI may have to respond to, but also prepares for any eventuality.

The COVID-19 pandemic response has provided a platform to really focus on emergency response over a prolonged period. The entire team has been engaged in the process. The experience underscores the value of a structure that clarifies roles, encourages partnerships, and facilitates real-time decision-making as an emergency situation evolves.

One of the steps in practicing or responding to emergencies is the debriefing that occurs at the conclusion of a process. This is identified by the organization as one of the most important opportunities for learning and continuous quality improvement.

There are strategic partnerships with other responders in the communities.

There are close working relationships between the Health Authority and the government to set and operationalize policy. Although the COVID-19 pandemic has intensified the collaborative process, there are well established policies and procedures to identify, analyze, and implement responses to potential outbreaks.

The organization is commended for the high degree of engagement that was observed during tracers related to Emergency Preparedness. The coordinator is highly engaged and well versed in the ICS structure and appears to be a valuable and respected resource to the leadership team. It is evident that the work around Emergency Preparedness is driven by leadership and that the system is designed to engage at the point of care to embed skills at the site level with information, opportunities to practice, and drills.

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: Cancer Care		
1.1	Services are co-designed with clients and families, partners, and the community.	!
1.8	Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.	
2.4	Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.	
8.12	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.	
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.	
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.	!

Surveyor comments on the priority process(es)

Health PEI has a long history of engaging patients and families in their health care as well in the improvement of the health care system. This commitment has recently been reaffirmed through their new mission statement “working with Island communities to deliver inclusive innovative and person-centered health care to all.”

A Patient and Family Centered Care Steering Committee was established in 2016 with the mandate to

develop strategies and processes to implement and monitor Health PEI's strategic performance indicators as they relate to person centered care. This structure has evolved to include a Patient and Family Partner Advisory Council. The Council's responsibilities are to review and provide feedback on structures and processes which guide care across HPEI, including policies and procedures, care guidelines, and patient satisfaction results. The Council meets a minimum of three times per year, is co-chaired by a Patient and Family Partner, and is supported by the Health PEI Patient Experience Manager as well as the Chief Nursing and Professional Practice Officer. The Patient and Family Partner Advisory Council is commended for its recent work in the development of an orientation program for new partners as well as the informal get togethers of patient and family partners that are held. The Council is encouraged to continue these informal sessions, perhaps rotating them as done prior to the COVID-19 pandemic and include an education session as part of the event.

In addition to the Council, there are twenty-one Quality Improvement Teams (QITs) across the different clinical programs and initiatives throughout HPEI. Each QIT has a patient and family partner on the committee. The Quality Improvement Teams create the forum for patients and family members to have direct input into service design and delivery in the clinical area or initiative. There is Patient and Family Partner representation on the HPEI Board as well as the Executive Leadership Team. Currently some QITs do not have patient and family representatives and these teams are encouraged to look to recruit representation as soon as possible.

The engagement of patients and family members, in the direct care of the patient, was seen across the areas reviewed by surveyors. There were many examples of strong collaboration with patients in care planning and transitions in care. Of note was the inclusion of a Partnership Care Plan in all ambulatory environments and in long-term care residents and family members are included in the discussion when the interdisciplinary team is reviewing the care of that resident. As well, in long-term care, it was observed that residents have the ability to self-determine their activities and the timing of those activities such that care is individualized to meet the residents' needs. Sensitivity to clients' needs was seen within public health where private sessions are arranged for clients who may have challenges with language, as well as the development of mobile dental setups to remove barriers to access for some children. Within the inpatient mental health units and community-based mental health organizations, there have been comprehensive surveys sent out to family/clients on wait times, group programming, and services offered. There is, also, a specific group looking at a major capital redevelopment project for Mental Health services. Several patient and family representatives are closely involved with this work.

Health PEI is commended for the work that has been done and continues to move forward to engage patients and family partners in designing and evaluating health care. The organization is encouraged to do further work on cascading patient and family involvement to the front-line staff and their day-to-day operations.

Priority Process: Patient Flow

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

Unmet Criteria	High Priority Criteria
Standards Set: Perioperative Services and Invasive Procedures	
9.9 Wait times for service are monitored and compared to identified targets (e.g., provincial wait-time targets).	

Surveyor comments on the priority process(es)

Health PEI has made patient access and flow a provincial priority and specific plans and changes to bed management oversight became effective at the beginning of 2022. Prior to this, bed management strategies were focused on local issues creating unequal access to important clinical resources. Leaders are proud of the collaboration and system integration efforts that have made some improvements in patient flow and access to services particularly since the beginning of 2022.

Several Industrial Engineering students have been engaged to assist the Patient Flow Manager with collection of the patient journey data. They plan to develop a software system to improve scheduling that will positively impact the patient journey.

However, it is noted that overcapacity and high ALC rates continues to be a primary concern with all teams. This results in offload delays with EMS (ambulance), additional pressures on patient wait times for assessment/treatment in EDs and depending on the severity of overcapacity across the hospitals, surgeries could be postponed/delayed. Health PEI is commended for their quality improvement activities related to patient access and flow and are highly encouraged to continue to advocate for resources to support their activities.

The bed management leaders indicated that their new approach to patient flow is a work in progress. Many of their policies are under development and require the provincial approach to be finalized. The daily provincial bed management meetings now include leaders from across the province and discussions cascade down throughout the individual hospitals.

There is an overcapacity policy in place that has recently been revised. During the survey, the Emergency Department had 18 patients admitted without bed assignments at Queen Elizabeth Hospital. An urgent bed meeting was held during the day to assist with moving patients into the beds that, in fact, were available. The team is encouraged to continue to educate leaders across the individual hospitals and province about the importance of collaboration and “pulling” patients up into beds on the inpatient side to avoid the need to request diversion. The organization is encouraged to continue to reinforce that patient flow is everyone’s business. Silos in community services continue to exist that prevent discharged patients from returning to the community with supports. While some improvements have been made, the

organization is encouraged to continue to find creative solutions and pathways that support integrated care.

The team reported many “wins” in relation to improved bed management such as better flow with mental health patients, bed openings that had previously been closed, and significantly improved collaboration between hospitals including repatriation processes.

Wait times are an issue for many of the services provided by Health PEI.

Surgical wait lists are monitored and there is a concerted effort to avoid surgical cancellations when surge capacity has been reached. However, there is an opportunity to optimize patient flow through the OR. The OR leadership is encouraged to review the OR scheduling processes and ensure they are in line with best practices.

Data analysts have developed a business intelligence tool that enables leaders to have access to information related to patient flow, such as wait times. The ED team is fortunate that the Electronic Health Record (Cerner EHR) has a tracking board that indicates the length of stay and various wait times against set targets. Quarterly reports with data, trending, and analysis of results are provided and accessible by all staff.

Prior to the COVID-19 pandemic, patient advisors had been members of the Patient Flow Steering Committees. The hospitals are encouraged to reinstitute their membership because of the importance of patient and family feedback on patient access and flow. Given the involvement that patient advisors used to have on the Bed Management Steering Committee, the standards requiring "with input from patients and families" are considered to be met.

Kings County Memorial Hospital closes at 8pm. The exterior “H” sign could be interpreted to indicate that their operational hours are 24/7. The team should reassess the signage for this hospital.

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		
2.5	The effectiveness of resources, space, and staffing is evaluated with input from the team, and stakeholders.	
3.6	The MDR department has floors, walls, ceilings, fixtures, pipes, and work surfaces that are easy to clean, non-absorbent, and will not shed particles or fibres.	!
3.7	The MDR department is clean and well-maintained.	!
4.1	Reprocessing equipment is purchased based on service volumes, input from team members, and considerations for maintenance, cleaning, and infection prevention and control.	
11.3	All flexible endoscopic reprocessing areas are equipped with separate clean and contaminated/dirty work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.	

Surveyor comments on the priority process(es)

As the surgical programs grow, the footprint of the MDRD will be challenged to keep up at both QEH and PCH. The organization would benefit from surplussing underutilized equipment to create additional space at QEH and decommissioning autoclaves in the sterile core at both QEH and PCH.

Initial MDRD equipment reprocessing training provided by a vendor representative; a Super User and Train the Trainer model is established. At QEH all scopes are processed by credentialed medical device reprocessors. At PCH, registered nurses are trained by vendor and reprocess all flexible scopes used in the operating room. This practice is intended to ensure that competency of the nurses is maintained in the event that a flexible scope is used during the off hours when the MDRD team is not available, however, a consideration for the organization is to leverage the expertise available during business hours to ensure the endoscopes are processed by those staff certified to do so.

Community Hospital O'Leary provides reprocessing services for Western Hospital, the O'Leary Family Health Centre, in addition to its own instrumentation. O'Leary is a small hospital with no Emergency Department or Operating Room. Most of the reprocessing items are those used for small non-invasive procedures. Reprocessing occurs within a new space that was purposefully designed to meet all reprocessing and infection prevention and control standards.

All current MDRD policies up to date.

PCH celebrates MDRD team members for a week each October with daily recognition and festivities.

Heath PEI sites partner with Saskatchewan Polytechnic to obtain certification of their MDRD teams. This innovative approach to ensuring comprehensive training to be commended.

All MDRD staff complete annual site-based competency assessments that follow the CSA standards.

Every autoclave load at both QEH and PCH, not just those with implants, contains a biological indicator - exceeds the standards and mitigates the need for recalls.

Although the majority of surfaces in MDRD at Prince County Hospital are easy to clean and nonabsorbent, the floor finish in the decontamination area is worn down to the concrete posing a hazard. The teams indicate this project has been submitted for approval in the past two years. The Queen Elizabeth Hospital has a very clean and well maintained MDRD. KCMH reprocessing area has broken and water-damaged floor tiles (possibly asbestos) and while the main work areas and some shelves have been changed to stainless steel, wooden cupboards and permeable counters are still within the department. There is also a decommissioned still which continues to occupy a section of the reprocessing area. The KCMH reprocessing area is well cleaned but the tile flooring is broken and lifted in areas.

KCMH has not evaluated the effectiveness of resources of staffing. A significant portion of the reprocessing is under private contract to external organizations. Team members and leadership were unable to find data on whether costs were covered for this service.

KCMH Maintenance department recently purchased a new sterilizer for the reprocessing area. Although the staff input was sought, the item purchased to not meet the specifications of the team. This equipment was installed but is unusable and awaiting retrofitted equipment to make this new purchase compatible with the equipment in the department and suitable for safe and effective use.

No externally contracted services in place. The reprocessing department at KCMH provides reprocessing services for several other facilities within HPEI. Formal contracts were not available for review and the cost-sharing for the reprocessing support provided to these other facilities was unclear in most cases. There is an opportunity for the KCMH reprocessing department to review their volumes and contract details with the supported facilities to ensure that costs incurred are covered for supplies, equipment, and staff. This is also an opportunity to determine whether disposable instruments and trays (speculums, suture kits and dressing trays) are a financially viable alternative to reprocessing.

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

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.

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	
8.5 Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.	ROP
8.5.5 The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with an accurate and up-to-date list of medications the client should be taking at the last visit or upon discharge from the clinic.	**MAJOR**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The ambulatory program consists of nursing care suites and ambulatory care services located at QEH, PCH, KCMH, and all the community hospitals. There are same day treatment clinics close to most patient's homes and the specialized clinics are centralized. Specialized services include the eye clinic, orthopaedic clinic, neurology clinic and vascular clinics at QEH. Both PCH and QEH have minor procedure, endoscopy, respiratory therapy, and cardiovascular services.

At all locations, patients can receive CADD pump maintenance, IV antibiotic treatments, iron infusions blood products, and complex vascular dressings. Patients with chronic diseases such as diabetes, vascular disease, or renal disease are also serviced through theses clinics. It is anticipated that patients with Long

Covid will soon be seen at these clinics.

The Provincial Renal Clinic consists of the Peritoneal Dialysis Program, Transplant, Conservative Care Program, CKD Program, In-Centre Hemodialysis, Acute Hemodialysis, PCH (In-Centre Hemodialysis), and Souris and West (Community Satellite Hemodialysis). Patients with acute kidney injury, acute kidney failure, chronic kidney disease, and end-stage kidney disease are served.

The clinic spaces at QEH, and PCH are spacious and bright. Western Hospital is a small program run by an RN (and a second RN is joining the team). Referrals to the clinics are completed through family physician offices and the physicians working in ED (family physicians). The clinical space is in the newer section of the hospital and is very clean and spacious. The ambulatory care department at KCMH is small and of inadequate size to safely, and privately, manage the volume of patients that receive care. Staff frequently need to move equipment to provide care and the proximity between spaces makes confidentiality challenging.

The organization should strongly consider relocating this service to a larger space better suited to providing safe patient care potentially closer proximity to the emergency to provide better support and coverage and to streamline resources.

Priority Process: Competency

Staff are cross trained to cover a variety of roles where possible and ongoing education is offered to ensure that best practice standards are being met. In some cases, virtual sessions are made available. Staff working in the nephrology clinics require specialized training. Similarly, staff working with sterilizing equipment must complete their training and certification. As new technology is introduced into the clinics, such as dialysis machines, the staff receive education on the equipment to ensure that patient safety is maintained.

Priority Process: Episode of Care

There are patient satisfaction surveys that have been conducted annually. Some comments identified a need to reduce patient wait times because many appoints were booked at the same time. This has been reviewed and the team made significant improvements in distributing appointment times throughout the day.

Prince County was able to install 2 speech passthrough systems in endoscopy and registration to improve the communication for hearing impaired persons.

Some of the quality initiatives include the 5 A Handoff which is a standardized partnership care plan that is being used in many of the clinics to document the reason for visit, education, risk factors, symptoms, history, support network, transportation, nutrition, and housing.

Priority Process: Decision Support

The ambulatory clinic documentation is paper based. However, the nephrology clinic has been successful in advocating for documentation of the patient's BPMH in the Cerner system. The electronic documentation facilitates improved communication to clinicians when the patient is admitted to one of the hospitals. An opportunity exists for the organization to leverage the existing CIS and expand to all clinical areas in the organization to mitigate the risk that hybrid documentation systems pose.

The ambulatory care team is in the process of transitioning from the KCMH form to the HPEI referral form for care. The team noted that the patient's date of birth was not included on the new form which impacts verifying the 2 patient identifiers

Metrics from the ambulatory care department should also be collected and reviewed in consultation with patients and families to determine volumes and referral patterns to ensure that staff resources are appropriately allocated to support the KCMH department.

Priority Process: Impact on Outcomes

The Best Possible Medication History (BPMH) collection rates are being monitored regularly. There is excellent completion of the BPMH rates. The team is encouraged to select a small, defined group, of patients to provide discharge Medication Reconciliation to ensure information is communicate to the next care provider.

