



ACCREDITATION CANADA



Driving Quality Health Services

Final Accreditation Report

Prepared for:
**Guysborough Antigonish Strait Health
Authority**
Antigonish, NS

On-site Survey Dates:
November 2, 2008 - November 6, 2008

July 7, 2009



ACCREDITATION CANADA
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Final Accreditation Report

About this Report

This Report documents updated information and action taken by Guysborough Antigonish Strait Health Authority to address areas for improvement identified in its Forecast Report issued in December 2008. It also shows the final accreditation decision.

The Report is based on information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the on-site survey and to prepare the Report. Any alteration of this Report compromises the integrity of the accreditation process and is strictly prohibited.

Confidentiality

This Report is confidential and is provided by Accreditation Canada to Guysborough Antigonish Strait Health Authority only. Accreditation Canada does not release the Report to any other parties.

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

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About the Qmentum Accreditation Program

Accreditation is a cornerstone of quality improvement and patient safety initiatives, enabling an organization to regularly and consistently assess and improve its services.

Accreditation Canada's Qmentum program offers a customized process aligned with organizational needs and priorities. Organizations complete self-assessment questionnaires, collect indicator and instrument data, and undergo an on-site survey during which peer surveyors assess their services against national standards of excellence. Qmentum also offers ongoing support from and liaison with Accreditation Specialists who work with each organization to address critical issues, assist with action planning, and monitor progress.

Accreditation results, and the accreditation decision, are documented as follows:

- ***On-Site Report:***
At the conclusion of the on-site survey, surveyors provide the organization with an On-site Report summarizing their findings. The organization reviews the results and starts working on areas identified for improvement.
- ***Forecast Report:***
Following the on-site survey, Accreditation Canada issues a Forecast Report, containing more detailed on-site survey findings, a summary of indicator and instrument data, and a forecast of the final accreditation decision.
- ***Final Report:***
The Final Report is issued six months after the Forecast Report. It shows updated data, based on action(s) the organization has taken to address areas identified for improvement in the Forecast Report, and the final accreditation decision.

The findings in these Reports guide the organization as it incorporates the principles of accreditation into its programs and improves the quality of care and services provided to clients and the community.

An important adjunct to the Accreditation Reports is the Quality Performance Roadmap, available to the organization through a designated online portal. The Roadmap allows organization teams to review accreditation requirements and results in detail, and develop action plans, submit evidence, and monitor improvements.

Accreditation Summary

Guysborough Antigonish Strait Health Authority

On-site survey dates	November 2 to 6, 2008
Forecast Report issued	December 8, 2008
Forecast of the accreditation decision	Accreditation with Condition

Final Report issued	July 7, 2009
Accreditation Decision	Accreditation

Accreditation History

Previous on-site survey dates	November 6 to 10, 2005
Accreditation Decision	Accreditation
Previous on-site survey dates	November 24 to 28, 2002
Accreditation Decision	Accreditation with Report
Previous on-site survey dates	November 14 to 19, 1999
Accreditation Decision	Accreditation with Report

Organization's Commentary

The organization has no comment at this time.

Leading Practices

Recognizing innovation and creativity in Canadian health care delivery

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

Leading Practices

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

Guysborough Antigonish Strait Health Authority is commended for the following:



GASHA has developed a regional trauma expertise integrated with EMS, the hospital network of GASHA especially St Martha's, and the referral centres in Halifax. Special training in teamwork within the hospital and within the community makes for rapid transfer to a medical facility, seamless transfer at the site, full complement of care givers and, where appropriate, seamless transfer to Halifax. Several examples were given where a life was saved because of the expertise and rapid transfer. (Home Care)

1 Results Overview

This section of the Report shows an overview of the organization's results, displayed according to three significant components of the accreditation program: quality dimensions, required organizational practices, and standards sections.

1.1 Overview by Quality Dimensions

Accreditation Canada standards and criteria can be categorized into eight quality dimensions.

The following table summarizes the percentage of criteria associated with each quality dimension that were met by the organization, as well as the national compliance rate from January 1 to December 31, 2008 for all Accreditation Canada organizations.