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		
3.2	The team regularly evaluates its arrangements with referral laboratories and external consultants to verify that the requirements are being met and documents the results.	
6.4	The team's competency is assessed following a new staff member's orientation and on a regular basis thereafter.	
9.2	The team regularly monitors and records environmental conditions within the laboratory.	
9.5	The team maintains an alarm system for applicable equipment to alert team members to changes in environmental conditions or malfunctions and tests this alarm system regularly.	!
11.3	The team updates its SOPs every two years or more often if required.	
11.6	The team regularly evaluates compliance with its SOPs and makes changes as needed.	
15.6	The team follows a policy for using expired reagents only under exceptional circumstances that requires validating their continued suitability for use.	

Surveyor comments on the priority process(es)

Priority Process: Episode of Care

Staff are aware of hospital falls prevention strategy. Phlebotomy areas are free of clutter and spacious enough to allow for ease of movement.

Priority Process: Diagnostic Services: Laboratory

The provincial laboratory system has made continued progress since the last accreditation. There are several provincial committees that meet regularly to share best practice and develop a standard approach to the provision of laboratory testing. Staff from all facilities indicated that these committees provide a forum for discussion, learning, and process improvement.

Management of referred out specimens is centralized at the Queen Elizabeth Hospital (QEH). The team maintains a registry of their referral laboratories and external consultants. There is no ongoing verification of the referral laboratories current accreditation status. This documentation should be requested and kept current.

Orientation and initial training and competency assessment is well done. Competency assessment is repeated in individual cases following incidents or if indicated. The Histology department developed a quality assurance tool that allows them to address competency issues in a timely manner. There is no formal, consistent, or ongoing competency assessment program at QEH or PCH. The team is aware this needs to be addressed and are committed to developing it through their provincial group. Kings County Memorial Hospital (KCMH) has a good competency assessment program for staff.

The team has embraced the document management system (Omni). Not all procedures have been reviewed in the 2-year period. There are several printed documents posted for ease of access. Consideration should be given to adding an authorizing signature and the date the document was posted to signify they are current versions. Signatures and dates of review are missing from several different documents (training and competency sheets, maintenance sheets etc.). The team is encouraged to move forward with ensuring review and documentation is complete.

Maintenance of equipment and instruments is consistently performed. Humidity is not monitored in the laboratory at PCH. Remote alarms were recently installed for all refrigerators and freezers at PCH. A process for testing of remote alarms needs to be developed.

There is no policy for use of expired reagents.

The QEH safety committee meets regularly, and standard policies are under development. Due to staffing issues and workload, the safety committee at PCH has not been meeting. This committee is encouraged to establish a method of checking in to ensure that safety issues are not being overlooked.

Many members of the team stated that the addition of a Quality Improvement coordinator has resulted is an increased level of engagement and commitment to quality initiatives. Several quality initiatives have been completed. These include an audit of blood culture volume, COVID-19 testing turnaround time (TAT) monitoring, evaluation of liquid-based collection for thyroid aspirates, specimen cancellation due to mislabeled tubes, and blood drawn from wrong patient. A physician survey on the Microbiology requisition resulted in some beneficial changes. Patient and physician satisfaction surveys are planned for Fall 2022. The provincial quality improvement team continues to meet regularly and is a perfect venue for developing solutions for identified gaps. The laboratory is encouraged to continue with the standardization of policies and procedures across the province.

CLSI documents are on Omni. Adding the CSA standards for Blood Products, the ISO 15189 standards, and other applicable standards so they are readily available to all staff will promote understanding and engagement in the quality process.

The configuration of the physical space at the QEH presents challenges regarding the installation of new equipment and centralizing duties such as the referred-out testing. Renovation of the laboratory at KCMH resolved many of the previously identified issues with space, flow, and patient access. The phlebotomy area and the ECG room are separate from the laboratory. The renovation was done with input from the technologists, resulting in a workspace that is efficient, effective, and safe. The laboratory at Western hospital is well run. However, there are challenges with the temperature control. The lab is excessively warm which can have a detrimental impact on both personnel and the function of instruments.

Staffing continues to be a challenge province wide. The team is encouraged to continue to review the scope and mix of duties assigned to MLTs and MLAs to optimize the appropriate utilization of staff. Several retirees are employed in casual positions, which has been a great asset.

The dedicated, engaged, and very committed members of the laboratory team are to be commended for maintaining a positive attitude and continuing to provide patients with high quality care while facing staffing shortages and all the challenges of the COVID-19 pandemic.

Standards Set: Cancer Care - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.5	Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of clients and the community.	
1.6	Partnerships are formed with local, provincial, federal, and/or international cancer agencies and programs.	
1.7	Information on services is available to clients and families, partner organizations, and the community.	
Priority Process: Competency		
11.4	Standardized communication tools are used to share information about a client's care within and between teams.	!
11.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
Priority Process: Episode of Care		
13.1	There is a process to respond to requests for services in a timely way.	
13.6	The team has and follows wait time guidelines for time from referral to consultation, and from ready to treat to first treatment.	
22.9	Information relevant to the care of the client is communicated effectively during care transitions. 22.9.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP **MINOR**
22.12	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	

24.4	Technologies, systems, and software are interoperable.	
Priority Process: Decision Support		
23.8	The flow of client information is coordinated among team members and other organizations, in partnership with the client and in accordance with legislation.	
23.9	There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.	!
Priority Process: Impact on Outcomes		
25.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
25.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
25.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
25.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
27.8	Wait time data are collected for cancer care.	
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 PEI Cancer Treatment Centre (CTC) operates out of two sites. The Queen Elizabeth Hospital (QEH)

provides both radiation and medical oncology services and the Prince County Hospital (PCH) provides medical oncology through their Ambulatory Care department.

The QEH site has four inpatient beds designated for patients with cancer-related diagnoses that require inpatient care. The PCH site does not have dedicated beds for cancer patient admissions. The CTC has developed strong partnerships with other provinces to provide specialized surgical and treatment options that are not available within the PEI CTC. Within HPEI, the CTC collaborates to provide surgery, diagnostic imaging, laboratory, and primary care services.

The QEH site has a separate and well-signed entrance to their Cancer Care Centre. The Centre is bright, inviting and well maintained. As the organization moves forward with future infrastructure projects, privacy considerations at the registration desk and a more spacious chemotherapy treatment area may be considered to manage the volume of patients requiring care more comfortably.

The PCH site is relatively new and patient and family involvement in the development of space is apparent in the bright and spacious design. The treatment area is bright and comfortable with clear sight lines from the nursing station to all the treatment areas.

The CTC multidisciplinary team provides comprehensive information to clients and families once they have been admitted to the oncology program to support the physical and emotional well-being of their clients and families. Patients are provided with paper and web-based resources and the website also provides links to appropriate resources and services.

The Cancer Care medical oncology team would benefit from a comprehensive review of volumes, wait times, and resources across both sites to identify opportunities and ensure that resources are matched to meet the patient requirements within this provincial service. Reviewing medical oncology data in conjunction with that of radiation oncology may demonstrate opportunities to further adjust and streamline resources to ensure allocation to where they best meet the needs of patients and families.

There is a gap in support from the time of cancer suspicion until the patient enters the oncology program. This gap is recognized by the team and a pilot navigator position has been introduced to assist in mitigating the significant risk to patient safety that exists within the province. A review of the navigator role will be ongoing to assess the impact of the program on safety and the patient experience. These community gaps compromise care and are a significant risk to patient safety. The CTC will need to work closely with partners to streamline services and close these gaps in accessing care.

The team has developed strong partnerships with other services and programs, both within and outside the province. There are gaps in this relationship, however, and delays in care due to communication failure are not uncommon. The team is working on a standardized referral program that will include confirmation of receipt and expected wait-time as one measure to mitigate this recognized risk. Earlier access to a navigator to assist new cancer patients with navigating the system at the time of symptom onset or screening detection is being piloted and the team is optimistic that this resource will further support the needs of clients and the community and help to bridge this gap.

Patient Experience Surveys are utilized twice, annually, and the public feedback system is used to further gather experiences, suggestions, and concerns. The team would benefit from collecting more real-time feedback from patients and may consider utilizing IPADs or QR codes to conduct surveys and collect additional feedback on the patient experience.

The Cancer Care team currently has two leads for the provincial oncology programs to reflect both medical oncology and radiation oncology. While this supports the different treatment focus of these two specialties, the department may want to consider a coordinated approach in leadership, team development, and communication. There is also an opportunity to support both programs through shared personnel resources including oncologist extenders, allied health, and clerical supports, which may provide better coverage for the department and the patients they serve.

Priority Process: Competency

The team has an opportunity to further standardize communication tools within and between teams at the two sites within CTC and for inpatient admission to the designated cancer patient beds at QEH.

Standardizing referral forms from all sources for entry into the CTC program is a priority for the team to better support the referral source, the patients, and their families. This gap is recognized as a contributor to delays in patient care due to incomplete and lost referrals.

The team function has not been formally evaluated. Team members within cancer care and from supporting areas report opportunities to improve effective communication and collaboration within the department.

Priority Process: Episode of Care

The clinical and support teams at both sites with the CTC demonstrate a love of oncology treatment and their role in patient care. Patients and families speak in glowing terms of the care received within the oncology department and feel well supported once admitted to this team.

The Radiation Oncology service has developed comprehensive guidelines and clinical care pathways to support their processes and treatments. The department is spacious and appropriate for the equipment and services provided through this modality.

The Medical Oncology program at the QEH site is facing some space challenges and the team has been creative in meeting the treatment needs of their patients, which has been made more challenging with the distancing requirement of COVID-19. The team is encouraged to continue to engage team members, patients, and families to optimize the spaces available.

The oncology team includes a Navigator to assist patients in accessing care and moving through the system. Patients interviewed have found the Navigator to be extremely valuable, especially when care

crosses several services and provinces. Advertising this service to screening organizations, primary care, and the public may be beneficial to assist people in accessing the navigation service earlier in their cancer journey.

A new nurse navigator program has been recently initiated to help address access for patients at the time of screening. Evaluating the success and opportunities of this pilot in conjunction with patients and families will assist in modifying or expanding the program to address the needs of the community. Patients interviewed were clear on the need for more resources and assistance in navigating the system and any gaps were identified. Many of these issues would benefit from a navigation team to ensure that referrals are sent and received and that patients are able to access services and treatment in a timely manner.

The Formulary Navigator is another invaluable service that should be evaluated to determine whether expansion is required to adequately support patients, families, and the clinical teams. Complicated funding models are challenging to navigate, and frontline staff describe that they have spent hours trying to get coverage for expensive treatments. This process might be better facilitated by expanded formulary navigation support.

Implementation of a standardized referral form is a re-vitalized project which the organization is strongly encouraged to roll out as soon as feasible. Patients and families were clear in their concern and experience that lost consultations delayed medical care. Standardizing the referral form with a mechanism to close the loop to confirm that receipt, priority, and wait-time are communicated to the referring provider and to the patient and family will be a valuable process to help close this gap.

The Medical Oncology service does not currently track wait times from referral to consultation or from ready to treat to first treatment. This information is valuable to determine barriers and develop means of mitigating these delays. Tracking referral volumes may also help to allocate staff resources to particular days or clinic locations and identify opportunities to minimize surges and downtime.

Oncology in-patients are primarily managed through oncology extenders with specialist oncology support on call. Reviewing this schedule to ensure that both radiation and medical oncology services are available to their patients for management may be considered to ensure that patients have access to their primary provider service for continuity of management.

Genetic testing is available out-of-province for those who qualify. With COVID-19, accessing some of this testing has improved as virtual consultation and couriered samples have become acceptable, limiting the geographic movements of patients. Fertility preservation remains a challenge. While it is available out of province, the logistical difficulties to access these services in the face of treatment requirements is a hurdle for many and limits accessibility.

There is an opportunity to evaluate the effectiveness of transitions. Currently, the paper chart must travel to the patient for treatment at the oncology clinic, emergency, in-patient or to other specialty clinics. This chart movement results in lost staff time in chart locating and in treatment delays. Quantifying these

issues may assist in supporting the implementation of an electronic health record that eliminates the hybrid chart. Evaluating other transition points may also assist the team in identifying gaps that delay care and compromise patient safety.

Priority Process: Decision Support

Health PEI has several technological and information gaps that have been identified, to the provincial government, as obstacles to integration and care. The organization is encouraged to continue to work with government partners to address these gaps to provide appropriate supports for staff and physician support and patient care.

Within the CTC, the patient chart includes an electronic health record and a paper chart plus a third electronic oncology platform which serves as the scheduler tool and radiation health record. This hybrid chart requires time-consuming duplicate charting for staff, creates a risk for transcription error, information is not consistently available to on-call physicians managing inpatients after hours, and the paper chart requires frequent movement across departments and sites resulting in charts being unavailable for appointments.

The hybrid chart is a patient safety risk and directly impacts the team's ability to provide timely patient care. The time spent duplicate charting and tracking medical files in transit or in other departments would more optimally be utilized in providing direct patient care and supporting patients and families in their cancer care journey.

Priority Process: Impact on Outcomes

The CTC has an opportunity to engage with clients and families and include them in the Quality team, as appropriate, to provide feedback on guidelines.

Wait time data for radiation oncology is regularly collected and benchmarked. Sharing this information with the department, patients, and families is suggested to celebrate successes and identify further opportunities.

Wait time data is not collected for medical oncology, presently. This is an opportunity to engage the team to compare to benchmarks and identify opportunities to improve this metric.

Quality improvement priorities for the department are in the early stages of development. As data comes available, it can be analyzed to determine the effectiveness of the activity. For example, tracking wait times for oncology services now could be compared to the wait times after rolling out the planned standardized referral form to verify if this has a positive impact. Sharing this information with the organization, department, patients, and families may further assist in identifying opportunities.

Priority Process: Medication Management

The Cancer Care program is supported by a dedicated pharmacy team including two pharmacists and two

technicians at the QEH site. The PCH is also supported by pharmacists and pharmacy technicians who have undergone chemotherapy-specific training to support the ambulatory clinic at that location.

The team has implemented standardized processes and procedures to support the prescribing, production, and delivery of chemotherapy agents.

The chemotherapy room at the PCH site has been developed but has not yet been operationalized due to infrastructural limitations that required prioritization due to the COVID-19 pandemic. The team is looking forward to moving into this newly designed and appropriately outfitted space.

Coverage for chemotherapy medications is an ongoing challenge for patients. Treatments in oncology are rapidly advancing and changing as new evidence emerges and patients frequently are recommended for medications for which there is no coverage. The organization is encouraged to continue to work with the government formulary controls to improve access and reduce barriers to accessing treatment.

The Cancer Care team is working with patients to help them navigate the exceptions system and access the required treatments. The medication navigator position is invaluable to the QEH site and the patients they serve. The team is encouraged to review the patient load and staff burden of navigating the many medication funding options at both sites. This data may support expanding the navigator role to provide support to both sites to optimize clinical staff focus and to better support patients from across the province.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
3.6 A universally-accessible environment is created with input from clients and families.	
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

A review of the mental health and addictions program has been recently conducted and the path forward is greater integration of both services. This direction is guiding most of the change within the program area. Some things can be done in the interim to get the two teams working together. Case conferencing and common assessment are two examples of this. The team is encouraged to move to more evidence-based practice.

In all program areas, surveyors saw dedicated, committed, innovative, and caring teams focused on the clients they serve.

The McGill site is a non-accessible site with cramped quarters for all clinicians. This program needs more space. At this site, clinicians need to look at how long they are keeping clients and develop service timelines and a focus on brief therapy. This is the only way to resolve waiting lists with an ever-increasing demand.

The Insight Program is a good example of a day treatment program for youth that is evidenced based. The team is encouraged to write up this program and, perhaps, publish it in a clinical journal so that it can

become a template for other programs of its kind across Canada.

Surveyor was impressed by the innovative way that some of the mental health programs are using psychiatrists as consultants using tele-medicine and how they pivoted during COVID-19 so that they could continue to provide services through innovative means. Overall, there is a shortage of psychiatrists in the province.

Many mental health clients and suffering due to lack of financial resources, in this time of high inflation. In some areas, a significant barrier to service is the cost of gas.

Priority Process: Competency

There are competent multidisciplinary teams at all sites. There is clear evidence of their client focus and caring nature.

Performance appraisals are regularly carried out.

There is a wide array of educational offerings to all staff.

Priority Process: Episode of Care

The team is very committed to the populations they serve. They will go out of their way to address the needs of the populations they serve. They are generally concerned about the impact of the current economy on their clients.

A number of clients in virtually all program areas were satisfied with the services they received, but they identified that more services were needed.

Given the mental health needs, it is important for all program areas to define the treatment offered and establish clear guidelines for time in treatment.

Priority Process: Decision Support

While tools and processes appear to be standardized, the chart is a combination of both paper and electronic.

Moving forward when implementing an electronic medical record, it is important to ensure that all parts of system can talk to one another electronically.

Priority Process: Impact on Outcomes

It is important that all mental health programs move toward only evidence informed or evidence-based services. While this is evident in some program areas, it is not evident in all.

As the integration of mental health and addiction services moves forward, it is important to ensure that clients continue to receive the treatment and services they need and that their primary need, at a point in time, continues to drive service provision for the individual.

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	
6.1 There is a process to screen potential clients against admission criteria for critical care.	
9.23 Information relevant to the care of the client is communicated effectively during care transitions. 9.23.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include: • Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer • Asking clients, families, and service providers if they received the information they needed • Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).	ROP **MINOR**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	
Priority Process: Organ and Tissue Donation	
The organization has met all criteria for this priority process.	
Surveyor comments on the priority process(es)	

Priority Process: Clinical Leadership

HPEI has two ICU units within the critical care department. The QEH site has eight ICU beds (with the potential of three surge spaces) and eight step-down beds with telemetry. This closed ICU offers hemodialysis as part of its intensive care clinical capability. The intensive care unit at PCH has six ICU beds (with the potential of two surge spaces) and is an open unit with specialist admissions. The critical care teams at both sites work in close collaboration with external partners to provide PEI residents with a full scope of critical care interventions not offered within the province.

The Quality Improvement Team has strived to continue implementing positive changes and ensure excellence despite the challenges of the pandemic. Acquiring additional Respiratory Technician coverage at PCH to facilitate 24-hour coverage, has been a significant success in supporting the team in patient care.

Surveys are conducted and patient feedback is collected to help guide quality improvement programs. In line with the organization's vision, the critical care team has identified indicators to monitor to support the “Healthy Teams” in their journey of continuous improvement.

The critical care team at each site forms all or part of the Code team. Mock codes in different inpatient units are regularly completed at both sites and the organization may consider expanding this expertise and support to other hospitals within HPEI to provide them with this support and training within lower volume centers.

QEH has established a Rapid Response Team to provide the inpatient units with support in managing deteriorating patients. PCH has recently acquired 24-hour RT coverage and is in the process of also implementing this program. Both teams are encouraged to monitor and quantify the successes of this program to support continued coverage.

Priority Process: Competency

Education continues to be a priority for the Critical Care team. This is evidenced by the establishment of a full-time nurse educator for critical care at each site and establishing a robust mentorship program for nurses new to the department.

The teams at both QEH and PCH are proud of the critical care educational opportunities they provide. QEH has a “Critical Care Series” educational series and PCH has implemented a successful Journal Club featuring monthly articles and prize draws to encourage participation. The teams are encouraged to continue efforts to share these educational sessions between sites and with other departments, facilities, and clinicians, as appropriate.

The Critical Care teams are highly invested in training and involved in regular mock codes to assure that the teams are comfortable and competent in their roles throughout their facility. Participation is documented and lessons learned are recorded to support procedure changes and education.

The Critical Care service provides adult services only, but the team has been trained in PALS in order to support the pediatric and emergency departments for this specialized patient population.

Ethics training has been provided to the team and team members are aware of how to access support. The organization may consider bringing ethics to the front-line staff with vignettes that deal with commonly encountered situations to work through the framework to assist and support staff in decision making.

Team members are recognized for their contributions, but the department is further assessing how they can do a better job at recognizing members in a meaningful way. They are collecting information to support a more robust program moving forward in order to improve the retention of valued team members.

Priority Process: Episode of Care

The critical care teams at both sites are very close and have an impressive commitment to patients and families. The multidisciplinary team expresses their dedication to and enjoyment of the critical care environment and their role in patient care.

The two sites within the Critical Care Department of HPEI have different approaches to physician coverage with QEH having a closed ICU and PCH having an open ICU. The PCH site restricts admissions to a specialist group. The two ICUs within Critical Care are encouraged to review admission criteria, length of stay data, and to evaluate multidisciplinary team function to ensure that both models function effectively at the two sites.

The department has ICU admission criteria, but they are poorly defined. The team would benefit by quantifying the admission criteria to better support physicians and staff in admitting and discharging patients from the unit.

The Rapid Response Team, which includes an intensive care nurse and respiratory technician at the QEH site has formalized the support the department, provides to the other inpatient units. This team assists with ICU avoidance, supporting and training the inpatient clinical care providers in acute care, and can assist in decision support for escalating care to the critical care unit. Formally evaluating the success of this model may help support the roll-out of this program to the PCH site now that they have acquired the RT resources to support the creation of this team.

Telemetry is not available at the PCH site, except in the ICU. The QEH site does have telemetry beds as part of the step-down unit. Evaluating bed utilization at both sites may assist the department in determining appropriate asset utilization and whether additional telemetry support is required to reduce ICU bed utilization for telemetry.

Priority Process: Decision Support

Technological support is an ongoing issue for the organization. The hybrid chart that combines paper with one or more electronic platforms to form the patient care record increases the risk of error in providing patient care.

The lack of a secure intranet and email system is identified as a barrier. These gaps further impact communication within and across departments and sites which impacts education and the ability to provide coordinated support and care throughout HPEI.

The organization is encouraged to continue to work with the elected officials to prioritize information technology funding to support patient care and safety.

Priority Process: Impact on Outcomes

The Critical Care department currently has two patient and family advisors on their Quality Committee. The team is reviewing ways to expand involvement both formally within the committee structure as well as identifying key groups to provide a patient and family perspective on particular projects.

The team has identified specific priorities to focus on through their quality journey and is engaging with the teams to move forward. Indicator data is prominently posted within the departments to support conversations with the critical care teams.

Priority Process: Organ and Tissue Donation

The PEI Organ and Tissue Donation program is developed and coordinated in partnership with Out-of-Province organizations. Organ and Tissue donors are identified, and eligibility is determined in conjunction with the Organ and Tissue donation team.

HPEI team members are provided with training on eligibility criteria and the identification of potential donors. Information is provided to support the team in this role and to communicate with the Organ and Tissue Donation team to facilitate the potential patient transfer.

Final decisions regarding Organ and Tissue donation and eligibility are made by partner organizations.

Standards Set: Diagnostic Imaging Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Diagnostic Services: Imaging		
9.1	The team has a process for providing referring medical professionals with resources for selecting appropriate diagnostic imaging examinations.	
10.6	For procedures involving radiation to the abdomen or pelvis on women, the team asks female clients of childbearing age whether they are or may be pregnant and documents the response.	!
11.2	The team shields clients and diagnostic imaging providers during diagnostic imaging examinations in line with Health Canada regulations and, if applicable, the Canadian Nuclear Safety Commission.	!
Surveyor comments on the priority process(es)		
Priority Process: Diagnostic Services: Imaging		

There is one unified Department of Diagnostic Imaging. At QEH, all services are provided, including X-rays, mammography, US, CT, IR, and MRI. The latter two services are only provided at QEH. Comprehensive data is collected on service volumes, wait times, and provider satisfaction. While wait times for urgent and semi-urgent care is mostly acceptable, routine studies can wait up to 69 weeks for ultrasound and 13 months for an MRI. All imaging studies for all sites are reported by the radiologists in QEH and access to the radiologists for consultation to the other sites is readily available. The signage is straightforward, readily understood, and waiting areas are appropriate. There is no established process for advising medical professionals about the appropriate choice of diagnostic imaging studies. On the advice of the department's staff medical physicist, women are not asked about pregnancy, and undergo all studies regardless of their pregnancy status. Similarly, there is no attempt to shield any part of the body from radiation exposure. The physicist claims that current evidence supports this practice. The DI team should consult if there are any other jurisdiction that does not follow precautions about pregnancy and shielding to ensure there are not risks.

The Department has undertaken impressive quality improvement initiatives and sets new goals with clear targets every year.

The processing of intracavitary ultrasound probes is problematic. Dirty probes and clean probes are placed in identical boxes on opposite sides of the same cart. The probes are properly cleaned by the MDR staff, but there needs to be clear separation of the dirty and clean probes with, ideally, a smooth one-way flow from clean, to dirty, to processing, to clean. Throughout the DI unit, there are pieces of paper stuck to walls and doors with tape. Many of these are stained and torn. From an IPC perspective, this is not appropriate.

The DI unit at PCH operates under the same leadership structure. X-ray, US, mammography, and CT are provided. Radiologists do not come to this facility at all, and the staff claim it has been at least two years since any of them came to the facility. All patients requiring any intervention or examination by a radiologist must go to QEH for re-examination. This approach seems to be inconsistent with patient-centred care. For example, if a woman has a mammogram in PCH that shows a suspicious lesion, she must travel to Charlottetown to have the mammogram repeated and a needle inserted. She then must travel back to Summerside with the needle in her breast where she has the appropriate surgery carried out. It is not clear why the radiologists cannot provide this service in PCH. The team is encouraged to review this practice to reduce risks and improve patient comfort.

Standards Set: Emergency Department - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.3	Specific goals and objectives regarding wait times, length of stay (LOS) in the emergency department, client diversion to other facilities, and number of clients who leave without being seen are established, with input from clients and families.	
2.4	An appropriate mix of skill level and experience within the team is determined, with input from clients and families.	
2.6	Seclusion rooms and/or private and secure areas are available for clients.	!
2.9	The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.	
2.11	A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency		
The organization has met all criteria for this priority process.		
Priority Process: Episode of Care		
12.2	All services received by the client, including changes and adjustments to the care plan, are documented in the client record.	
13.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
16.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
16.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
16.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!

16.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
18.1	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.	
18.2	The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.	
18.12	Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.	

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

There are four hospitals in the Health PEI system that have Emergency Departments (ED). Two hospitals have full service 24/7 access (Queen Elizabeth and Prince County). Western Hospital becomes Collaborative Emergency Centre with a RN, Advanced Care Paramedic, and virtual physician (8pm-8am). Kings County Memorial Hospital closes between 8pm-8am. Many provincial initiatives have been created, such as stroke and MI strategy, in which pathways were developed with specific timelines to ensure high-quality and evidence-based care results in positive outcomes. Agreements have also been developed with neighbouring provinces/cities for specialized care, such as neurological interventions and cardiac catheterizations.

Trauma services, stroke, and cardiac care services are only provided by Queen Elizabeth Hospital and Prince County Hospital. Should patients at the other hospitals require this level of care, the patients would receive initial care and then be transferred.

Several partnerships and agreements are in place with other cities/provinces to enable access to certain health specialties, such as Saint John Regional Hospital (NB) for cardiac and stroke patients, Moncton for neurosurgical services, and Halifax (IWK-pediatrics and poison control).

The staff are very caring and passionate about the work they do. Teamwork and collaboration was identified as one of their major strengths. They are very proud of the way they can maintain privacy and confidentiality, particularly for those who work in very rural communities.

Several trends have been identified, by Health PEI, that impact patient access to appropriate services.

They are experiencing an increase in patients with mental health and addiction issues, numbers of seniors, unaffiliated patients, ambulatory care patients requiring follow-ups such as blood transfusions and IV antibiotics, particularly over the weekend, and EMS transfers and delays requiring patients to remain in ED for extended periods.

The provincial EDs welcome approximately 85,000 patients annually (2021 - 2022). Queen Elizabeth Hospital (QEH) accounts for almost half of these visits and the ED was redeveloped a little more than 10 years ago. It is a very well-designed space that was based on 4 pillars: confidentiality/privacy, quality and safety, education, and infection prevention and control. The team was very creative to support the requirements associated with COVID-19, such as two triage rooms for unaffected patients and those with COVID-19 symptoms or close contact. The teams are commended for their ingenuity during this very difficult time. All the EDs worked diligently to try to make their ED spaces safe in light of the COVID-19 restrictions.

Signage is effective and the number of admitted patients is posted in the QEH waiting room. A separate ambulance entrance with a dedicated off-loading space and computer enables safe monitoring and transfers despite many patients experiencing off-load delays. The team leader is assigned to receive transfer of information for these patients.

Prince County Hospital (PCH) has outgrown its space requirements and Western Hospital (WH) is anticipating its renovations to be started within two years. Kings County Memorial Hospital (KCMH) reports that the facility is expecting a rebuild. This particular site should be evaluated, and interim solutions should be implemented in anticipation of the new build.

The interdisciplinary teams in all of the 4 EDs have a similar composition with the two larger sites (QEH, PCH) having an all-RN staff. Other members of the teams include physicians, social workers (Monday to Friday), respiratory therapists, and crisis response team members. There is access to these professionals, but they are not, necessarily, dedicated to the EDs. Volunteers have continued to play an important role to support patients and families during the pandemic. Clinical pharmacists are not members of the team but, at some sites, a Pharmacy Technician performs the Best Possible Medication Histories. At other sites, the nurses perform this task.

Health PEI has a new strategic plan that has identified patient access to timely care as a priority. However, the Emergency Departments have indicated they do not have specific goals and objectives written, although they do have targets, but they were not established with input from patients and families. The teams are encouraged to establish processes to involve patient advisors in the development of these goals and objectives with targets at the local levels.