Quality Dimension	Organization compliance rate %		National compliance rate * %
	Forecast Results	Final Results	
Population Focus <ul style="list-style-type: none"> ▪ Working with communities to anticipate and meet needs 	89	95	91
Accessibility <ul style="list-style-type: none"> ▪ Providing timely and equitable services 	93	94	93
Safety <ul style="list-style-type: none"> ▪ Keeping people safe 	95	98	86
Worklife <ul style="list-style-type: none"> ▪ Supporting wellness in the work environment 	96	96	91
Client-centred Services <ul style="list-style-type: none"> ▪ Putting clients and families first 	93	95	92
Continuity of Services <ul style="list-style-type: none"> ▪ Experiencing coordinated and seamless services 	96	97	92
Effectiveness <ul style="list-style-type: none"> ▪ Doing the right thing to achieve the best possible results 	91	94	86
Efficiency <ul style="list-style-type: none"> ▪ Making the best use of resources 	92	92	91

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the criteria associated with each quality dimension.

1.2 Overview by Required Organizational Practice (ROP)

Required Organizational Practices are essential practices that Accreditation Canada requires organizations to have in place to enhance patient and client safety and minimize risk.

This section shows two tables. The first summarizes the safety areas addressed by each ROP, and shows the organization's compliance status and the percentage of Accreditation Canada organizations nationally that met the ROP from January 1 to December 31, 2008.

To help organizations identify specific areas for action related to ROPS, the second table shows detailed requirements for unmet ROPs, and the standards sections in which they appear.

Following the on-site survey and receipt of the Forecast Report, organizations have opportunities to submit evidence of action taken to address areas identified for improvement. ROPs that continue to be rated unmet may be a result of the organization submitting incomplete or insufficient evidence, or because it has chosen to focus on other areas.

1.2a Overview by ROP Safety Areas

Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Culture			
Adopts client safety as a written, strategic priority or goal	Met	Met	76
Produces quarterly reports on client safety, including recommendations from adverse incidents	Unmet	Met	77
Has a reporting and follow-up system for sentinel events, adverse events, and near misses	Met	Met	88
Discloses adverse events to clients and families	Met	Met	82
Conducts one client safety-related prospective analysis per year	Met	Met	61
Communication			
Educates clients and families about their roles in promoting safety	Unmet	Met	63
Ensures effective information transfer at transition points	Unmet	Met	89

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Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Communication			
Uses verification processes and other checking systems for high-risk activities	Met	Met	87
Conducts medication reconciliation at admission	Unmet	Met	36
Conducts medication reconciliation at transfer	Unmet	Met	34
Uses two client identifiers before administering medications	Unmet	Met	84
Medication Use			
Stores concentrated electrolytes away from client service areas	Met	Met	87
Standardizes and limits number of medication concentrations	Met	Met	92
Provides training on infusion pumps	Met	Met	79
Worklife/Workforce			
Delivers client safety training and education at least annually	Unmet	Met	84
Develops and implements client safety plan	Met	Met	82
Defines roles, responsibilities, and accountabilities for client care and safety	Met	Met	61
Has a preventive maintenance program for medical devices, equipment, and technology	Met	Met	78
Infection Control			
Ensures policies and procedures meet infection control guidelines	Met	Met	93
Delivers hand hygiene education and training	Met	Met	96
Tracks and shares information on infection rates	Met	Met	67

Safety Areas For Required Organizational Practices	Status at the Time of Forecast Report	Status at the Time of Final Report	Organizations that met the ROP %
Infection Control			
Monitors processes for reprocessing equipment	Met	Met	88
Administers the influenza vaccine	Met	Met	91
Administers the pneumococcal vaccine	Met	Met	86
Falls Prevention			
Implements a falls prevention strategy	Met	Met	56

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1.2b Overview of Unmet ROPs by Standards Section and Criterion

The organization is required to submit, through the Organization Portal, evidence of the action it has taken to meet the following ROPs in each of the identified standards sections.

Unmet Required Organizational Practice	Standards section and criterion #
Communication	
The team reconciles the client’s medications following triage, and with the involvement of the client.	· Emergency Department Services 8.2
The team reconciles the client’s medications upon admission to the organization, and with the involvement of the client.	· Obstetrics/Perinatal Care Services 7.2
The team reconciles medications with the client at referral or transfer, and communicates the client’s medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.	· Obstetrics/Perinatal Care Services 12.2
The team reconciles medications with the client at referral or transfer and communicates the client’s medications to the next provider of services at referral or transfer to another setting, service, service provider, or level of care within or outside of the organization.	· Emergency Department Services 10.6

1.3 Overview by Standards Section

The following table shows the percentage of high priority criteria in the identified standards section with which the organization has complied.