The electronic health record supports patient flow in the EDs by tracking and displaying various important wait times. However, there is a hybrid health record (paper chart continues to be used from triage and is the place where orders are documented). The teams are encouraged to continue to advance the full implementation of CPOE and related features to transition to a full electronic ED health record.

The community has access to information about wait times and services provided at the hospitals via their websites.
Paediatric equipment is available in all EDs including Braslow carts, masks, appropriate-age scales, and every pediatric patient is weighed at triage in case medication must be administered (weight-based dosing).

There is a significant opportunity for the ED teams to engage more actively with patient and family advisors so that their processes and practices can be specifically reviewed. While a Patient Partner/advisor is a member of the quality improvement team, and they are attempting to recruit another one, patient influenced practices will become more robust with more opportunities for input by these patient partners.

Health PEI is encouraged to conduct a review of the provincial road signage indicating where hospitals are located. For some hospitals that do not have emergency departments or those that close or convert to more of an urgent care centre, an alternate signage should be considered.

Priority Process: Competency

Health PEI is commended for providing additional (dedicated) educator resources for the EDs, since the last accreditation survey. A robust orientation is provided to new staff, particularly, since many new graduates are hired directly into the EDs (often they have completed their consolidation experience in the EDs). IV pump training is provided upon hire and annually thereafter. The IV pumps are standardized to improve patient safety.

Required training and education (mandatory) has been identified for the ED staff and the teams are encouraged to evaluate the education opportunities for staff based on formal or informal feedback from patients and families.

Staff have access to (ACLS) Advanced Cardiovascular Life Support and (PALS) Pediatric Advanced Life Support (hospital staff are trainers) education in addition to non-violent crisis intervention training.

New staff are assigned to the admitted patient's area and fast track to develop expertise in emergency nursing skills. In order to work in the triage area, nurses must have accrued at least two years of emergency experience. There has been a focus on ethics education and staff are able to identify how to access ethics resources. Consider offering more ethics education on a regular basis including case studies that are pertinent to the emergency department.

Priority Process: Episode of Care

The teams are commended for their caring and compassionate approach when providing essential care to the patients and families presenting to the Emergency Departments (ED).

Care pathways and order sets are implemented that support evidence-based practices and standardized

care processes. The ED teams are encouraged to continue their work to implement standardized order sets and pathways across the province for consistency and to ensure that all citizens receive the same quality of care.

Good collaboration and communication was evident during the ED tracers. Staff report that one of the main strengths of the EDs is the teamwork and trust that is essential for the provision of high quality ED care. The relationship with the EMS teams is also highly valuable. Patients and families who were interviewed during the tracers reported a high level of satisfaction making statements such as “the nurses and doctors are angels”, “they told me what to expect at every point in my ED stay”, and “as a family member I was never made to feel that I was in the way”. They also reported that staff check their identity using two different pieces of information (name and birthdate), perform hand hygiene regularly, educate them about their medication, and discuss the discharge plans should this involve being discharged home or to an inpatient unit/surgery.

Suicide risk assessments and falls risk assessments are components of the patient assessment that has been implemented provincially.

Medication reconciliation (best possible medication history) is performed by either nurses or pharmacy technicians depending on the ED site.
Translation services are available should they be required.

Patients who present with mental illness symptoms have access to a crisis team. The EDs report they have made significant improvements with the flow of mental health patients into appropriate care locations.

Transitions in care have not been evaluated with input from patients and families. If there was a patient satisfaction survey, the effectiveness of transitions could be evaluated. Audits of the SBAR documents would provide this time of outcome indicators to ensure the appropriate information is shared. Additionally, consider a strategy to involve patients and families with the type of information that should be shared at care transitions.

Priority Process: Decision Support

The ED teams are commended for implementing the Cerner ED electronic module however the CPOE component was not included in this process. The result is a hybrid patient health record that could lead to errors and safety events (illegible writing with physician orders for examples).

The electronic documentation does provide nursing, for example, with a comprehensive review of patient assessments and transfer of information at shift exchange using standardized communication processes (SBAR, situation, background, assessment, and recommendation tool).

Priority Process: Impact on Outcomes

The ED teams monitor wait times, left without being seen (LWBS) rates, door to needle times, stroke

indicators, number of patients according to CTAS levels, and a variety of other important ED indicators. They are closely assessing the increase in LWBS rates and are evaluating the rates in a CTAS level stratified approach given the potential risk when more acute patients leave without receiving care. Ensure that specific targets are developed for each indicator.

Many patients seen in the EDs are unaffiliated patients. This results in return visits to the ED for follow-ups. The ED, therefore, becomes more of an outpatient clinic. The leaders are encouraged to continue in their efforts to advocate for more primary care resources across the province.

General safety practices and discussions with patients and families, coupled with various audits that occur in the Eds, help to inform safe practices and risk mitigation strategies.
The procedure to select guidelines and best practices would be enhanced by feedback from patient advisors, or partners, who sit on the quality improvement team.

Patient and family satisfaction surveys are not conducted; although, the team does review compliments and complaints. This feedback would be very valuable to help the teams identify potential quality improvement projects. The teams would benefit from formalizing a patient and family satisfaction survey so that this type of valuable information can be assessed and an action plan developed.

The quality and risk staff are very active in supporting the EDs to address quality improvement needs. However, there is no evidence that the outcomes of these activities are shared with patients, families, or other organizations at QEH. Indicator data is posted on a QI board located in the administration area where patients and families cannot view the results. The Quality improvement boards are located in areas visible by patients and families in EDs at other locations.

The stroke time is the only indicator visible on a poster in an ED hallway at QEH. The teams are encouraged to identify ways in which to share information about QI activities with community partners.

Priority Process: Organ and Tissue Donation

A Provincial Coordinator is responsible for engaging with the Organ and Transplant team in Nova Scotia (Halifax). Policies and procedures are in place as per the Nova Scotia requirements.

Standards Set: Home Care Services - Direct Service Provision

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Health PEI Home Care Program has been undergoing an enormous transformation project. Progress, to date, is very impressive and staff are commended for their hard work and are encouraged to continue the path forward.

Partnerships have been formed, or enhanced, to provide the best possible care for the clients on their caseloads. This has been especially true with Public Health in response to the COVID-19 pandemic. The collaboration has insured positive outcomes for clients, families, and staff.

Services are provided based on the needs of residents of each community. Required resources are identified and shortfalls are communicated to Senior Leaders. It was indicated that most gaps in resources, that were identified, have been acknowledged by management and addressed if possible.

Priority Process: Competency

The Health PEI Home Care staff have the appropriate training and education to fulfill their roles. A comprehensive orientation is provided, and ongoing education as needed. This includes infusion pump training on orientation and twice annually thereafter. Other education includes such areas as managing workplace violence, OHS policies on safety, and cultural competence training.

Position profiles are completed, and all staff work to their full scope of practice.

Staff performance appraisals are completed on a regular basis. Additional training is provided as needed. Professional development is offered regularly.

An ethical decision-making framework is apparent, and staff are encouraged to use the resources available to them.

Team members are recognized for their contributions both formally and informally. Long service awards are given out. Accolades from clients are included on the staff's personnel file. Prior to COVID-19, staff gatherings were held to show appreciation for their work. This will be reinitiated when possible.

Home Care staff work collaboratively. Various disciplines work together to provide optimum care to the clients.

Priority Process: Episode of Care

The Health PEI Home Care program strives to provide services to all clients who require care. If it is not possible, or the care requested is outside the scope of the Home Care program, steps are taken to try to assist the client to get the services they need. Currently some challenges have been encountered because of staffing shortages, day program availability due to the COVID-19 pandemic, and reduced capacity for in-facility respite to name a few.

Staff provide respectful, culturally appropriate, care to clients and their families. Open communication is seen as key for a therapeutic relationship. Translation services are available as needed, either in person or by telephone. Client-centred care is evident throughout the Home Care program. Client engagement surveys are conducted to gain the perspective of the client and their families and to adjust the program accordingly.

Informed consent is obtained prior to any services being initiated. If the client is not able to give consent, a substitute decision maker will provide the consent.

An ethics framework has been developed and education regarding this, as well as additional resources, is being rolled out to all staff. Tabletop exercises have been conducted to proactively look at ethical issues that may arise in the Home Care area.

Medication reconciliation occurs beginning with Best Possible Medication History at the time of admission and reconciliation at all transition points. Any discrepancies are discussed between client, physician and pharmacy to come to the appropriate resolution.

Skin and wound assessment (Braden tool) is done on admission and regularly thereafter.

The client's chart is comprehensive and complete. Assessments, individualized care plans, medication administration, staff notes, diagnostic/lab results, and medical history are all easily found. Care coordination and an interdisciplinary team approach is fostered through the client's chart and is available to everyone providing care.

When a client is transitioning to another service, including temporary admission to hospital, a predetermined set of documents are included in the transfer record. They are shared with the receiving organization.

A safety risk assessment of the home is done on admission and regularly as care continues. Safety for clients and staff is paramount for the Home Care program.

Priority Process: Decision Support

Health PEI Home Care Program has recently migrated to a sophisticated IT system to allow quick and easy access to client information while mobile. The system allows for monitoring staff location at client's homes and charting on smartphones or tablets. This new system has required significant training for field staff which has gone extremely well. The system also ensures that the client's record is accurate and up to date in real time.

Standardized health assessment tools are utilized for all clients. The program has recently adopted the interRAI assessment tool for all clients at intake. The information on all assessment tools is available on the chart for review by all staff providing care to that client.

Clients and/or families wishing to access the information present on the client's chart are allowed to view the chart when requested.

There are policies and procedures for the use of electronic charting and communication. This includes the circumstances when information can be disclosed and to whom.

Priority Process: Impact on Outcomes

The Health PEI Home Care Program provides client care based on the most recent evidence-based guidelines. These guidelines also assist with insuring consistent, competent care is provided to all clients.

The Home Care Quality Improvement Team (QIT) identifies areas of improvement and measures and monitors progress towards identified goals. The data gathered is shared broadly with organizational partners, staff, clients, and families as well as reported to the Leadership QIT as well as the Quality and Safety Subcommittee of the Board.

Numerous quality initiatives are underway allowing best practices to evolve and ensure safety for staff and clients on the program.

Patient safety incidents are reported, tracked, and investigated. Based on the findings of these investigations, changes are made to practices as required.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
9.2 Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.	ROP
9.2.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.	**MAJOR**
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The Leadership Team at the Provincial Palliative Care program truly reflects the values of the organization. They are client centered, advocates, and strive for excellence in care delivery. They are connected to many services across the entire island and serve as a source of support and mentorship to other providers. They have a strong volunteer program and that is evident by physical presence of volunteers but also in the contributions to items and the enhancements to the grounds at the facility.

One challenge for this team is the existing health record practices within the organization. The various technology does not integrate which has potential for gaps in knowledge across the health care continuum. Having one health record would ensure all team members have the most up to date assessment to help assist the palliative team in caring for their clients.

Priority Process: Competency

There is a strong, connected, team at the center. They are dedicated to care provision. Staff cite recent pump education. There is an ethical view on care and the team approach is based on the ethical framework. The team is committed to providing consultation and support to health care professionals and help ensure a consistent approach to care.

Priority Process: Episode of Care

This site is exemplary in client and family centered care. Families are present 24 hours a day. They are provided places to sleep and meals. We spoke with a family member who has been living at the site since November. She spoke highly of being included and supported as she provides care to her loved one. The Required Organizational Practices (ROP) had clear evidence of being met with the exception of the 2 client identifiers. In the provision of medications, the client did not have an arm band and the nurse did not have a MAR with a picture or any other way to confirm the identity. In speaking with the other staff at the site, they agree that 2-person specific identifiers are a challenge at times in medication delivery. Leadership has agreed to look at options to address this issue.

Priority Process: Decision Support

Health records are paper based at the site. The team would like to have one health record as many of the clients stay home until they need admission. With the current charting system, the team does not have the ability to monitor that. There is a strong verbal connection within the team to work around this gap to ensure their client needs are met.

Priority Process: Impact on Outcomes

There is a safety culture at this facility; staff are committed to providing safe care. There is feedback from occurrences. Disclosure happens when errors happen. There is open communication with clients and families and processes are continuously tweaked based on input.

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

Unmet Criteria		High Priority Criteria
Priority Process: Infection Prevention and Control		
8.4	Team members, and volunteers have access to dedicated hand-washing sinks.	
9.6	When cleaning services are contracted to external providers, a contract is established and maintained with each provider that requires consistent levels of quality and adherence to accepted standards of practice.	
9.7	When cleaning services are contracted to external providers, the quality of the services provided is regularly monitored.	
14.1	There is a quality improvement plan for the IPC program.	!
14.2	IPC performance measures are monitored.	
Surveyor comments on the priority process(es)		
Priority Process: Infection Prevention and Control		

Health PEI is working towards a provincial Infection Prevention and Control (IPAC) program. This is part of the Quality and Patient Safety mandate. The goal is to maintain a safe environment for patients by reducing the risk of potential spread of disease. The most recent Quality Improvement Plan was completed in September 2021. The influence of IPAC is far reaching and touches many aspects of the healthcare system beyond patients in hospitals and long-term care. The IPAC team is undertaking numerous quality initiatives.

The IPAC team, comprised of one provincial manager and nine infection prevention and control professionals spread across the province, are doing an amazing job of leading this program, especially given that there are two vacancies in the IPAC professionals group. Additional resources for IPAC support are being requested. One such area of note was Home Care. They do not have any dedicated IPAC personnel attached to their program.

The IPAC team has managed the COVID-19 pandemic response admirably. The spread of disease was kept under control with good policies, procedures, and processes put in place under difficult circumstances. Early detection and appropriate responses to those presenting with symptoms helped keep the COVID-19 pandemic contained. Continuous and rapid adjustments to protocols were required.

Strong relationships have been formed with internal and external partners. Some of these partners include lab services, pharmacy, public health, environmental services, dietary, laundry, acute care, and

long-term care. These partnerships are essential in keeping staff, patients, clients, volunteers, and families safe. An interdisciplinary committee needs to be re-established to provide direction to the IPAC program.

Surveillance and auditing is a key component of the IPAC program. Unfortunately, this work is currently done manually at many sites. This is labor intensive and a huge waste of time for a commodity (IPAC practitioners) in short supply. There are automated computer systems that would be better suited for these tasks. These systems would also promote a standardization of surveillance programs across the province. The organization should continue advance its surveillance program to improve monitoring infection rates and reporting rates to key stakeholders.

Hand hygiene education has been well done but regular auditing has been a challenge given other priorities during the COVID-19 pandemic. Compliance with hand hygiene practices have been checked irregularly but when non-compliance is recognized it is handled immediately with the individual in a positive manner. When hand hygiene audits have been completed the results have been widely shared.

There are some environmental issues identified at all sites that are problematic for maintaining a clean, infection free, zone. These include paper posters or notices on the walls, corkboards, and wood in patient/client care areas. These items cannot be properly cleaned and disinfected to prevent the spread of disease.

The IPAC team is commended for updating policies and procedures and making sure they are available to staff electronically. The Infection Prevention and Control (IPAC) manual was recently updated with current references.

The IPAC team is encouraged to continue their hard work and movement towards a provincial system.

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		
5.5	The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.	
6.4	There is a policy that guides team members to bring forward complaints, concerns, and grievances.	
6.5	Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.	!
6.6	Education and training are provided on how to identify, reduce, and manage risks to client and team safety.	!
Priority Process: Episode of Care		
8.11	Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.	
8.12	Ethics-related issues are proactively identified, managed, and addressed.	!
8.15	A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.	!
11.9	The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.	
Priority Process: Decision Support		
13.2	Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.	
13.3	Policies and procedures for disclosing health information for secondary use are developed and followed.	
Priority Process: Impact on Outcomes		
14.1	There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.	!

14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
14.4	Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.	!
14.5	Guidelines and protocols are regularly reviewed, with input from clients and families.	!
14.6	There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.	!
15.1	A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.	!
15.2	Strategies are developed and implemented to address identified safety risks, with input from clients and families.	!
15.3	Verification processes are used to mitigate high-risk activities, with input from clients and families.	!
15.4	Safety improvement strategies are evaluated with input from clients and families.	!
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.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The inpatient units are structured to meet the needs of the community. The COVID-19 pandemic has led to significant changes including the designation of one unit as “The Covid Unit” at QEH.

The inpatient units have quality improvement initiatives with posted progress on each indicator. There are established targets which are regularly reviewed and updated. In each patient room, there is a whiteboard with the estimated date of discharge posted for each patient. There is evident pride and enthusiasm along with an emphasis on quality improvement.

Most of the inpatient units have a mix of medical and surgical patients. Though, on several units there are beds designated for the care of specific patients such as psychiatry, cancer, and stroke services.

Priority Process: Competency

There is a strong commitment to collaboration with other members of the health care community. The team should now evaluate the effectiveness of these collaborations.

Performance reviews are conducted at least every two years. Staff are presented with opportunities to advance through the availability of educational activities.

During interviews with team members, it was identified that some team members were unaware of the process of bringing forward complaints, occupational health and safety policies, or risk management procedures. The organization is encouraged to provide this education consistently to all staff.

Priority Process: Episode of Care

Inpatient services are provided in a timely and appropriate way. The COVID-19 pandemic has been challenging but, overall, care has been able to proceed. Families are involved in the care of the patient to the extent desired by the patient.

There appears to be uncertainty regarding translation services. In some cases, staff or patient relatives can translate. The teams also use a telephone service in cooperation with Nova Scotia. The inpatient services will benefit from establishing a clear process for translation services.

There seems to be an absence of clinical research related to inpatient services. If these activities are taking place, the team members interviewed were not aware of this work.

Some sites need to improve the process for dealing with claims from patients that their rights were violated.

It will be important to evaluate the effectiveness of the client transitions as well as the readmission risks.

On the Pediatric Unit, there are detailed quality initiatives that are carefully monitored and transition to adult care is considered. However, there is concern that up to one-third of the beds are occupied by elderly Alternate Level of Care (ALC) patients. The organization is encouraged to address this issue to ensure the team can provide the best care for this population.

Western Hospital has engaged a company called Maple that involves virtual rounding each morning on the inpatient unit. This was originally a pilot study to assess whether this model of rounding would be effective and efficient. The staff report high satisfaction with this new model of rounding.

Priority Process: Decision Support

Operative dictations by surgeons are electronic using the Cerner system and consents are paper-based. Some medical care is guided by standardized order sets. Few of the staff interviewed were unaware of the

existence of policies regarding the use of electronic communications or the secondary use of health information. The team might like to strengthen the education provided on these topics.

Priority Process: Impact on Outcomes

During interviews with team members, it was identified that some team members are unaware of the organization's policies.

The units are very good at collecting quality indicators, but it is not clear how the information is used. The inpatient teams are encouraged to monitor indicators and analyze the data collected to develop and implement quality improvement initiatives and evaluate their effectiveness.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
The organization has met all criteria for this priority process.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The physical space in long term care is designed with the resident at the center. There is clear input from client and families and evidence of inclusiveness with cultural diversity. The environment is free from clutter and the atmosphere is home like. One of the challenges that exists is the charting within the program. There is a hybrid paper and electronic charting that is a concern for staff.

LTC is using paper-based charting and has a read only access of the larger CIS system. Communication could be improved with one system that was integrated.

Priority Process: Competency

The long-term care team provides training to its staff to ensure a standardized approach to care. Gentle Persuasive Technique is provided to all staff. There is evidence of concern for spiritual and cultural beliefs and residents are encouraged to embrace their heritage. The program follows a Least Restraint policy. There is strong collaboration in all departments at the sites. There is a feeling of pride and ownership of the building, and everyone is wanting the best experience for their residents.

There are no infusions pumps present in LTC currently.

The team speaks of having performance conversations and feel that feedback is ongoing with their leadership. Formal performance evaluations were in place but has been some time since the last ones.

Priority Process: Episode of Care

Long Term care is a champion of in person / family centered care. They have threaded the principles throughout all staff. This is evident in food choices, the physical spaces, and the design. Residents and family pick a winner for staff who show leadership in this initiative. There is evidence of cultural diversity. Bilingual services are available in some neighborhoods in LTC. Staff demonstrate a commitment to quality care and are interested in improving safety and quality of experience for their residents and families. Medication carts have just been introduced in some of the homes. There is opportunity to help the staff create a low distractible space to assist in safer delivery of medications with the new carts. The program has recently changed their policy on suicide assessment and are in the process of formalizing a new tool. This new tool will help increase the standardization of this ROP. Education is under way but not fully implemented. There has been much attention to detail by staff around mealtimes and insuring meal choices are offered. One site has added a service worker to mealtimes as a result of data around falls. This service worker assists with morning meals and allows nursing staff to attend to residents who want to have a delayed start to the day. It has helped lower falls. This service worker is also tracking all intake on a new form which, in turn, assists the clinical team in assessing nutritional status, impacting skin integrity. LTC in PEI does not have infusion pumps at their sites.

Overall, LTC has shown evidence in meeting the Required Organizational Practices (ROP). They are an eager committed team who are, clearly, interested in resident safety and love what they do.

Priority Process: Decision Support

There is a provincial ethics framework and the team that can be accessed as needed to support decisions. The health records are paper paper-based and kept in the units in cupboards.

There is evidence of audits and feedback on the health record.

Priority Process: Impact on Outcomes

There is a strong safety culture in long term care. The Quality and Risk manager is connected with the program and there is ongoing dialogue on incidents and how to prevent occurrences. Staff spoke of disclosure at the time of occurrence (E.g. a fall or medication error) and transparency with residents and families. There is a quality board at the sites.

Wedgewood Manor long-term care facility is an older facility with a very committed staff and very appreciative residents. Residents in this home tend to have very complex nursing needs.

The leadership, for this home, also supports two other homes and they are to be commended for their efforts in having staff work across all three homes to support the staffing needs. To assist with workload, the support staff have been training to take on additional roles. This includes making beds, which then

frees up the time for nursing staff.

Residents spoken to feel very comfortable in the facility and indicated they it feels like a “family”.

Interactions seen with residents were very respectful and individualized.

Residents have had the opportunity to be engaged in groups planning the gardens as well as indoor space and feel it very much represents their home.

There is a good awareness of the ethics program and the supports that are available to the team.

Recognizing the importance of nutrition to the health and safety of the resident, the home created a nutrition intake sheet to monitor the amount of food and drink the resident was consuming.

Several indicators are being monitored at the Wedgewood Manor including pressure ulcers, hand hygiene, polypharmacy situation, and incidents for responsive behaviors. Results of audits are found on the quality boards within the resident care areas.

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

Unmet Criteria		High Priority Criteria
Priority Process: Medication Management		
2.11	The interdisciplinary committee has a policy on handling sample medications.	!
13.1	Access to medication storage areas is limited to authorized team members.	!
13.6	Medication storage areas meet legislated requirements and regulations for controlled substances.	!
13.7	Separate storage in client service areas and in the pharmacy is used for look-alike medications, sound-alike medications, different concentrations of the same medication, and high-alert medications.	!
14.3	Chemotherapy medications are stored in a separate negative pressure room with adequate ventilation and are segregated from other supplies where possible.	!
15.8	Steps are taken to reduce distractions, interruptions, and noise when team members are prescribing medications or transcribing and verifying medication orders.	
16.1	The pharmacist reviews each medication order prior to the first dose being administered	!
17.3	There is a separate negative pressure area for preparing hazardous medications, with a 100 percent externally vented biological safety cabinet.	!
21.5	The organization has a policy and procedure to manage how it procures and tracks medications.	
Surveyor comments on the priority process(es)		
Priority Process: Medication Management		

In March 2020, Health PEI implemented a Provincial Pharmacy leadership model to align with the new corporate direction. Health PEI Provincial Pharmacy Services leads medication management throughout Acute Care Hospitals (QEH and PCH), Community Hospitals (CHO, WH, KCMH and SH), Mental Health & Addictions (HH, PATF), Provincial Palliative Care Centre (PPCC), and provincially run Long Term Care Homes (CM, RV, BGH, PEH, MWM, SM, MSEH, MM and SMH). Provincial Pharmacy and Pharmacare are also

included in the Provincial Pharmacy Services portfolio.

The oral solid unit dose packaging is consolidated at the Queen Elizabeth Hospital for all the hospitals and 600 LTCH residents using 2 PACMED machines and 1 PACVision machine. The unit dose rolls are distributed daily or weekly respectively for acute and LTCH patients. Health PEI is encouraged to consider expanding pharmacy space at QEH as the current space no longer meets the needs of the centralized packaging and distribution that occurs at this location.

There are several specialized pharmacist roles such as Drug Utilization, Antimicrobial Stewardship, Order set analyst, and Informatics which support the team. Dedicated pharmacy technicians conduct BPMH 7 days per week (when staffing allows) at the QEH and PCH acute care hospitals.

Pyxis Automated Dispensing Cabinets (ADC) have been implemented in several locations in each acute hospital and there is a robust plan to deploy, as the main drug distribution system, throughout Health PEI as funding becomes available. A significant number of ADCs were purchased for LTCH, but the implementation was delayed due to staffing challenges in the LTCHs, and the equipment is currently on site in storage.

The Antimicrobial Stewardship program (ASP) has recently expanded the IV to PO stepdown program for antimicrobials across Health PEI hospitals. Many of the ASP resources are available to the pharmacist and physicians on a software app called “First Line”. Nurses reported improvement in the treatment of UTIs at the LTCHs due to this program. There is a gap in the formalized program with the departure the Medical Microbiologist from the Committee.

Staffing recruitment is a challenge due to the lack of Regulated Pharmacy technicians available as well as College Programs which are in other parts of the Maritimes.

Health PEI is encouraged to remove narcotic stock from the night cupboard at PCH to prevent any potential drug diversion in this location. Narcotics can be obtained from other nursing units if required during evening hours when the pharmacy is closed. The organization is encouraged to review current processes regarding the management and security of controlled substances.

The pharmacy and medication rooms in KCMH are old and cramped. There is insufficient space in the ED to store all the medications in the Pyxis cabinets and the medications in the Ambulatory clinic are not locked up.

Some of the Community hospitals do not have access to pharmacy technicians in completing the BPMH and would benefit from these additional resources.

As Health PEI plans for further implementation of the Clinical Information System (CIS) to include all the ambulatory clinics/locations, they are also encouraged to consider plans for Bedside Medication Administration (BCMA) with scanning of barcodes on medications to achieve a closed loop medication system.

Standards Set: Mental Health Services - Direct Service Provision

Unmet Criteria			High Priority Criteria
Priority Process: Clinical Leadership			
The organization has met all criteria for this priority process.			
Priority Process: Competency			
3.14	Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.		!
3.16	Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.		!
Priority Process: Episode of Care			
9.18	Information relevant to the care of the client is communicated effectively during care transitions.		ROP
	9.18.1	The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.	**MAJOR**
	9.18.4	Information shared at care transitions is documented.	**MAJOR**
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

Inpatient Mental Health services are provided at three sites. Hillsborough Hospital, with 66 inpatient beds, provides specialized acute and rehabilitation psychiatric services for adults, youth, and children over 8 years of age. Prince County and Queen Elizabeth Hospitals both provide inpatient acute adult psychiatric services with 14 and 11 beds, respectively. A crisis response team also supports each of the acute care emergency departments providing a very strong link to the inpatient mental health unit, the community and community mental health programs.

Since the last accreditation, the Prince County site has been designated as a schedule 1 facility. All but one

of the 14 beds is supported by the services of a psychiatrist. Due to workload, the psychiatrists are unable to take on the remaining inpatient bed which then is covered by rotating on-call psychiatrists and/or family physicians. This situation has created a lack of consistency and focus for the care of the patient that happens to be admitted to the 14th bed. The organization is encouraged to address this situation to support quality care for all patients admitted to this unit.

The Queen Elizabeth Hospital (QEH) unit has undergone several moves in the past two years. In order to increase inpatient medical beds during the COVID-19 pandemic, the unit was moved to the Hillsborough Hospital. It was moved back to QEH last year and it is now slated to be permanently integrated with the adult mental health unit at the Hillsborough Hospital at the end of the month. There is agreement that this integration will benefit staff and patients. However, staff describe the amount of change as stressful. The Hillsborough Hospital has continued to alter the focus of their programs to meet the needs of the population and the community. In addition to the inpatient acute mental health beds, the hospital has psychiatric intensive care unit and a transition unit to support patients working to re-integrate into the community.

All the adult mental health beds across the three sites, Prince County, Queen Elizabeth, and Hillsborough, are considered a provincial resource and daily bed meetings are held to support patient flow across these units as the local emergency departments.

In keeping with HPEI's strategic plan, goals and objectives were identified verbally by the leaders of all the sites. In particular, the need to support staff and to focus on access and transitions were identified as being relevant to the Mental Health program. The program is encouraged to develop these in writing as SMART goals to be shared with staff and clients.

The Mental Health program is commended for the significant work underway to standardize care across the sites so that patients will get the same level of care at any of the three acute care sites. The community mental health programs and the crisis response team in the emergency departments are major partners with the inpatient units. Weekly rounds are held with community mental health agencies to support discharge planning and follow-up on those patients discharged previously. Transitions are supported with the assistance of the Mobile Mental Health Team which does a follow-up phone call, and visit if deemed necessary, three to five days post discharge.

Priority Process: Competency

Collaborative, interdisciplinary, teams support care on the inpatient mental health programs. Team members include registered nurses, licensed practical nurses, patient care workers, occupational therapists, occupational therapy assistants, social workers, psychiatrists, and the recent addition of two psychologists. Nursing staff are not required to be licensed psychiatric nurses but do undergo an extensive orientation and training in non-violence crisis intervention and advanced code white training.