Standards Section	Organization compliance rate %		National compliance rate * %
	Forecast Results	Final Results	
Governance	69	97	89
Proactive and Supportive Organization	92	100	86
Infection Prevention and Control	98	100	92
Managing Medications	97	99	92
Populations with a Chronic Condition	25	75	70
Child and Youth Population	88	100	82
Maternal/Child Population	62	100	80
Mental Health Population	100	100	80
Community Health Services	94	100	75
Critical Care Services	96	100	80
Diagnostic Imaging Services	100	100	88
Emergency Department Services	94	94	79
Home Care	92	96	73
Hospice Palliative and End-of-Life Services	100	100	84
Medicine Services	92	100	72
Mental Health Services	100	100	78
Obstetrics/Perinatal Care Services	87	91	82
Operating Rooms	98	100	93
Public Health	96	100	90
Rehabilitation	83	96	81
Standards for Blood Banks and Transfusion Services	100	100	91
Standards for Laboratory Analyses	94	100	75

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

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Standards Section	Organization compliance rate %		National compliance rate *
	Forecast Results	Final Results	
Standards for Laboratory and Blood Services	89	99	64
Substance Abuse and Problem Gambling Services	96	100	83
Surgical Care	94	100	84

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

2 Status of Unmet, High Priority Criteria (from Forecast Report)

This section lists the high priority criteria from each standards section that were rated unmet at the time of the Forecast Report, and their current status. This table excludes the ROP data that is displayed in the previous section.

Following the on-site survey and receipt of the Forecast Report, organizations have opportunities to submit evidence of action taken to address areas identified for improvement. Criteria that continue to be rated unmet may be a result of the organization submitting incomplete or insufficient evidence, or because it has chosen to focus on other areas.

Governance	Organization compliance status (Final Report)	National compliance rate * %
4.6 The governing body selects a concise set of indicators to monitor whether the goals and objectives are being achieved.	Met	67
17.3 The governing body selects and monitors a balanced set of performance measures.	Met	82
17.4 The governing body receives and analyses performance data and information trended over time.	Met	89
17.6 The governing body monitors performance against goals and objectives, identifies opportunities for improvement, and takes actions to address them.	Met	86
18.1 The governing body has a set of criteria to guide accountability discussions and decision-making.	Met	91
18.3 The governing body is transparent with its stakeholders in terms of organization performance and decision-making.	Met	95
19.2 The governing body reviews the frequency and severity of adverse events.	Met	91
19.3 The governing body analyses incidents and new or increased risks to identify trends and opportunities for improvement.	Unmet	84
19.4 The governing body promotes the ongoing search for leading practices and benchmarking opportunities.	Met	86
19.5 The governing body provides leadership for quality improvement and fosters a quality improvement culture throughout the organization.	Met	88
20.3 The governing body encourages open communication and a blame-free dialogue about client safety issues, incidents, and potential problems.	Met	97

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Proactive and Supportive Organization		Organization compliance status (Final Report)	National compliance rate * %
8.8	The organization shares the results of the Worklife Pulse Tool with staff and service providers, and uses the information to make improvements.	Met	72
9.1	The organization works with the governing body to set the quality agenda.	Met	90
16.10	The organization communicates the results of improvement activities to everyone in the organization.	Met	71
Infection Prevention and Control		Organization compliance status (Final Report)	National compliance rate * %
12.5	All staff, service providers, and volunteers know how to apply the protocol.	Met	82
Managing Medications		Organization compliance status (Final Report)	National compliance rate * %
10.2	The organization uses a computerized prescriber order entry (CPOE) system with the capacity to guide the use of accepted drugs and established protocols, and alert attention to unsafe orders during input.	Unmet	53
Populations with a Chronic Condition		Organization compliance status (Final Report)	National compliance rate * %
2.2	The organization uses the information it collects about the community in program planning and decision-making.	Met	76
2.3	The organization uses a process to stratify populations according to risk and the need for programs and services.	Unmet	76
7.2	The organization identifies a comprehensive interdisciplinary team based on the needs of the population(s) served.	Met	76
14.1	The organization identifies and monitors both process and outcome measures for its chronic disease management services.	Met	43
14.2	The organization monitors clients' perspectives on the services for populations with a chronic condition.	Met	67
14.3	The organization identifies successes and opportunities for improvement, and makes improvements as needed.	Unmet	67