Two simultaneous Code White emergencies occurred on the unit during the surveyor's visit and staff are to be commended for their calm, respectful, approach with these patients. Patients interviewed spoke

highly of the staff and their respectful, caring, approach towards patients. Staff at the PCH site indicated they had received performance reviews in the past two years; however, this in not the case at the QEH site.

Priority Process: Episode of Care

The physical site at the Prince County Hospital is bright, secure, and well designed to support mental health care. Cameras are needed for the observation rooms and have been ordered with installation proceeding shortly. The physical site at the Queen Elizabeth Hospital is older. It has smaller patient rooms but secure and good programming space. The physical environment at the Hillsborough Hospital is also much older but well maintained, clean, and safe. Plans are underway for a major capital project which will create an entirely new mental health campus on the site of the current Hillsborough Hospital.

Access to inpatient mental health services is available 24/7. The local hospitals emergency departments are the primary referral sites and admissions are coordinated through nursing leadership and a psychiatrist. Although a transfer of information sheet exists, some issues have arisen from incomplete information being made available to the unit as the patient is transferred from the emergency department to the inpatient mental health units. The sites are encouraged to work with peers in the Emergency departments to address this lack of information on transition. Occupancy has been very high across all three sites and daily bed meetings are held to support the allocation of any available beds to the most urgent need.

Clinical services are recovery-oriented and further programming has been added over the past few years including Dialectic Behaviour Therapy (DBT). However, no programming is available in the evening nor on weekends. Several interviewed patients described this as an issue and noted it on a recently completed patient satisfaction survey. The departments are encouraged to review the ability to spread programming across seven days even if this means fewer activities on some days during the week. Electroconvulsive therapy (ECT) is provided at the QEH site and patients from the other sites are transferred in for this day procedure.

The Crisis Response Team (CRT), in the emergency department, are strong partners with the acute inpatient units. These teams work 24/7 in the PCH emergency and 18 hours per day in the QEH emergency. The teams support the care of patients in the ED until such time as the patient is admitted to an inpatient unit or discharged. There is also very strong collaboration with community mental health agencies. Discussions are held with the various agencies prior to the patients' discharge from hospital. A standardized form is used to guide the transfer of information for patient transfer from one mental health unit to another and for discharge to the community.

Best possible medication histories are routinely gathered at the point of entry into the system and medication reconciliation is completed once the patient is admitted. However, the timing of this completion varies, and the organization is encouraged to address this issue. The falls prevention program has been a focus for the inpatient mental health sites and work continues to be done to monitor and review any trends that are occurring with incidents of falls. A recent intervention at the Prince County site

was the introduction of electric beds which lower, almost to the floor, thereby reducing the risk of severe injury if the patient did fall out of the bed. All sites support a least restraint approach.

Priority Process: Decision Support

The mental health programs, currently, have both electronic and paper charting. Although much of the documentation is electronic, there are still several forms and observation sheets that remain in a hard copy chart. A software program that will support electronic documentation of the behavioral observations is being explored. Health PEI is encouraged to move towards phasing out the paper charting and supporting all documentation electronically.

Priority Process: Impact on Outcomes

The inpatient mental health sites are supported by a provincial Mental Health and Addictions Quality Improvement Team (QIT) which is responsible to review and revise guidelines and protocols. Patient and family advisors are a part of the QIT and, as such, are asked to comment on guidelines, protocols, and upcoming projects. This input at the provincial level is very important to ensuring consistency across a multi-sited program. All sites are monitoring a number of indicators including hand hygiene, completion of the suicide risk assessment, BPMH, falls, behavioral incidents, and completion of transition of care documentation. Quality boards are found in the departments and are up to date.

The mental health program is commended for their high rate of patient satisfaction identified in a recent survey completed. The survey received 467 respondents. Over 90% of the respondents agreed, or strongly agreed, that they felt welcomed, that their cultural needs were supported, and that staff were professional and helpful. Respondents made several suggestions including the need for more evening and weekend activities and more in-house self-help meetings.

As a quality initiative aimed at supporting Health PEI's goal of access to and coordination of care, the inpatient mental health sites are working closely with community agencies to support the patients' transition into the community and avoid readmission. One such program is the follow-up provided by the Mobile Mental Health team in which the discharged patient receives a phone call and, if needed, a in-person visit 3 to 5 days post discharge to assess how they are managing. To date, this program is felt to be very effective in keeping patients in the community and avoiding readmissions.

All incidents are recorded and reviewed. Rates of incidents are tracked, and trends are explored. Daily huddles and staff meetings provide opportunities for the manager to review safety issues and to report back to staff on any trends or relevant interventions.

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	
3.12 Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.	!
Priority Process: Episode of Care	
7.14 Clients and families are provided with information about their rights and responsibilities.	!
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The two tertiary care facilities, Queen Elizabeth, and Prince County hospitals, provide the obstetrical services for Prince Edward Island. Together these facilities see approximately 1300 deliveries per year with the majority of these supported by an obstetrician, one family physician, and an interdisciplinary obstetrical team. Home deliveries through the support of midwives is planned to begin later this year in the Charlottetown area. There are no planned deliveries in the smaller rural hospitals across the island. However, to support the emergent unplanned births, training by the obstetricians has been provided to EMS staff and rural family physicians. Obstetricians are available to support by phone should this be required. The Queen Elizabeth and the Prince County Hospitals also have neonatal intensive care units. At Queen Elizabeth Hospital they provide care at level 2B; at Prince County they provide care at level 2. Paediatricians support newborn care if a difficult birth is expected; Otherwise, nursing staff fulfill this role.

The Prince County Hospital has six Labor, Delivery, Recovery, and Post-delivery (LDRP) beds; they see approximately 40% of the births across the island. The unit is bright, well organized, and adjacent to the special care nursery and the paediatric unit. The obstetrical service at the Queen Elizabeth Hospital, which sees approximately 60% of the province's deliveries, has 14 post-partum beds and a separate labour and delivery suite containing 6 labour rooms. The Neonatal Intensive Care unit (NICU) is adjacent to the post-

partum beds, but the labour and delivery rooms are adjacent to the operating room which is on the same floor but in a different wing of the hospital. This separation of the labour and delivery rooms is not ideal; particularly when staff from the NICU or postpartum unit are needed to urgently support a birth. The hospital is encouraged to address the issue at the time of redevelopment for this area. Both hospitals have a “care by mother” room which can be utilized by discharged mothers who wish to stay with their newborn who is not yet ready for discharge.

The obstetrical units are commended for the work that is being done to standardize practices across the two sites and encouraged to continue on the journey to ensure that patients have access to the same level of care regardless of location. Much of the planning, service design, and setting of goals occurs at the provincial level through the Maternal Newborn Quality Improvement Team (QIT). There is a patient advisor on this Team. The organizations are encouraged include further input from clients and families at a local site level.

Priority Process: Competency

Both obstetrical units have strong collaborative teams consisting of obstetricians and nursing staff. The teams are commended for their commitment to the MORE OB program as a method of continually increasing their understanding of evidence-based practice and engaging in this learning experience as a team.

Nursing staff are required to have additional training in obstetrical care, labour, and delivery. At both sites, nursing staff are crossed training to work in both labour and delivery and post-partum. They have the option to take further training and work in the NICU. There is a strong orientation program where regular reviews and refreshers are made available on an ongoing basis. The units also have the support of clinical educators who are available to provide ongoing learning opportunities. Although education, regarding the ethical framework, is available to staff, staff interviewed did not appear to be familiar with the framework or what supports are provided. The organization is encouraged to attempt to find ways to make the information more meaningful for staff. Further attention to the completion of performance reviews is required at the QEH site.

Priority Process: Episode of Care

Communication with the obstetrician offices provides the obstetrical units with an understanding of mothers who may go into labour in the coming weeks. Once registered at the admitting department, patients are directly admitted to the obstetrical unit. On admission, a comprehensive assessment is conducted, and interventions are begun to monitor the status of fetus and mother. Standardized assessment tools are used to collect and share patient information. A structured approach is used to document fetal assessments and actions taken during labour. The staff interviewed were well versed in the steps to take to mobilize resources and services in emergency situations. Post-delivery, the mother and newborn are cared for either in the LDRP rooms in PCH or in the postpartum area of the unit at QEH. Skin to skin contact is supported and breast feeding encouraged. Medication reconciliation and falls assessments are conducted.

Standardized OR times are available for planned C-sections; as well, time slots are made available to accommodate emergency cases. All reprocessing is done in the Medical Devices Reprocessing Department (MDRD) and no flash sterilization is done.

Patients and family members interviewed indicated they were invited to be engaged in their care and were kept well-informed throughout the process. They expressed a high level of satisfaction with their care. No evidence was able to be provided to indicate that patients and families are informed about their rights and responsibilities and the units are encouraged to post this information so that is visible to patients and families.

Priority Process: Decision Support

Documentation within both obstetrical units is a hybrid of electronic and paper charting. Physician orders are on-line and nursing flow sheets and documentation is a hard copy. This creates a potential risk if care providers do not review both sources. Health PEI is encouraged to move to a full electronic medical record to reduce this potential risk for errors. Policies and guidelines are developed at the provincial level, with input from patient and family advisors. The QIT is working towards a more provincialization of policies. There are still several site-specific policies and procedures related to obstetrics care that should be standardized across the province.

Priority Process: Impact on Outcomes

Formal, hospital-wide, patient satisfaction surveys are completed every 2 years. More pertinent and timely feedback about the obstetrical units is gained through the complaints and complements cards and a, newly released, online survey; both are accessible to patients and family members. Incident reporting is on-line, and all reports are reviewed by the managers. Daily huddles and regular staff meetings provide the opportunities to discuss incident trends and potential recommendations that may come out of the analysis of the incidents.

The provincial Quality Improvement Team (QIT) has representation from both sites as well as patient and family advisors. Much of the development, review and revision of policies and guidelines occurs at the QIT. The Quality Improvement Team has representation from both hospitals as well as patients and family members. Several indicators are being monitored at the two sites. This includes breastfeeding rates, hand hygiene, participation in MORE OB, incident rates, and rates of induction and C-section. The obstetrical units are encouraged to post the monitoring of these indicators on the quality board monitor for staff and patients and families to see. The units are commended for their work on a number of quality initiatives including fetal surveillance education, the Baby Friendly Initiative, care transitions at shift change, and MORE OB.

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

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
The organization has met all criteria for this priority process.		
Priority Process: Competency		
6.6	Education and training are provided on the organization's ethical decision-making framework.	
Priority Process: Episode of Care		
10.14	Ethics-related issues are proactively identified, managed, and addressed.	!
14.5	All of the client's jewelry, body piercings, contact lenses, prostheses, dentures, and eyeglasses are removed prior to surgery.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
The organization has met all criteria for this priority process.		
Priority Process: Medication Management		
The organization has met all criteria for this priority process.		

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

Leadership at both QEH and PCH is strong and passionate about the delivery of quality patient centred surgical services. In a relatively short period of time, they adjusted their resources to recover any postponed surgical cases during the COVID-19 pandemic. The teams all have specific goals with clear plans to work towards achieving them.

A patient representative sits on the Surgical Quality Improvement Team. The Surgical Quality Improvement Team includes representatives from other service areas.

Priority Process: Competency

All clinical members of the perioperative team are certified perioperative nurses through the AORN. Smart pump training occurs upon hire and thereafter is required on an annual basis.

Performance appraisals have not been conducted for some teams during the COVID-19 pandemic; they are in the process of resuming for such teams. Despite this, teams indicate they have felt supported in their ongoing education. Both sites offer annual skills days and weekly inservicing for hot topics. Ethics education is available but not required; a more robust training model would benefit the organization.

Priority Process: Episode of Care

QEH and PCH offer services such as orthopaedics, urology, plastics, general surgery, obstetrics and gynecology, and ENT. Other more complex services such as neurosurgery, thoracic, and cardiac are referred to other programs outside of PEI.

Surgical volumes continue to grow, and the perioperative programs will be tasked with adequately resourcing their programs to meet demand or see an increase in waitlists.

The collaborative and patient focused culture of both QEH and PCH ensure that patients rarely get canceled due to lack of an inpatient bed; this culture is to be commended.

All perioperative staff at both QEH and PCH complete AORN certification.

Standardized admission and assessment tools are embedded in the CIS and support consistent care for all surgical patients. Use of two person identifiers, the safe surgery checklist and the medication reconciliation criteria are consistent practices in the perioperative programs.

Performance appraisals are either up to date or in the process of resuming post COVID-19 pandemic response.

Patient facing quality boards are made available with metrics for some quality improvement activities. A more comprehensive disclosure to the front-line teams, regarding quality outcomes, would benefit the organization in future activities.

An ethics framework exists. However, ethics education is available but not mandatory for front line staff; a more robust training model would benefit the organization.

Preoperative teaching regarding removal of jewelry is completed in the Preadmission Clinic and confirmed upon admission. Some patients elect to keep jewelry and this is permitted and charted in the patient document that risks have been advised.

Priority Process: Decision Support

The patient care record continues to be a hybrid paper and electronic chart in the clinical information system (CIS). The organization would benefit from transitioning to a fully electronic chart to optimize patient safety opportunities that exist within a clinical information system. The documentation collected, either paper or in the CIS, is standardized.

Priority Process: Impact on Outcomes

Normothermia measurement practices are scaled and spread across surgical programs at QEH and PCH. Patient representatives sit on the Surgical Quality Improvement Team. Patient facing quality boards are in place and metrics for some quality improvement activities are made available. A more comprehensive disclosure to the front-line teams regarding quality outcomes would benefit the organization in future activities.

Teams utilize the incident management system; the organization would benefit from more consistent follow up with initiators of incidents reported to optimized learning opportunities.

Priority Process: Medication Management

PYXIS medication cabinets have been introduced in some perioperative environments except for the operating rooms. Despite this, medications are secure, standardized, and managed appropriately. An anesthesia assessment is completed prior to every surgical procedure. Medications were drawn up by scrub nurse using aseptic technique and labelled appropriately on the field. There is a consistent practice for medication containers to be retained until the end of the procedure.

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

Unmet Criteria	High Priority Criteria
Priority Process: Point-of-care Testing Services	

The organization has met all criteria for this priority process.

Surveyor comments on the priority process(es)
Priority Process: Point-of-care Testing Services

The Point of Care Testing (POCT) program is accountable for oversight and management of Point of Care Testing throughout all Health PEI facilities and is committed to ensuring that accurate patient testing is carried out. There is a provincial committee that reviews all requests for POCT devices. The committee must approve the acquisition of the device before it is purchased and implemented for use. Each piece of equipment is validated and calibrated prior to being placed into service.

All staff performing POCT must successfully complete initial training and competency assessment, on each device they will be operating, prior to being granted access for testing. There are annual competency requirements that must be met to retain access. All training and competency is documented. Each health care professional is assigned a unique identification number which is scanned into the instrument. While observing two employees perform testing during this visit, it was noted that they manually input their ID number instead of scanning it. This could be a source of error. The POC staff is assisted in the training of the large number of users by a team (nurse educators, laboratory managers) who have completed additional “train the trainer” modules.

Standard Operating Procedures, written in accordance with the requirements of the standards, are available for each POCT procedure. They can be accessed in Omni. They are also available in hard copy in the POCT binder in the care areas. The team has also created authorized summary sheets that are posted on the nursing units.

The organization has standardized the type of equipment used for each procedure. There is an accurate and up to date inventory of all POCT supplies and reagents. New supplies and equipment are evaluated using a documented process prior to purchase of the new lot number. Reagents are evaluated periodically and removed if expired or substandard.
Users perform quality control checks on each instrument according to the established protocol. All quality control results are maintained electronically and reviewed by the POC coordinators. The care areas maintain a checklist to document the performance of QC and maintenance.

The organization participates in an external POCT quality control program. The samples are rotated among the staff who perform testing.

The team recently began a quality initiative to reduce the number of POC patient ID related errors. This will be accomplished by education on the importance of scanning patient and user identification and the impact on patient safety and care created by erroneous or missing results.

The Point of Care Testing (POCT) program has accomplished a great deal since the last accreditation. The addition of a second technologist to the team was a definite asset. However, the challenges presented by the COVID-19 pandemic and the need to train 400+ people, the majority of whom had no medical background, on the ID Now device put additional strain on the program. They are to be commended for their dedication and continued enthusiasm to improve the program.

Standards Set: Primary Care Services - Direct Service Provision

Unmet Criteria		High Priority Criteria
Priority Process: Clinical Leadership		
1.2	Information is collected from clients and families, partners, and the community to inform service design.	
1.3	Service-specific goals and objectives are developed, with input from clients and families.	
1.4	Services are reviewed and monitored for appropriateness, with input from clients and families.	
Priority Process: Competency		
10.6	Access to spiritual space and care is provided to meet clients' needs.	
Priority Process: Episode of Care		
6.6	During regular hours, same-day access to primary care services is available to clients and their families, as required.	!
6.8	An out-of-office and after-hours care process is followed for clients and families requiring access to primary care services outside regular business hours.	!
9.5	When prescribing any medication, the team reconciles the client's list of medications.	!
Priority Process: Decision Support		
The organization has met all criteria for this priority process.		
Priority Process: Impact on Outcomes		
14.2	The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.	
14.3	There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.	!
Surveyor comments on the priority process(es)		
Priority Process: Clinical Leadership		

Primary Care Services for Health PEI has based their services on several factors including population demographics, Community and Patient Survey, and physician and professional staff input.

Partnerships have been initiated, or expanded, to meet the growing needs of the population and to cover the entire spectrum of care. Collaboration occurs between all sectors of care - acute care, long-term care, home care and specialized health services.

Information regarding Primary Care Services is widely available to the community members.

Staffing and available space seem to be a universal issue for all Primary Care offices. The needs have been identified and provided to Senior Leadership.

Priority Process: Competency

Primary Care staff have the training and education required to fulfil their respective roles. Credentials and qualifications are verified and on their personnel files. Position profiles are in place and all staff work to their full scope of practice.

Additional education and training provided at orientation and annually, as required, including the ethical decision-making framework, IT, cultural competence, safe use of equipment, and workplace violence prevention.

Performance evaluations have fallen behind at the Montague Health Centre given the lack of management for a period of time. There is a plan to have these reviews completed now that new management staff are in place.

Ongoing professional development is offered in various forms - in person and/or virtually.

Lack of staffing and space have been evident at several sites and Senior Leadership is aware. Plans are in place to address these issues where possible.

Team members are recognized for their hard work both formally and informally. Staff appreciation events have been curtailed during the COVID-19 pandemic, but plans are in place to restart them.

Priority Process: Episode of Care

The referral to the provincial rehabilitation unit has defined criteria for admission.

Primary Care Services for Health PEI are in high demand with finite resources. However, a concerted effort is placed on providing services in a timely fashion to all clients requiring their services. In some clinics, same day appointment spots can be held for those clients in urgent need of being seen on the same day that they call in.

Defined information, using standardized assessment tools, is collected at the time of intake and when service is initiated. If services cannot be provided, for whatever reason, efforts are made to assist the

client to find alternative services.

An out-of-office and after-hours process is in place for clients seeking service at these times. Tele-triage is available 24/7.

A health risk assessment is completed for all clients. Preventable health screening exams are planned and follow up with clients, regarding the results, occurs. Clients and families are encouraged to be engaged in managing their own health needs as much as possible.

Informed written consent from the client, or substitute decision-maker, if necessary, is gained prior to any invasive procedures. Implied consent is used for many regular appointments.

Clients and families are made aware of their rights and responsibilities. If these have been violated, a process is in place for complaints to be made. These are followed up immediately by an investigation and a resolution is shared with the client.

Diagnostic and laboratory testing is readily available and expert consultation occurs in a timely manner. Clients are made aware of the result of their tests quickly. Abnormal results are handled immediately.

The primary health care team is multidisciplinary, but they also work with other health care providers as necessary to manage the needs of clients with complex healthcare needs and/or multiple co-morbidities.

Each client, that is part of the primary healthcare clinic, has an individualized care plan outlining goals and progress towards these goals of care. Treatment protocols are consistent for each client based on the disease process presented.

When clients are transitioned to other services, or referrals are made, a complete and standard set of information is provided. The transition information is documented in the client's file. Following referrals or hospitalizations the clients are seen in the clinic for appropriate follow up.

The Primary Care Networks and their teams are to be commended for the excellent work and care they are providing to their clients; especially, given the challenges they face. The vision of the Patient Medical Home is very exciting.

Priority Process: Decision Support

Primary Care services have initiated a new collaborative health record/electronic medical record. Different health centres are at different levels of utilization. Some are quite advanced while others are struggling to use the system to its full extent. Unfortunately, the implementation has been paused to address concerns about the system.

Policies and procedures are in place to securely store, retain and destroy paper files. Policies and procedures for managing electronic files are also present, including the disclosing of information to

others. The EMR allows ease of access for multiple care providers to access the clients file and document the care they are providing. Clients may access information on their records.

Priority Process: Impact on Outcomes

Primary Care has standard protocols and procedures for certain disease entities that ensures consistent care is provided to all clients. The most up-to-date, evidence-based guidelines are in place to provide excellent care to all clients.

Client safety incidents are documented, tracked, and trended. Client safety incidents are disclosed to the client and families in a timely fashion. Follow up is completed to determine the cause of the incident and how to prevent its reoccurrence. Clients are contacted with the outcome of the investigation and the steps to mitigate a reoccurrence.

Quality improvement initiatives are occurring at the local levels as Plan-Do-Study-Act (PDSA) proceeds.

Standards Set: Public Health Services - Direct Service Provision

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

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

The team is responsive to community needs and seeks input from all its partners especially client and families.

Priority Process: Competency

The team is quite diverse and covers many aspects of community health. The overarching provincial program, the Government of Prince Edward Island Chief Public Health Office (CPHO) is responsible for setting the public health agenda and this teams works collaboratively to ensure access for the clients and families.

Leadership provides consistent feedback to the team; one staff person had a performance appraisal last month. The team seeks creative ways to deliver services considering cultural diversity, privacy, access, and personal factors that enable higher engagement with the client.

Priority Process: Impact on Outcomes

Quality improvement in this program is influenced by many things. The Health Authority has a quality and risk program that works with the public health leadership to address issues that arise from occurrences or complaints and help to improve. The province has an active public health office that sets the provincial standards that impacts the services that public health offices deliver. They have an amazing dental program where dentists take portable equipment into schools and provide dental care while the students are at school.

The Summerside site has upgraded the washroom and accessibility into the building since their last accreditation. They feel that there are improvements always happening because of feedback from clients.

The Charlottetown group spoke of creativity in offering prenatal classes and has adopted a virtual option for those not wanting in person classes.

Overall, a strong sense of quality exists and the commitment to meet the needs of the community they work with.

Priority Process: Public Health

The Department of Health and Wellness CPHO completes overarching needs assessments and policies for the public health program in PEI. This is a separate office from Health PEI. The public Health program within Health PEI is made up of public health nurses, the dental program, nutrition services, hepatitis program, psychology services, and Speech and Audiology. This group follows the directions set out from the government and there are connections between both streams. However, the accountability for many of the standards lies with the province; hence, the N/A status in the ratings.

This team is working hard to address the needs of children, families, and parts of the adult population within their mandates. There is strong evidence of partnerships, community connections, and best practice being offered in their various programs. The Hepatitis program has been so effective, it has now been able to pivot, the rates have lowered, and there is an ability to add another stream of work to that program.
The vaccine program is stellar with such a tremendous response to COVID-19 and the ongoing booster program. The staff are patient centered showing adaptability in all areas and have a strong ethical approach to care.

The data collection is localized with the responsibility for data being with the Government of PEI CPHO.

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	
12.1 Training and education about legislation to protect client privacy and appropriately use client information are provided.	
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

Leadership for rehabilitation services is strong. Staff interviewed expressed feeling well supported in all aspects of their roles.

QEH rehabilitation services has both patient and family advisors on their quality team and actively engaged in developing team goals.

QEH rehab services has strong linkages with community-based groups and societies, such as Parkinson's, MS, and spinal cord injury.

Rehab services includes medical staff and Allied Health occupational therapists, physiotherapists, speech language pathologists, social workers, nursing, and other support members.

Priority Process: Competency

Initial and ongoing education is offered of all members of the rehabilitation services team, and they are well supported to attend sessions offered outside of the organization.

All professional staff have verified up-to-date, credentials. Education sessions have been provided by the Newcomers society along with other special interest groups.

Orientation is comprehensive and includes many program-specific areas of learning such as the Hemisphere stroke course. Initial and ongoing inservices are offered for all equipment used in rehab services. Smart pump user guides are available on each pump. Education is required upon hire and annually thereafter.

Performance appraisals are current for all staff in rehab services.

Bedside rounds occur daily and weekly. Multidisciplinary rounds occur with the patient in attendance. Bedside whiteboards are consistently utilized.

Staff take training related to a safe workplace and feel supported in how incidents of violence are managed.

Priority Process: Episode of Care

Bedside rounds occur daily and weekly. Multidisciplinary rounds occur with the patient in attendance. Bedside whiteboards are consistently utilized. A comprehensive multidisciplinary discharge planning meeting, that includes the receiving facility or outpatient team along with the patient and family, is conducted for all patients leaving the unit.

The rehabilitation unit employs a variety of communication modalities to ensure information is understood by the patient and family. Interpreter services are accessed as required.

Verbal consent is obtained prior to every rehabilitation session and written consent as indicated.

Ethics is a standing agenda item on quality team meetings and are addressed in multidisciplinary rounds.

A comprehensive admission package is provided to patients and families. The package outlines their rights and responsibilities and directs them on how to voice their concerns.

A BPMH is generated and documented at each admission by the admitting nurse. It is updated, as required, by the pharmacy. Medications are reconciled by the hospitalist at transitions or discharge.

Braden score is initiated upon admission and updated weekly or as changes occur. 2 person identifiers are used; teams are reminded to be consistent in this practice given that the length of stay of rehabilitation patients leads to more familiarity. SBAR is utilized broadly across continuum. Additionally, the CIS has standardized transfer of care documentation.

Given the complexity of rehabilitation patients, a future readmission is anticipated, and care planning is put in place to mitigate this for as long as safely possible.

Priority Process: Decision Support

The patient record is within the clinical information system.

Training exists regarding patient privacy. The rehabilitation unit at the QEH has a public facing patient bed board that displays the patients' last names and first initial. The organization is recommended to use initials only to comply with patient privacy legislation.

Priority Process: Impact on Outcomes

QEH rehab services has both patient and family advisors on their quality team. Quality metrics are posted on a public facing quality board for all stakeholders' reference. As the provincial rehabilitation unit, the scale and spread of quality improvement activities to other sites is well documented.

Data for length of stay, stroke median functional independence measure, falls, discharge satisfaction, pressure ulcers, hand hygiene, and therapy time are consistently monitored and utilized to inform change. Current initiatives are underway to understand the predictive ability of the functional independence measure on falls.

Patient satisfaction surveys are conducted on a routine basis.

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

Unmet Criteria	High Priority Criteria
Priority Process: Clinical Leadership	
2.7 A universally-accessible environment is created with input from clients and families.	
Priority Process: Competency	
The organization has met all criteria for this priority process.	
Priority Process: Episode of Care	
The organization has met all criteria for this priority process.	
Priority Process: Decision Support	
The organization has met all criteria for this priority process.	
Priority Process: Impact on Outcomes	
The organization has met all criteria for this priority process.	

Surveyor comments on the priority process(es)

Priority Process: Clinical Leadership

In all areas of this program, well-functioning. client-centered teams were observed. There is a significant amount of change occurring in this program area as well as in mental health. Leadership needs to ensure that clients continue to get the services they require throughout the transition.

There are apparently two opiate replacement programs in the Charlottetown area. One that is private and one through Health PEI. To ensure appropriate client outcomes, these programs need to be standardized.

There are several older facilities in the program which need to be upgraded or replaced. The development of a new campus in the Charlottetown area is noted, however facilities such as Talbot House are not moving to this new campus.

The cleanliness of the Provincial Addiction Treatment Facility (Mount Herbert site) was impressive. As this integrated program moves forward it is important to make sure that any new electronic clinical record system that is developed can integrate with the hospital-based system and the primary care system.

The STRENGTH program at Summerside is to be commended. An opportunity area is the lack of medical consultation for such things as standing orders and prescriptions. The valuable time of nurses is being interrupted to call family doctors and/or referring agencies regarding these matters. This time would be better used in programming.

Priority Process: Competency

Competent multidisciplinary teams seen in all areas. It was observed that staff were very respectful of the clients they serve.

Staff do receive regular performance appraisals.

There is an impressive monthly calendar of educational offerings.

Staff well trained in a number of treatment models.

The INSIGHT Program should be written up and published. It is a very good program and sharing it can benefit other organizations.

Priority Process: Episode of Care

All programs visited were voluntary. Staff are attentive to transitions and particularly the transition back to the community. They will go out of their way to make sure that clients have the supports they need to be successful. There is a chronic affordable housing shortage in PEI and this is having a detrimental effect on some clients who cannot fine affordable, safe, housing. This is also true for the mental health program.

Clients speak highly of the services they receive. They simply want more of them in other areas of the province and or longer stays at existing programs.

Priority Process: Decision Support

There is a combination of paper and electronic charts at all sites.

Recently a mental health and addictions review has been carried out and this will guide the development of this program in the future.

Priority Process: Impact on Outcomes

Good use of evidence-based practice in many program areas.

Good risk assessment and response processes are in place.

Significant attention is paid to transitions.