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

Child and Youth Population		Organization compliance status (Final Report)	National compliance rate * %
11.2	The organization monitors clients' perspectives on its services for child and youth populations.	Met	75
Maternal/Child Population		Organization compliance status (Final Report)	National compliance rate * %
6.1	The organization's leaders identify a comprehensive interdisciplinary team based on the needs of the populations served.	Met	86
11.1	The organization identifies and monitors process and outcome measures.	Met	62
11.2	The organization monitors clients' perspectives on its services for maternal/child populations.	Met	75
Community Health Services		Organization compliance status (Final Report)	National compliance rate * %
8.5	The team identifies, reports, records, and monitors in a timely way incidents such as sentinel events, near misses, and adverse events.	Met	80
Critical Care Services		Organization compliance status (Final Report)	National compliance rate * %
16.1	The team identifies and monitors process and outcome measures for critical care services.	Met	75
Home Care		Organization compliance status (Final Report)	National compliance rate * %
16.4	The team compares its results with other similar interventions, programs, or organizations.	Unmet	54
16.5	The team uses the information it collects about performance to identify successes and opportunities for improvement, and makes improvements as needed.	Met	72

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

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Medicine Services		Organization compliance status (Final Report)	National compliance rate * %
16.1	The team identifies and monitors process and outcome measures for medicine services.	Met	62
16.2	The team monitors clients' perspectives on medicine services.	Met	71
Operating Rooms		Organization compliance status (Final Report)	National compliance rate * %
10.3	The team documents the type, amount, and dosage of all drugs, agents, and fluids provided to the client during the procedure, including blood and blood products.	Met	99
Public Health		Organization compliance status (Final Report)	National compliance rate * %
4.2	The organization and partners tailor the communication strategy to meet the needs of different target audiences and community groups.	Met	96
5.2	The organization continually shares the results of relevant research and evidence, including the community needs assessment, with partners and community networks.	Met	78
Rehabilitation		Organization compliance status (Final Report)	National compliance rate * %
12.5	Following transition or discharge, the team contacts clients, families, or referral organizations to evaluate the effectiveness of the transition, and uses this information to improve its transition and end of service planning, as appropriate.	Unmet	68
Standards for Laboratory Analyses		Organization compliance status (Final Report)	National compliance rate * %
1.5	The laboratory follows a policy for identifying and handling urgent requests.	Met	92
CSA Reference: Z15189-03, 5.4.11			

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

Standards for Laboratory and Blood Services		Organization compliance status (Final Report)	National compliance rate * %
2.3	The laboratory annually reviews its contracts with service providers to confirm requirements are being met. CSA Reference: Z15189-03, 4.4.1, 4.4.5	Unmet	22
11.6	The laboratory protects the security and confidentiality of records. CSA Reference: Z902-04, 19.1.6, 19.1.7	Met	83
14.3	All work areas, including floors and walls, are clean and well-maintained. CSA Reference: Z15189-03, 5.2.10; Z902-04, 21.1.3, 21.2.2	Met	81
14.5	All staff members have access to hand washing procedures and facilities that are adequately supplied. CSA Reference: Z902-04, 21.1.3	Met	81
21.5	The safety officer audits the program annually and makes revisions, as needed.	Met	19
22.5	The laboratory annually reviews its risk-reduction strategies and all incidents, and makes changes to its policies or training activities.	Met	25
23.1	The laboratory regularly evaluates staff compliance with its safety program and safe personal behaviours. CSA Reference: Z902-04, 4.5.1.3	Met	36
25.3	The laboratory management delegates the key functions of the quality management system, and communicates all policies to staff. CSA Reference: Z15189-03, 4.1.5, 4.2.1, 4.2.4	Met	42
Substance Abuse and Problem Gambling Services		Organization compliance status (Final Report)	National compliance rate * %
5.7	Team members feel safe when performing their roles and responsibilities.	Met	83

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

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Surgical Care	Organization compliance status (Final Report)	National compliance rate * %
9.5 Prior to a procedure, the team provides the client with an opportunity to consent to organ donation.	Met	65

* Percentage of Accreditation Canada organizations surveyed from January 1 to December 31, 2008 that are in compliance with the specified high priority criteria.

3 Performance Measures (Instruments and Indicators)

As part of the accreditation process, organizations collect performance measurement data. These measures consist of both instruments and indicators, and are valuable components of evaluation and quality improvement.

This section compares the organization’s performance measurement data with national data submitted by Accreditation Canada organizations. It can be used by the organization for benchmarking or other purposes.

3.1 Instrument Results

Instruments are questionnaires completed by a representative sample of board members, clients, staff, leadership, or other stakeholders.

Governance Functioning Tool

The Governance Functioning Tool is an opportunity for governing body members to assess their internal structures and processes, provide their perceptions and opinions, and identify areas for improvement.

The organization’s governing body members completed the Governance Functioning Tool between February 13 and April 2, 2008. This table compares the results to national results obtained from January 1 to December 31, 2008.