The Talbot House residence needs to be reviewed to ensure it provides a respectful environment for clients. It is a multi-story, older home.

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		
4.3	The team has a formal program to maintain team members' competence that includes evaluating their theoretical and practical knowledge on transfusion services using a variety of techniques.	
4.5	Team managers document the results of competency assessments and reassessments.	
4.8	The organization maintains and retains complete and up-to-date records on qualifications, training, and competence, including competency assessments and reassessments, and remedial actions for each team member.	
18.4	When tested blood components are not available, the organization has a policy for releasing untested blood components in emergency situations that requires the inclusion of a comprehensive release voucher, documented client informed consent, and documented approval of the recipient's attending physician.	!
18.5	When untested blood is released, the team immediately communicates the results to the appropriate team members when they are received from the appropriate organization.	!
18.6	The team maintains a record of each case where blood is released prior to completion of testing.	!
Surveyor comments on the priority process(es)		
Priority Process: Episode of Care		

Staff are aware of the hospital falls prevention strategy. Phlebotomy areas are free of clutter and spacious enough to allow for ease of movement.

Priority Process: Transfusion Services

Transfusion Medicine testing on PEI is provided by the Queen Elizabeth Hospital (QEH) and the Prince County Hospital (PCH). Kings County Memorial Hospital (KCMH), Western Hospital, and the 2 community hospitals are dispensing sites that do not do any serological testing. Testing of specimens, provision of

product, and oversight for these 4 facilities is provided primarily by QEH transfusion laboratory. The QEH also acts as a reference laboratory to PCH for their complicated cases.

The transfusion laboratory at Prince County Hospital (PCH) is staffed by well-trained technologists that perform testing and crossmatching and limited antibody identification in a core lab setting. They will also provide support to the Western Hospital and the Community Hospital O'Leary, if required.

There is a Medical Director of the Transfusion Service (TS) who is responsible for all Transfusion and Haematology laboratory service on PEI. She ensures that there is consistent practice regarding patient testing and blood product storage, dispensing, and utilization.

The equipment and maintenance records at all sites are complete and there is documentation of review. All storage units are equipped with recording charts and alarms that sound remotely. The alarms are tested on a regular basis. At the smaller facilities, where the laboratory is not staffed during the overnight hours, the alarm is monitored on the nursing unit. The manager at KCMH developed a training module which has been presented to all nursing staff to ensure there is a good understanding of the process.

There is an excellent training process in all facilities and there is documentation of completion of training and attainment of initial competency. PCH does not have a robust program for measuring ongoing competency. There is such a program at QEH. The team at QEH is encouraged to share the process and documents with the PCH supervisor. Competency training at the smaller facilities is complete for both technologists and nursing.

Quality initiatives: The PCH team project was to develop a process to provide un-crossmatched emergency blood products in a timelier manner. This is complete and working well.
The QEH team validated the Credo cubes for transport of blood products. This is a nationally recognized packaging used by Canadian Blood Services for product transport. It consists of "phase" changing tempered plates which allow for a stable internal temperature regardless of the outside ambient temperature. Plasma Protein products are routinely shipped from QEH to all other facilities. The implementation of this transport system has resulted in no loss of these very expensive products due to delays or temperature failure.

Ongoing audits are performed on outdating of various blood products and turnaround times for STAT specimens. The results are posted for staff to review. There are no specimens with a status of "urgent" so any time sensitive requests are included in the STAT category.

The QEH did not formally participate in the Choosing Wisely red blood cell usage project due to a lack of resources to perform the necessary data collection. They do, however, refer to the Choosing Wisely guidelines in the practice of transfusion of product.

There is a home care program for patients who self-infuse plasma protein products and coagulation factor replacement. Patients can access care at the facility of their choice.

The transfusion committee meets regularly and includes representatives from the clinical staff. There is a provincial Transfusion Medicine/Haematology laboratory group. Team members are enthusiastic about this group and the potential for sharing best practices and exchanging information.

The Transfusion service consists of experienced, knowledgeable, and dedicated technologists and a medical director; all of whom work cohesively to provide transfusion support to patients across the province.

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: June 19, 2020 to July 18, 2020**
- **Number of responses: 6**

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.	17	0	83	95
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	0	0	100	97
3. Subcommittees need better defined roles and responsibilities.	50	17	33	73
4. As a governing body, we do not become directly involved in management issues.	0	17	83	87
5. Disagreements are viewed as a search for solutions rather than a “win/lose”.	0	0	100	96

	% 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.	17	17	67	97
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	0	0	100	95
8. Members come to meetings prepared to engage in meaningful discussion and thoughtful decision making.	0	0	100	95
9. Our governance processes need to better ensure that everyone participates in decision making.	67	17	17	61
10. The composition of our governing body contributes to strong governance and leadership performance.	33	33	33	92
11. Individual members ask for and listen to one another's ideas and input.	0	0	100	95
12. Our ongoing education and professional development is encouraged.	33	17	50	84
13. Working relationships among individual members are positive.	0	0	100	97
14. We have a process to set bylaws and corporate policies.	0	50	50	94
15. Our bylaws and corporate policies cover confidentiality and conflict of interest.	0	0	100	97
16. We benchmark our performance against other similar organizations and/or national standards.	50	0	50	80
17. Contributions of individual members are reviewed regularly.	33	50	17	69
18. As a team, we regularly review how we function together and how our governance processes could be improved.	17	17	67	79
19. There is a process for improving individual effectiveness when non-performance is an issue.	20	80	0	53

	% 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.	0	33	67	82
21. As individual members, we need better feedback about our contribution to the governing body.	0	33	67	43
22. We receive ongoing education on how to interpret information on quality and patient safety performance.	17	0	83	83
23. As a governing body, we oversee the development of the organization's strategic plan.	17	0	83	93
24. As a governing body, we hear stories about clients who experienced harm during care.	0	17	83	79
25. The performance measures we track as a governing body give us a good understanding of organizational performance.	0	0	100	95
26. We actively recruit, recommend, and/or select new members based on needs for particular skills, background, and experience.	60	0	40	90
27. We lack explicit criteria to recruit and select new members.	17	0	83	78
28. Our renewal cycle is appropriately managed to ensure the continuity of the governing body.	33	50	17	90
29. The composition of our governing body allows us to meet stakeholder and community needs.	83	0	17	92
30. Clear, written policies define term lengths and limits for individual members, as well as compensation.	17	33	50	92
31. We review our own structure, including size and subcommittee structure.	17	0	83	81
32. We have a process to elect or appoint our chair.	20	0	80	90

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	0	33	67	83
34. Quality of care	17	50	33	83

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2020 and agreed with the instrument items.

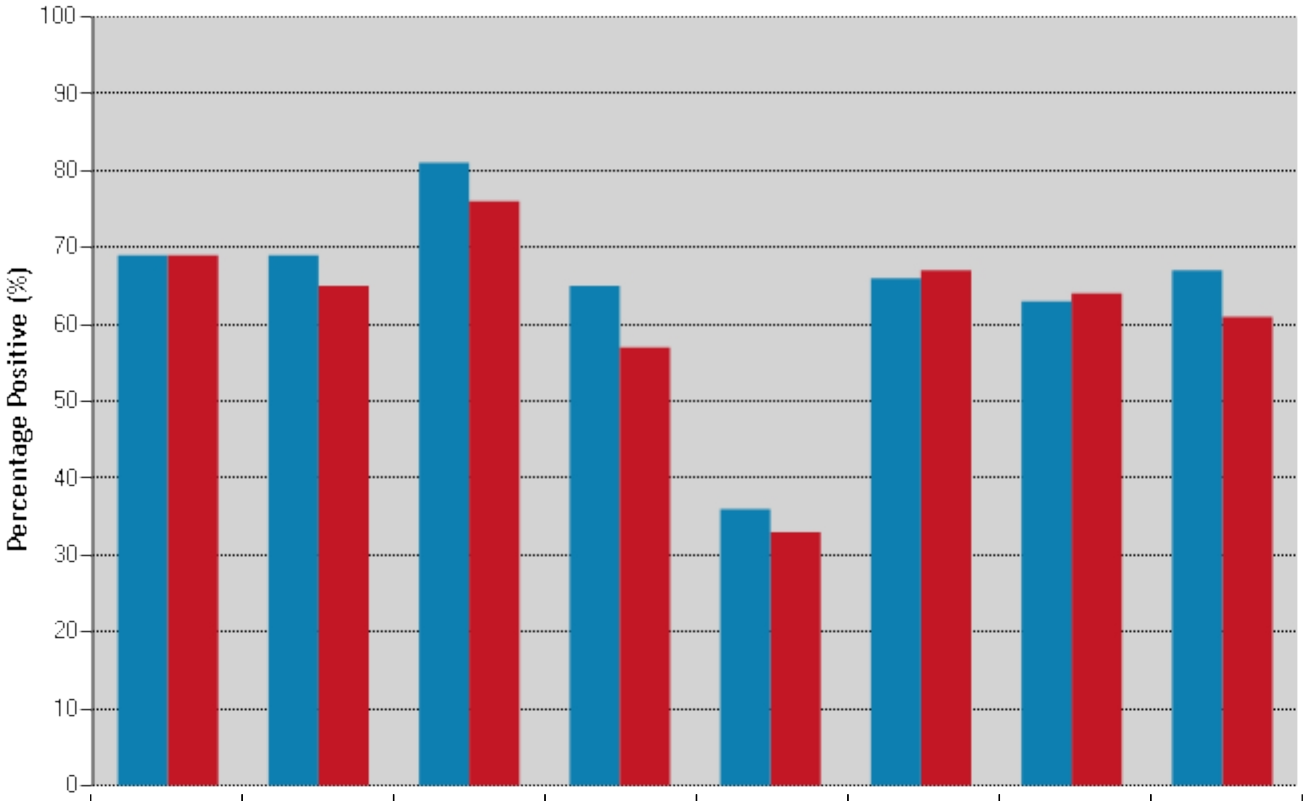
Canadian Patient Safety Culture Survey Tool

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 18, 2019 to October 4, 2019**
- **Minimum responses rate (based on the number of eligible employees): 353**
- **Number of responses: 935**

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
	69%	69%	81%	65%	36%	66%	63%	67%
	69%	65%	76%	57%	33%	67%	64%	61%

Legend

Health PEI

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2021 and agreed with the instrument items.

Worklife Pulse

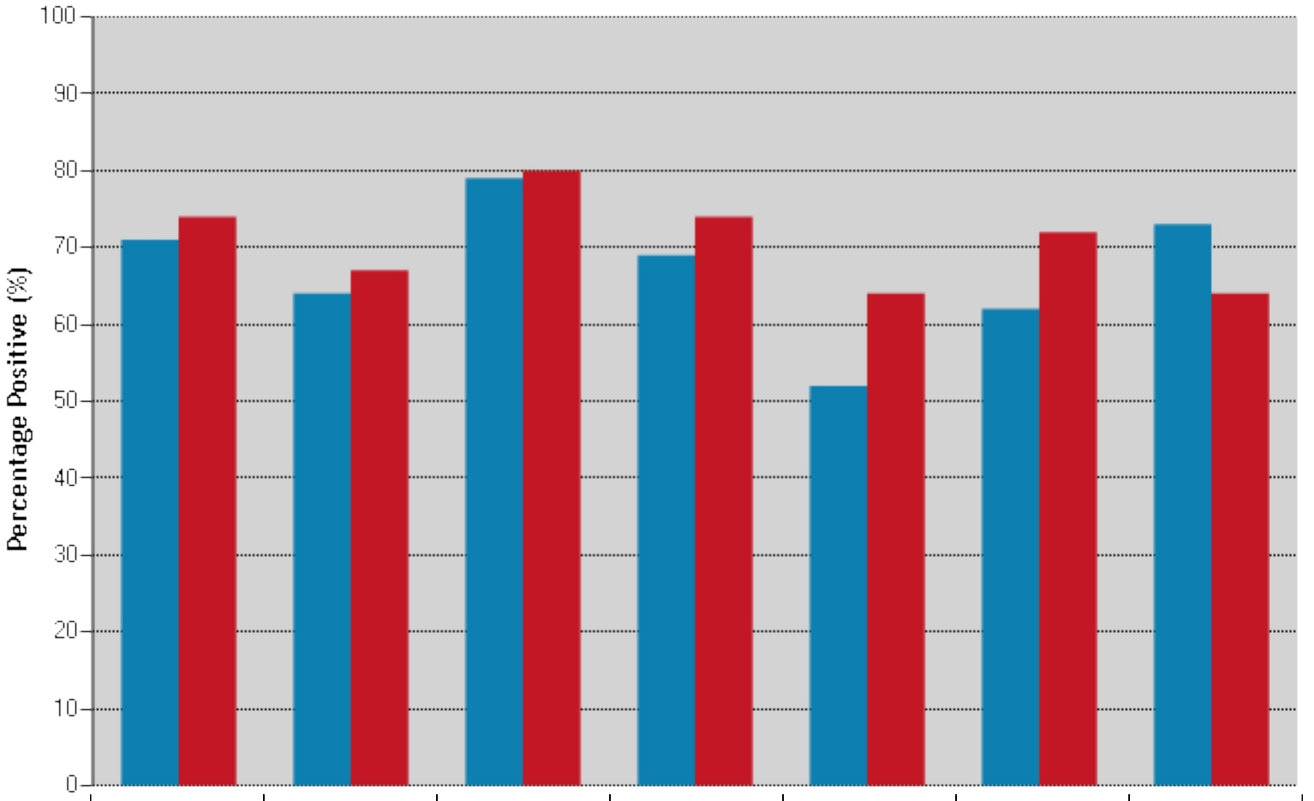
Accreditation Canada helps organizations create high quality workplaces that support workforce wellbeing and performance. This is why Accreditation Canada provides organizations with the Worklife Pulse Tool, an evidence-informed questionnaire that takes a snapshot of the quality of worklife.

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.

Accreditation Canada provided the organization with detailed results from its Worklife Pulse 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: June 12, 2020 to July 1, 2020**
- **Minimum responses rate (based on the number of eligible employees): 355**
- **Number of responses: 1442**

Worklife Pulse: Results of Work Environment



	Job	Training and Development	Coworkers	Immediate Supervisor	Senior Management	Safety and Health	Overall Experience
	71%	64%	79%	69%	52%	62%	73%
	74%	67%	80%	74%	64%	72%	64%

Legend

Health PEI

* Canadian Average

*Canadian average: Percentage of Accreditation Canada client organizations that completed the instrument from July to December, 2021 and agreed with the instrument items.

Client Experience Tool

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

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

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

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

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

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

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

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

Appendix A - Qmentum

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

As part of the Qmentum accreditation process, client organizations complete self-assessment questionnaires, submit performance measure data, and undergo an on-site survey during which trained peer surveyors assess their services against national standards. The surveyor team provides preliminary results to the organization at the end of the on-site survey. Accreditation Canada reviews these results and issues the Accreditation Report within 15 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