Number of survey respondents = 9 respondents

Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
1 We actively recruit, recommend and/or select new members based on needs for particular skills.	43	88	0	0	57	12
2 We have explicit criteria to recruit and select new members.	25	80	0	0	75	20
3 Our renewal cycle is appropriately managed to ensure continuity on the governing body.	100	91	0	0	0	9
4 The composition of our governing body allows us to meet stakeholder and community needs.	89	95	0	0	11	5
5 The composition of our governing body reflects the diversity of the community served.	89	85	0	0	11	15
6 Clear written policies define term lengths and limits for individual members, as well as compensation (as applicable).	100	95	0	0	0	5

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Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
7 We regularly review, understand, and ensure compliance with applicable laws, legislation and regulations.	89	91	0	0	11	9
8 Governance policies and procedures that define our role and responsibilities are well-documented and consistently followed.	100	93	0	0	0	7
9 We review our own structure, committee practices, scope of authority and bylaws regularly.	63	85	0	0	38	15
10 Our committees have clearly-defined roles and responsibilities.	100	96	0	0	0	4
11 Our roles and responsibilities are clearly identified and distinguished from those delegated to the CEO and/or senior management. We do not become overly involved in management issues.	100	93	0	0	0	7
12 We each receive orientation that helps us to understand the organization and its issues, and supports high-quality decision-making.	100	89	0	0	0	11
13 Disagreements are viewed as a search for solutions rather than a “win/lose”.	100	93	0	0	0	7
14 Our meetings are held frequently enough to make sure we make timely decisions.	100	96	0	0	0	4
15 Individual members carry out their roles and responsibilities in between meetings, including committee work (as applicable).	100	97	0	0	0	3
16 Members come to meetings prepared to engage in meaningful discussion and thoughtful decision-making.	100	94	0	0	0	6
17 Our governance processes make sure that everyone participates in decision-making.	89	92	0	0	11	8
18 Individual members are actively involved in policy-making and strategic direction.	100	87	0	0	0	13
19 The composition of our governing body contributes to high governance and leadership performance.	100	92	0	0	0	8

Governance Structures and Processes	% Agree		% Neutral		% Disagree	
	Organization	National	Organization	National	Organization	National
20 Our governing body's dynamics enable group dialogue and discussion. Individual members ask for and listen to one another's ideas and input.	100	94	0	0	0	6
21 Ongoing education and professional development is encouraged.	100	90	0	0	0	10
22 Working relationships among individual members and committees are positive.	100	97	0	0	0	3
23 We have a process to set bylaws and corporate policies.	75	96	0	0	25	4
24 Our bylaws and corporate policies cover confidentiality and conflict of interest.	100	98	0	0	0	2
25 We formally evaluate our own performance on a regular basis.	86	72	0	0	14	28
26 We benchmark our performance against other similar organizations and/or national standards.	80	65	0	0	20	35
27 Contributions of individual members are reviewed regularly.	60	55	0	0	40	45
28 As a team, we regularly review how we function together and how our governance processes could be improved.	88	71	0	0	13	29
29 There is a process for improving individual effectiveness when non-performance is an issue.	60	54	0	0	40	46
30 We regularly identify areas for improvement and engage in our own quality improvement activities.	86	75	0	0	14	25
31 As a governing body, we annually release a formal statement of our achievements that is shared with the organization's staff as well as external partners and the community.	100	80	0	0	0	20
32 As individual members, we receive adequate feedback about our contribution to the governing body.	57	61	0	0	43	39

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Patient Safety Culture Survey

The Patient Safety Culture Tool asks staff to provide their perceptions about the culture of patient safety with the organization. It identifies areas of strength, areas for improvement, and mechanisms to monitor changes.

The organization's staff completed the Patient Safety Culture Tool between January 16 and April 15, 2008. This table compares the results to national results obtained from January 1 to December 31, 2008.

Number of survey respondents = 390 respondents

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
1 Patient safety decisions are made at the proper level by the most qualified people	6	11	11	14	83	75
2 Good communication now exists up the chain of command regarding patient safety issues	10	16	15	17	75	66
3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	89	79	4	11	7	9
4 Senior management has a clear picture of the risks associated with patient care	13	20	21	24	66	56
5 My department takes the time to identify and assess risks to patients	5	8	7	11	88	81
6 My department does a good job of managing risks to ensure patient safety	5	6	6	10	90	84
7 Senior management provide a climate that promotes patient safety	8	13	17	20	75	67
8 Asking for help is a sign of incompetence	96	93	3	3	2	4
9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	97	94	1	3	2	3
10 Telling others about my mistakes is embarrassing	71	67	8	12	21	21
11 I am less effective at work when I am fatigued	9	11	8	9	83	80
12 Senior management considers patient safety when program changes are discussed	8	13	27	30	65	57
13 Personal problems can adversely affect my performance	30	32	17	17	53	51

A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
14 I will suffer negative consequences if I report a patient safety problem	94	86	4	9	2	5
15 If people find out that I made a mistake, I will be disciplined	61	56	25	24	14	20
16 I am rewarded for taking quick action to identify a serious mistake	29	37	40	32	31	31
17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care	51	42	23	24	25	34
18 I have enough time to complete patient care tasks safely	16	30	21	20	63	50
19 Clinicians who make serious mistakes are usually punished	50	46	38	37	12	16
20 In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	72	54	11	19	17	27
21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	22	34	22	20	56	46
22 I have made significant errors in my work that I attribute to my own fatigue	86	80	7	12	7	9
23 I believe that health care error constitutes a real and significant risk to the patients that we treat	16	14	17	15	67	71
24 I believe health care errors often go unreported	26	26	22	24	52	50
25 My organization effectively balances the need for patient safety and the need for productivity	13	20	22	27	65	53
26 I work in an environment where patient safety is high priority	7	10	8	13	85	77
27 I believe that most serious occurrences happen as a result of multiple small failures, and are not attributable to one individual's actions	17	14	35	24	48	62

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A. Patient Safety: Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
28 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	18	26	25	23	58	52
29 My supervisor/manager seriously considers staff suggestions for improving patient safety	7	15	15	18	78	67
30 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	83	69	12	17	5	14
31 My supervisor/manager overlooks patient safety problems that happen over and over	82	74	8	14	10	11

B. These questions are about your perceptions of overall patient safety	% Good/ Excellent		% Acceptable		% Poor/ Failing	
	Organization	National	Organization	National	Organization	National
32 Please give your unit an overall grade on patient safety	74	66	23	30	3	5
33 Please give the organization an overall grade on patient safety	64	53	32	39	4	8

C. These questions are about what happens after a Major Event	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
34 Individuals involved in major events have a quick and easy way to capture/report what happened	4	9	19	21	77	71
35 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	9	12	17	19	75	69
36 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	9	11	35	32	57	56

C. These questions are about what happens after a Major Event	% Disagree		% Neutral		% Agree	
	Organization	National	Organization	National	Organization	National
37 Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	18	16	36	34	46	50
38 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	16	17	41	37	43	45
39 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	18	17	19	19	63	64
40 There is a pharmacist who is a full member of the patient care team on the unit (e.g. they participate in rounds and are accessible to people on the unit)	46	30	25	25	29	45

D. These questions ask about some of your own actions	% Seldom/ Never		% Occasionally		% Often/ Always	
	Organization	National	Organization	National	Organization	National
41 If I see someone engaging in unsafe care practice, I confront them	10	9	28	25	62	66
42 I take shortcuts which involve little or no risk to patient safety	83	77	14	17	3	6
43 I talk about patient safety issues with fellow workers	10	10	33	31	58	59
44 I engage in unsafe care practice in order to get the job done	99	95	1	3	1	2
45 I report the errors I make	2	3	5	9	93	89
46 I learn from errors made by my colleagues	4	3	20	15	76	82

3.2 *Indicator Results*

Indicators collect data related to important aspects of patient safety and quality care. The tables in this section show the indicator data that has been submitted by the organization.

Medication Reconciliation at Admission

Transition points in the care continuum are particularly prone to risk, and the communication of medication information has been identified as a priority area for improving the safety of healthcare service delivery. This performance measure will provide a practical guide for organizations as medication reconciliation is conducted more widely throughout the organization.

Medication Reconciliation at Admission -					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)		Notes received from the Organization
GREEN	St. Martha's Regional Hospital (Rehabilitation)	District Medical (Rehabilitation) Team	01/10/2008 31/12/2008	100	A pharmacist was dedicated to the unit. All patients have a med rec completed on admission. Some may have been completed in the ER but are verified by the pharmacist on the unit.
GREEN	St. Martha's Regional Hospital (Rehabilitation)	District Medical (Rehabilitation) Team	01/01/2009 31/03/2009	100	By the end of March we were at 100%. During the months March/April/May we are running at a 100% completion rate on admission. This is done using a manual recording process to ensure all new admissions are done.
RED	St. Martha's Regional Hospital (Medicine Services)	District Medical Team	01/07/2007 30/09/2007	38	Data is only for the month on September and for the Progressive Care unit only.
RED	St. Martha's Regional Hospital (Medicine Services)	District Medical Team	01/10/2007 31/12/2007	38	Pharmacy Department was concentrating their efforts in PCU at this time. Staffing compliment allowed for only one pharmacist on clinical duty.

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Medication Reconciliation at Admission -					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)		Notes received from the Organization
RED	St. Martha's Regional Hospital (Medicine Services)	District Medical Team	01/01/2008 31/03/2008	38	Pharmacy Department was concentrating their efforts in PCU at this time. Staffing compliment allowed for only one pharmacist on clinical duty.
RED	St. Martha's Regional Hospital (Medicine Services)	District Medical Team	01/04/2008 30/06/2008	15	Pharmacy Department was concentrating their efforts in PCU at this time. Staffing compliment allowed for only one pharmacist on clinical duty at a limited basis during this time.
RED	St. Martha's Regional Hospital (Medicine Services)	District Medical Team	01/07/2008 30/09/2008	30	Pharmacy Department was concentrating their efforts in PCU at this time. Staffing compliment allowed for only one pharmacist on clinical duty. Vacations also limited time allowance.
RED	St. Martha's Regional Hospital (Medicine Services)	District Medical Team	01/10/2008 31/12/2008	20	The numerator does not include those done as pre-admission orders in ER. This is a manual recording process that needs to be established.

Medication Reconciliation at Admission -					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)		Notes received from the Organization
GREEN	St. Martha's Regional Hospital (Medicine Services)	District Medical Team	01/01/2009 31/03/2009	100	Med Surg have been completed at 100% via a manual process by the pharmacist working on the unit. Many patients on PCU have been completed. There data is "stuck" in PCS without a reporting feature available at this time to get the information out.

Threshold for Flags

RED: < 75/100
 YELLOW: >= 75/100 AND < 90/100
 GREEN: >= 90/100

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Health Care Associated Infection Rates

Health care associated C. difficile and MRSA infections represent a significant risk to the individuals receiving care and are a substantial resource burden to organizations and the health care system. Measuring infection control performance measures has the additional benefit of informing and shaping the staff's view of safety. Evidence suggests that as staff become more aware of infection control rates and the evidence related to infection control there is a change in behaviour to reduce the perceived risk.

Health Care Associated Infection Rates - C. difficile					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days	Notes received from the Organization
GREEN	Eastern Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	Eastern Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	Eastern Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0	
GREEN	Eastern Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/01/2007 31/03/2007	0	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/04/2007 30/06/2007	4	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/07/2007 30/09/2007	3.2	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/10/2007 31/12/2007	3.7	

Health Care Associated Infection Rates - C. difficile					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days	Notes received from the Organization
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/01/2008 31/03/2008	1.8	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	Public Health Agency of Canada and the Communicable disease Report (April 1999) , Infection rate 6 per 1000 admission
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0.89	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0.44	Historically rates were collected and reported per 1000 admission. This report reflects a denominator of actual patient days
GREEN	Guysborough Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	Guysborough Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	Guysborough Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0	

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Health Care Associated Infection Rates - C. difficile					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days	Notes received from the Organization
GREEN	Guysborough Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	1.2	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0.67	
GREEN	St. Mary's Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	St. Mary's Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	St. Mary's Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0	

Health Care Associated Infection Rates - C. difficile					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection / 1000 patient days	Notes received from the Organization
GREEN	St. Mary's Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0	
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0.46	
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0	

Threshold for Flags

RED: > 8/1000
 YELLOW: >= 6/1000 AND < 8/1000
 GREEN: <= 6/1000

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Health Care Associated Infection Rates - MRSA					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days	Notes received from the Organization
GREEN	Eastern Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	Eastern Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	Eastern Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	2.1	
GREEN	Eastern Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/01/2007 31/03/2007	5	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/04/2007 30/06/2007	2	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/07/2007 30/09/2007	4.3	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/10/2007 31/12/2007	2.8	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/01/2008 31/03/2008	1.8	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	

Health Care Associated Infection Rates - MRSA					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days	Notes received from the Organization
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0.18	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0.53	
GREEN	Guysborough Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	Guysborough Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	Guysborough Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0	
GREEN	Guysborough Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	

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Health Care Associated Infection Rates - MRSA					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days	Notes received from the Organization
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0.81	
GREEN	St. Mary's Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	St. Mary's Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	
GREEN	St. Mary's Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0	
GREEN	St. Mary's Memorial Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0	
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	0	
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	0	

Health Care Associated Infection Rates - MRSA					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	# cases of infection + colonization / 1000 patient days	Notes received from the Organization
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	0.46	
GREEN	Strait Richmond Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	0	

Threshold for Flags

RED: > 8/1000
 YELLOW: >= 6/1000 AND < 8/1000
 GREEN: <= 6/1000

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Surgical Site Infection

Timeliness of administering antibiotic prophylaxis is a universal process measure applicable to many surgical procedures and with widely recognized benefits in reducing post-surgical infections in selected high risk procedures.

Surgical Site Infection - Hysterectomy					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics	Notes received from the Organization
YELLOW	GASHA (Infection Prevention and Control)	District Infection Control	01/04/2006 30/06/2006	81	
YELLOW	GASHA (Infection Prevention and Control)	District Infection Control	01/07/2006 30/09/2006	83	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/10/2006 31/12/2006	94	
YELLOW	GASHA (Infection Prevention and Control)	District Infection Control	01/01/2007 31/03/2007	87	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/04/2007 30/06/2007	100	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/07/2007 30/09/2007	100	
YELLOW	GASHA (Infection Prevention and Control)	District Infection Control	01/10/2007 31/12/2007	83	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/01/2008 31/03/2008	100	
GREEN	GASHA (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	100	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/01/2008 31/03/2008	100	

Surgical Site Infection - Hysterectomy					
Flag	Location	Team Name (standard section)	Dates (dd/mm/yyyy)	% timely administrations of antibiotics	Notes received from the Organization
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/04/2008 30/06/2008	100	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/07/2008 30/09/2008	100	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/10/2008 31/12/2008	100	
GREEN	St. Martha's Regional Hospital (Infection Prevention and Control)	District Infection Control	01/01/2009 31/03/2009	100	

Threshold for Flags

RED: < 80/100
 YELLOW: >= 80/100 AND < 90/100
 GREEN: >= 90/100

4 Follow Up Required

The organization has earned Accreditation. To ensure ongoing quality improvement, the organization should show progress on the unmet criteria identified in this Report before the next on-site survey.

Evidence of action taken should be submitted through the Organization Portal.

Closing Thoughts from the President and CEO

Congratulations on reaching this important milestone on your accreditation journey. We salute and celebrate your achievements, and look forward to continuing to work with you as accreditation increasingly strengthens and supports your quality improvement and patient safety initiatives.

Your ongoing efforts to incorporate Accreditation Canada standards and tools into your programs and services have been, and will continue to be, of great benefit to your organization, your staff, the people you serve, and your community. Please contact your Accreditation Specialist, or use the Organization Portal, if you have questions or require additional information in this process.

Thank you for your commitment and dedication to improving quality health care through accreditation.

Wendy Nicklin
President and CEO
Accreditation Canada

Appendix A - Accreditation Decision Guidelines

Under Qmentum, the two most important factors in determining an organization's accreditation status are the degree to which it meets high priority criteria and Required Organizational Practices (ROPs).

- High priority criteria: criteria focused on priorities such as safety, ethics, and quality improvement, and deemed sufficiently important by Accreditation Canada that not meeting them usually results in a request to the organization for further information and clarification.
- ROPs: practices focused predominately on patient safety, and deemed sufficiently important by Accreditation Canada that not meeting them results in a request to the organization for further information and clarification.

Based on the above, and after review of all findings, Accreditation Canada issues one of the following accreditation decisions.

- 1 **Accreditation** is awarded, with resurvey in three years, under the following circumstances:
 - (a) 10% or less of high priority criteria unmet per standard section
AND
 - (b) satisfactory compliance with all of the Required Organizational Practices.
- 2 **Accreditation with Condition (Report, Focused Visit, or both)*** is awarded under the following circumstances:
 - (a) more than 10% and less than 30% of high priority criteria unmet per standard section
OR
 - (b) unsatisfactory compliance with any one of the Required Organizational Practices.

*The specific condition and timelines are determined by Accreditation Canada based on the nature of the findings.

To maintain accreditation, organizations that earn Accreditation with Condition in their Final Report must comply with the requirements of the condition by the dates specified in the Final Report. If satisfactory follow up is not submitted by the specified dates, a one-time extension of six months may be granted, based on surveyor input and proof of progress. Failure to comply within the maximum allotted time may result in loss of accreditation, at Accreditation Canada's discretion.

- 3 **Non Accreditation** is issued under the following circumstance:
 - (a) more than 30% of high priority criteria unmet per standard section
OR
 - (b) Unsatisfactory compliance with all of the Required Organizational Practices.